

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health Care Finance**



**Memo**

**Re:** Center for Medicare and Medicaid Innovation RFI on State Innovation Model Concepts

**Date:** January 9, 2017

**From:** Claudia Schlosberg, Senior Deputy/Medicaid Director

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The District of Columbia has an ongoing commitment to increasing the availability and provision of quality home and community-based services (HCBS) for the District’s Medicaid beneficiaries, with the goal of ensuring that eligible Medicaid beneficiaries safely receive supportive services in a home and community-based setting (versus in institutional settings).

The District maintains two 1915(c) waivers; one focused on individuals with intellectual and developmental disabilities (“IDD Waiver”) and one focused on elders (age 64 and above) and those with physical disabilities (“EPD Waiver”). DC’s commitment to HCBS is borne out by the fact that in FY2015, the District spent \$402,040,000 in total costs for HCBS, as compared to \$327,927,000 in total costs for intermediate care facilities for persons with developmental disabilities and nursing homes combined.

As the District continues its efforts to ensure eligible Medicaid recipients have access to quality home and community based services, DC’s Department of Health Care Finance (DHCF) appreciates the opportunity to communicate those specific issues CMS can impact to accelerate DC’s progress.

Chief among these is the recognition by CMS that HCBS waivers take an extraordinary amount of work on the behalf of states (with regards to both development and implementation). It is to CMS’ benefit to afford states maximum flexibility in administering HCBS. Particularly, this is of relevance when discussing the potential for CMS to implement federal requirements for personal care workers or to conduct rate review processes focused on home care worker wages, for instance. This flexibility is also important to the administration of services for people who are transitioning between long term care settings and their communities. At present, CMS does not offer states the full flexibility necessary to prepare HCBS settings and supports for people who choose to transition from institutional settings such that these settings and supports are ready to start on the day of discharge from a facility.

DC encourages CMS to treat the District as a partner in administration of its waivers, and to support as much autonomy and independence as possible in reaching the joint goals of accelerating progress of access to HCBS and achieving an appropriate balance of HCBS and institutional services.

Beyond this overarching recommendation, DC has added feedback on the following specific areas:

- *What are the additional reforms that CMS can take to accelerate the progress of access to HCBS and achieve an appropriate balance of HCBS and institutional services in the Medicaid LTSS system to meet the needs and preferences of beneficiaries?*
  - Ensuring parity between HCBS and institutional policies
    - Spend-down
    - Payment for room and board
  - Providing case management while institutionalized
  - Continuing waiver services for those experiencing homelessness
  - Exploring value based purchasing
- *What actions can CMS take, independently or in partnership with states and stakeholders, to ensure quality of HCBS and beneficiary health and safety?*
  - Understanding the impact of DOL's Fair Labor Standards Act
- *What program integrity safeguards should states have in place to ensure beneficiary safety and reduce fraud, waste, and abuse in HCBS?*
  - Person-centered thinking: Balancing dignity of risk against ensuring safety & welfare
  - Reducing fraud, waste, and abuse
- *What specific steps could CMS take to strengthen the HCBS home care workforce?*
  - Enhancing family and caregiver supports

### **Ensuring Parity Between HCBS and Institutional Policies: Spend-down**

The District looks to CMS to provide options to remedy the disparate impact of spend down rules on those in waivers versus those in nursing homes. An individual who is over the income limit for institutional care who lives in a nursing home can use projected nursing facility costs to spend down to DC's medically needy income level (MNIL). Since the individual is able to use projected costs while institutionalized, individuals who are over the income limit can generally meet spend down and will qualify for Medicaid. But, an individual who is trying to remain in the community cannot use projected waiver expenses and must spend down to the MNIL, often leaving them with insufficient funds to remain in the community, especially in a very high cost area such as Washington, DC.

In July of 2015, CMS told DHCF that projected waiver expenses could not be applied to spend-down for HCBS applicants with excess income. Instead, CMS proposed two options. DC could either allow HCBS waiver applicants/recipients to spend-down excess income to the MNIL or DC could evaluate HCBS waiver applicants under a hypothetical categorically needy covered group. Under this option, if the individual is over income, his/her income could be tested against the state's average cost of nursing facility care. If the individual's countable income is below the average nursing home Medicaid reimbursement rate, then the individual could be considered hypothetically eligible for HCBS waiver services under 42 CFR 435.217. Unfortunately, the District cannot adopt this standard because it has the effect of raising eligibility standards for the waiver, where using the average cost of nursing home reimbursement (i.e., \$9701.70/month) means an individual with income of up to \$116,000 per year would be eligible for waiver services.

In October of 2015, DHCF asked CMS if it was possible to use a percentage of the average nursing home Medicaid reimbursement rate instead of the average cost. CMS again demurred, clarifying that the income standard must be tied to the District's nursing home reimbursement rate (which could be the lowest rate). In DC, the lowest nursing home reimbursement rate is

\$7,062/month, which would more than triple the income eligibility level, therein providing Medicaid HCBS services to individuals with incomes of over \$84,000 per year and likely displacing DC's poorest and most vulnerable beneficiaries.

In July of 2016, DC asked CMS for guidance on the option of increasing the MNIL for HCBS applicants who are over income. CMS explained that the MNIL is connected to the State's 1996 AFDC payment standard for a household of two, and that using the proposed approach would likely exceed the limit for the federal financial participation (FFP) set in 42 CFR 435.1007.

CMS was amenable to DC applying a monthly income disregard equaling the difference between the MNIL and 300% of the SSI income standard, which would effectively increase DC's the MNIL from \$630.56 to \$2,199. During an August 2016 conference call, CMS told the District that using this approach would mean that any individual with income equaling or below the disregard plus the MNIL would be medically needy eligible without a spend down. CMS further clarified that if DC elected to provide a disregard at the medically needy level, the District would need to apply the same disregard to all aged, blind, and disabled (ABD) beneficiaries residing in the community, not just those applying for long term care. Again, this was considered cost prohibitive, as it would significantly increase the Medicaid enrollment for community ABD individuals. It also doesn't make sense since DC can only apply the 300% of SSI standard to individuals who meet nursing facility level of care and are seeking nursing home or waiver services.

In the end, the District was left without a workable solution to address this inherent institutional bias in the Medicaid program. DHCF is asking CMS to use its authority to allow establishment of an income disregard for people with a nursing facility level of care who are applying for the waiver that is equal to the average cost of maintaining a home in the community. This would allow DHCF to treat HCBS and nursing home applicants/recipients equally without substantially increasing costs of the Medicaid program. Alternatively, DC could consider the option discussed in August but only by limiting this option to beneficiaries with a nursing facility level of care who are eligible to apply for waiver services. Allowing an HCBS waiver beneficiary to use projected waiver costs would also help keep people integrated in their community.

DHCF is anxious to find a workable solution for people who want to remain in the community but are "forced" into nursing homes because they are slightly over income and cannot spend down to the MNIL since it leaves them with insufficient income to pay for rent, utilities and food. Certainly, the District is interested in partnering with CMS to promote community integration while eliminating this vestige of institutional bias.

### **Ensuring Parity Between HCBS and Institutional Policies: *Payment for Room and Board***

In addition to the disparate application of spend-down rules for HCBS versus institutional care, DHCF sees similar disparity in its ability to cover the cost of room and board via institutional care but not in home or community based settings. For the past decade, the District of Columbia has experienced ever increasing costs in housing, such that DC is now routinely ranked one of the most expensive cities in the United States. This makes it particularly difficult for Medicaid beneficiaries to find and maintain access to affordable housing, even with major District initiatives such as enhancement of DC's first-time homebuyer programs and a \$100 million investment supporting 19 projects that will create or preserve more than 1,200 affordable housing units. The cost of housing

in the District is acutely felt by waiver beneficiaries, in particular, for two major reasons. One relates to the discussion above of the inability to meet DC's MNIL while still being able to pay for rent, utilities and food. The other relates to the challenges of securing housing for individuals seeking to transition out of institutional care back into the community.

When individuals are ready to return to their communities from an institution, the biggest hurdle to that return is securing housing that is both affordable and accessible. The District has various funding mechanisms (Medicaid and otherwise) available to individuals allowing them to make environmental adaptations to their home that are necessary to ensure the health, safety, and welfare of the individual and/or increase independence in the home and without which the individual would be at risk of institutionalization. However, it is often all but impossible to locate affordable housing. This serves as a barrier even for individuals with Housing Choice Vouchers, a federal program administered by the DC Housing Authority that provides rental assistance to eligible families or individuals who find their own housing as long it meets the requirements of the program. In the current market, properties have become increasingly selective, often pricing out low-income residents in the leasing application process who disproportionately experience poor credit and criminal history. Because of this challenge, people are in effect "trapped" in institutional settings even when they seek to integrate back into their communities. Even payment of at least an individual's first month's rent under the 1915 (c) (as an allowable transition expense) would greatly support timely transitions.

While the District appreciates CMS' guidance on how Medicaid dollars can be used for certain housing-related activities, as detailed in the June 2015 State Medicaid Director letter, this fails to resolve the fundamental issue that nursing home residents on Medicaid are unable to afford housing in the District of Columbia. DHCF is confident there is a way by which CMS could partner with states to cover some portion of these housing costs, maintain a cost savings relative to nursing home services, and support the individual in returning to his/her community. To the extent that room and board remain a prohibited cost, CMS recognition of and strategies to address housing barriers is essential, including those supports available to help individuals establish and maintain community residences.

### **Providing Case Management while Institutionalized**

The District seeks guidance from CMS on how best to connect individuals in institutions with much needed waiver-related case management while seeking to move back into their communities. DC faces this issue in two scenarios, the first of which is when individuals in an institution seek to enroll in a waiver. These individuals need the support of a waiver case manager to help with ensuring services are in place upon entry back to their home/community, but CMS rules do not permit DHCF to pay for case management services for individuals transitioning back into the community.

This issue is also felt for those waiver-enrolled individuals returning to their communities after time in an institution. The District allows people to remain enrolled in the EPD waiver for up to 120 days of institutional care and up to 180 days for IDD waiver participants, and believes it crucial that case managers stay connected with individuals during that time span to actively engage in the discharge planning process and to ensure a seamless transition back to their homes. Although DC has secured CMS approval for "Transitional Case Management Services," CMS rules do not permit

payment for waiver case management services while an individual is in an institution. Thus, case managers providing Transitional Case Management Services will not be able to bill or receive payment for services until the beneficiary actually returns to the community. This means that a case manager who follows their client into an institution to ensure an orderly return to the community may have to wait four months or longer to be paid for their work. This payment arrangement is less than ideal and ultimately may undermine our efforts to promote continuity of care and seamless transitions back to the community. We urge CMS to consider providing states with the flexibility to compensate waiver case managers when a waiver beneficiary is temporarily institutionalized.

The District realizes that some of the responsibility for appropriate discharge to the community rests with the institution's discharge planners, especially given that DC law mandates that discharge planning begin upon an individual's admission to a nursing facility. While there are efforts to strengthen this service in the District, it is also important to develop mechanisms to best harness the strength and expertise of the waiver case managers as it relates to transitions to home and community based settings. As the Money Follows the Person Demonstration and its dedicated funding for transition coordination comes to an end, addressing this challenge presents with increasing urgency.

### **Continuing Waiver Services for Those Experiencing Homelessness**

As a highly urban area experiencing an ever-increasing cost of living and unprecedented development, DC faces an extraordinary burden of individuals facing homelessness. In fact, in a recent publication by the Community Partnership for the Prevention of Homelessness, as of January 2015, "On any given night, there are 8,350 people homeless persons in the District of Columbia." Of these, 318 were living on the street, 6259 resided in emergency shelters, and 1773 were living in transitional housing. This equates to a 16% increase in homelessness since 2014. Because of high need (as indicated by a long waiting list) and low turnover of housing subsidies, the DC Housing Authority stopped accepting new applications for housing subsidies in 2013. There is little movement on the existing waiting list with the exception of a small number of preference groups including veterans, people transitioning from long term care facilities to the community, and people with serious and persistent mental health diagnoses. Even for these groups, the supply of housing subsidies does not meet the demand.

Some District residents can spend months or even years in transitional housing. Some waiver enrollees may lose their housing, and temporarily seeking lodging in an emergency shelter. Given that a number of waiver enrollees cycle through homelessness, DHCF is seeking guidance on how best to serve these people. Preferably, these individuals would continue receiving HCBS in emergency shelters or transitional housing while working towards securing permanent housing with the supports of waiver case managers.

Assuming CMS allows this interpretation of "home and community-based," DC would be unable to hold emergency shelters and transitional housing to the standards published in CMS' January 2014 HCBS Settings Rule. If CMS mandates that emergency shelters and transitional housing used by waiver enrollees must meet the settings requirement, then the District would necessarily have to discharge those individuals experiencing temporary homelessness from the waiver. Instead, given their temporary nature, we recommend that CMS treat these settings similar to respite settings and explicitly exempt them from the requirements of the HCBS Settings Rule.

## **Exploring Value Based Purchasing**

The District encourage CMS to think more broadly about value based purchasing strategies that can be used for long-term care services and supports that would promote innovative service delivery and high-quality care. DHCF intends to move away from billing and paying for units of service and toward a payment method that promotes whole person, integrated care with a focus on outcomes. Much of the national discussion on value within the LTC space is focused on managed long term care, but for various reasons, this is not a realistic option in the District.

## **Understanding the Impact of DOL's Fair Labor Standards Act**

In May 2016, the Department of Labor published its final Fair Labor Standards Act (FLSA) rule, which updated the minimum wage and overtime standards. In particular, DOL goes to some length explaining the meaning and applicability of "joint employment" under the FLSA. As CMS is aware, this has had major impact upon states' ability to implement participant directed service programs, and the District is no exception. As part of this RFI, CMS posed the following questions, for all of which the FLSA has some bearing:

- What are the benefits and consequences of implementing standard federal requirements for personal care workers in agency-directed and/or self-directed models of care?
- What other program integrity safeguards should be put in place, either as an alternative to, or in addition to, the controls recommended by OIG, for agency-directed PCS? For self-directed PCS?
- Are the program integrity safeguards that are appropriate for agency-directed personal care services also appropriate for self-directed personal care services?

With regards to benefits and consequences of implementing federal requirements for personal care workers in self-directed models of care, states deemed joint employers by DOL experience a substantial budgetary impact as a result, specifically with regards to payment incurred for overtime and travel time. DC is interested in opportunities for assistance that can off-set some portion of this added cost if, in fact, DC were determined to be a joint employer as it continues expanding its participant directed services.

With regards to program integrity safeguards, DHCF seeks guidance from CMS as it struggles with how best the District can monitor health and safety of individuals participating in self-directed care without being determined joint employers by DOL.

## **Person Centered Thinking: Balancing Dignity of Risk against Ensuring Safety & Welfare**

The District recognizes and applauds CMS commitment to person-centered thinking and urges continued consistency and growth in this area, including ongoing technical support and partnership with states to provide more guidance on expectations related to person-centered planning and service delivery to ensure a continued focus on people who receive supports. With CMS' worthwhile push towards person-centered care and away from a medical model of care, the District has been actively engaging through its No Wrong Door initiative to train a vast array of individuals on person-centered thinking skills and tools. Certainly, DC is defining person-centered planning as that which is based on individual needs, goals, and preferences that includes HCBS, per CMS

guidance. Even so, an issue that continues to arise is how best to balance an individual's "dignity of risk" against the District's need to ensure the health and safety of waiver enrollees, given that this is one of the mandated quality assurances for 1915(c) waivers.

Per the Disability Practice Institute, "dignity of risk" is defined as "respecting each individual's autonomy and self-determination (or 'dignity') to make choices for himself or herself. The concept means that all adults have the right to make their own choices about their health and care, even if healthcare professionals believe these choices endanger the person's health or longevity." Given that person-centered principles encourage the individual to develop a plan specific to his/her identified needs and goals, which may or may not include areas of most risk to that individual, the District is seeking guidance from CMS on how this comports with the DHCF's requirement to assure health and welfare. The District is also struggling with how to properly monitor person-centered plans and hold providers accountable for their requirements to ensure the health and welfare of their waiver clients, while using person-centered thinking to allow people to make informed choices and experience the dignity of risk.

### **Reducing Fraud, Waste & Abuse**

Given the District's history over the past decade of oversight challenges associated with fraud and abuse in the HCBS arena, DHCF has been engaged in myriad activities to ensure proper utilization of these services. In particular, the District has successfully implemented such measures as requiring criminal background checks that disclose criminal records for the seven prior years, registering all PCS attendants and assigning them unique numbers for purposes of tracking claims, and maintaining a state-administered home care registry via DHCF's sister agency, the DC Department of Health.

DHCF strongly agrees that, at a minimum, States should have claims tracking and data mining capabilities to identify aberrant patterns of care delivery and billing; a State-administered HHA/PCA (personal care aide) registry; requirements for both agency-directed and self-directed caregivers to obtain NPI enumeration; and to include the identifier on claims or invoices for payment under Medicaid. The consequences of not implementing safeguards and oversight became evident when, in 2014, nearly half of the home health care providers in the system were suspended from Medicaid participation due to widespread fraud. Not only was this a misappropriation of large sums of Medicaid dollars, it created an enormous disruption to DC Medicaid recipients.

With regards to other program integrity safeguards, DHCF believes an important support for the utilization review and auditing of agency-directed PCA services arises from the ability to track the PCA as an individual provider of care. The ability to isolate the rendering PCA by NPI number allows payments to be reconciled with timesheets by beneficiary and validates the number of hours billed by the agency. Additionally, it is important that edits in the claims system detect and prevent PCAs from billing through multiple agencies in excess of the number of hours in a day. Caregivers who function as "employees" of self-directed program participants do not bill Medicaid directly. This presents a challenge to detect fraud or abuse. The program participants schedule and verify the hours billed and directly control the funds disbursed to the caregivers. Flags for Program Integrity would be instances when one self-directed caregiver is providing services for two program participants (i.e., a husband and wife) living in the same residence. There is a probability that

overlapping hours (such as meal preparation) would be billed separately to both individuals, which would be a misuse of Medicaid dollars.

### **Enhancing Family and Caregiver Supports**

The District has endeavored to develop a more robust package of supports for waiver enrollees' caregivers, understanding that supporting caregivers is what allows many individuals to remain in their communities and stay connected with family, friends, and their greater community. As documented in the "Building a National Agenda for Supporting Families with a Member with Intellectual and Developmental Disabilities," from the Wingspread Conference Center in March 2011, there are three strategies by which caregivers ought to be supported:

- "Information, education, and training on best practices within and outside of disability services, accessing and coordinating community supports, and advocacy and leadership skills.
- "Connecting and networking a family with other families, including parents with disabilities, self-advocates and siblings, grandparents and other guardians for mutual support.
- "Services and goods that are specific to the daily support and/or care-giving role for the person, such as planning for current and future needs, respite, crisis prevention and intervention, systems navigation, home modifications, and health/ wellness management."

To date, though, the main support mechanism available through the waiver is respite, which is helpful but fails to address the larger set of activities necessary to amplify the strengths and capabilities of these caregivers. DC encourages CMS to think more broadly about caregiver supports and what could be offered through an HCBS waiver service and/or incorporated into administrative support of HCBS programs; for example, peer-to-peer supports for family members that would help them navigate public and private supports, as well as connecting them with other family members who are experiencing similar caregiving challenges.