STATEMENT OF

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ON

ASISSTIED LIVING

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Senator Nelson, Chairman Kohl, Ranking Member Corker, and members of the Committee, thank you for the invitation to discuss how the Centers for Medicare & Medicaid Services (CMS) can support States in offering the kinds of long-term care options for Medicaid beneficiaries that promote independence and choice, and assure that they have the opportunity to live in and fully participate in their communities.

Background

For most individuals, long-term care is provided by family members and friends who receive no payment for their services. Others turn to professional assistance, ranging in degree from a home health aide who visits several times a week in their own homes to assist with meal preparation and household chores, to adult day care, to an assisted living facility, or, for those in need of 24-hour nursing care, to a nursing home. For non-elderly individuals with disabilities, long-term services and supports may include occasional or ongoing support staff assistance with activities of daily living, employment related or other day supports, group homes, adult foster care, caregiver respite options, and intermediate care facilities for individuals with intellectual disabilities.

Not all Americans who need long-term services and supports have family members and friends who are able to provide the necessary care. Medicare, which is not a long-term care program, is not a source of primary support. Medicaid, which can provide a broad array of long-term services and supports for eligible individuals who need these supports, has become an indispensable resource for those with long-term care needs who are unable to pay for the full cost of services. Medicaid is the largest purchaser of long-term services and supports in the nation, paying about 62 percent of the $203.2 billion spent on long-term care services in fiscal year 2009. Of the total amount Medicaid spent on long-term services and supports in 2009, about 45 percent was spent on home and community based services (HCBS) and 55 percent on institutional care. In comparison, only about 24 percent of Medicaid long-term care spending was directed towards home and community based services in 1997.[1]

[1] http://www.nhpf.org/library/the-basics/Basics_LongTermServicesSupports_03-15-11.pdf

As you know, Medicaid is a shared partnership between the Federal Government and the States. The Federal Government provides financial matching payments to the States, conditioned on each State designing and running its own program consistent with the Federal statute. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to meet the needs of their beneficiaries within their unique political, budgetary, and economic environments. As a result, there is considerable variation among the 50 States in eligibility, services, and reimbursement rates to providers and health plans. States are responsible to design the scope of their benefit within Federal standards, enroll beneficiaries, license and contract with providers, set reimbursement rates, negotiate managed care contracts, and provide oversight of access and quality.

State-designed Medicaid programs of long-term services and supports offer services in a variety of settings, delivered by a variety of providers, to individuals with diverse needs. Individuals in need of this type of care may be frail elderly Americans or younger Americans with significant physical, intellectual, developmental, or mental disabilities. CMS seeks to ensure that all long-term care is person-centered, appropriate for each individual's unique physical and social needs, and allows aging-in-place when appropriate.

State Flexibility Regarding Assisted Living Facilities

The term "assisted living facilities" usually refers to residential housing facilities that provide individuals with personal care and other supportive services to assist with the activities of daily living, as well as social and recreational programming and medication assistance. Depending on State licensure laws, some assisted living facilities may even provide 24-hour nurse access on-site or have a nurse on call. Generally, all provide less intensive 24-hour services designed to ensure residents' supervision and security.

CMS does not define what qualifies as an assisted living facility, nor is assisted living defined consistently among the States. Depending on the State, assisted living facilities may take the form of group homes, adult day or foster care, or senior living communities. Assisted living facilities therefore can vary in terms of the population served (residents may include elderly individuals with disabilities or a need for assistance in activities of daily living, or younger persons with cognitive,

behavioral health, or physical disabilities), size (a 4-person group home or a large complex with many apartments or living units), and payer mix (some facilities have mostly private pay residents, while other may serve large percentages of individuals with Medicaid coverage).

States also have significant discretion regarding the types of home and community-based long-term services and supports, such as "assisted living" supportive services, that they provide to Medicaid beneficiaries. Unlike nursing home care, which States are required to provide under Federal Medicaid law, State Medicaid programs are not required to cover services offered at assisted living facilities, even for residents who are otherwise covered by Medicaid. Many States choose to reimburse assisted living facilities for services that assist individuals in the activities of daily living to provide a community-based alternative to institutional care for individuals who prefer to delay or avoid nursing home care, but can no longer remain in their own private homes.

Again in contrast to nursing home services, Medicaid may not cover the cost of "room and board" in any assisted living facility or other community-based residential setting; Medicaid only provides for this type of cost in statutorily defined institutional settings (e.g., nursing homes, hospitals, and intermediate care facilities for persons with intellectual/developmental disabilities).

States can cover HCBS in assisted living settings in several ways. One option is to provide services like personal care under section 1915(c) of the Social Security Act, which authorizes the Secretary of Health and Human Services (HHS) to waive certain Medicaid statutory requirements so that a State may offer HCBS to State-specified target group(s) of Medicaid beneficiaries. In addition, States may use HCBS State plan authorities, like the 1915(i) and 1915(k) options noted below, to cover HCBS in assisted living settings.

There is widespread support for increased flexibility and options for offering HCBS, and Congress has provided new legislative authority and Federal grant programs to help States build their HCBS infrastructure. These tools include expanding the Money Follows the Person (MFP) demonstration, where States received enhanced Federal matching funds to support individuals who can move from living in institutional long-term care settings into integrated community housing. Forty-three States and the District of Columbia are currently participating in MFP, developing infrastructure that better supports community based service options. Other new authorities provided under the

Affordable Care Act include section 1915(i) State Plan authority to offer "waiver-like" services and supports to targeted groups; section 1915(k), Community First Choice, which allows States to offer community attendant services and other HCBS with a 6 percentage point increase in their Federal matching rate; and the Balancing Incentive Program, which offers States which are still heavily dependent on institutional long-term care services up to four years of increased Federal matching funds for HCBS to build improved systems that support community based long-term services and supports. Both Community First Choice and the Balancing Incentive Program became available to States on October 1, 2011. To date, approximately 15 States have expressed interest in the Balancing Incentives Program.

Home and Community Based Services Waivers

The vast majority of HCBS are provided in States through section 1915(c) waivers. Section 1915(c) waivers enable States to promote and support community living for Medicaid beneficiaries and, thereby, avoid institutionalization. Prior to the enactment of section 1915(c), the Medicaid program provided for little in the way of coverage for long-term services and supports in non-institutional settings, but offered full or partial coverage of institutional care. Section 1915(c) was enacted to enable States to address the needs of individuals who would otherwise receive institutional care by furnishing cost-effective services (personal care, homemaker services, enhanced nursing or therapies, transition services) to assist them to remain in their homes and communities.

In 1999, the Supreme Court ruled in *Olmstead v. L.C.*, 527 U.S. 581, that States are obligated to serve individuals with disabilities in the most integrated setting appropriate to their needs, and that unjustified institutionalization of people with disabilities is a form of unlawful discrimination under the Americans with Disabilities Act (ADA). This landmark decision marks the first time that the Court interpreted the ADA in a way that directly impacts Medicaid. Generally, under the *Olmstead* decision, States are required to provide for community-based services for persons with disabilities otherwise entitled to institutional services under the State's programs when: 1) community placement is appropriate; 2) the person does not oppose such placement; and 3) the placement can reasonably be accommodated taking into account resources available to the State and the needs of others receiving State-supported disabilities services. Services offered under section 1915(c)

waivers are an important tool for States to comply with the *Olmstead* decision and offer care to Medicaid beneficiaries in the most integrated setting appropriate to their needs.

Forty-eight States and the District of Columbia offer services through HCBS waivers. Arizona and Vermont operate similar programs under section 1115 research and demonstration authority. There is no Federal requirement limiting the number of HCBS waiver programs a State may operate, and currently there are more than 320 active HCBS waiver programs in operation throughout the country. There is also no limit on the number of services that a State may offer in a waiver, nor are States required to include specific services in the waiver, although States must specify the services that will be furnished through the waiver. The waiver authority allows States to limit services to specific regions and to target services to certain groups—strategies normally prohibited under Medicaid. Services provided under 1915(c) waivers complement and/or supplement the services that are available through the Medicaid State plan and other Federal, State, and local public programs.

Because CMS gives each State the freedom to tailor its 1915(c) waiver applications to meet the unique needs of its State, Medicaid coverage of HCBS varies widely between States. And because CMS allows States the flexibility of defining many of the services, terminology varies widely across States. For example, one State's Medicaid program may not cover services offered in an assisted living facility, another may have defined a collection of waiver services as "assisted living supports" and designate assisted living facilities as providers, and a third may reimburse assisted living facilities, as well as other providers, for the supports and services commonly thought of as "assisted living," but refer to these services by another term like "personal care" or "community supports." Additionally, such services may be targeted to specific populations with different eligibility requirements.

Federal Regulation of Nursing Homes vs. HCBS Providers

Federal Medicaid participation requirements for providers offering services under a 1915(c) waiver are significantly different from Medicaid participation requirements for nursing homes and other institutional long-term care settings. These differences are based in differences in Federal law and regulation. Nursing home services have been specifically defined in Medicaid and Medicare

through a long legislative history, most notably the OBRA '87 Nursing Home Reforms, which remain the structure for Federal regulations and CMS policy. Medicare covers rehabilitation and skilled nursing home care; Medicaid nursing homes similarly offer skilled care and rehabilitation, and also long-term care. Federal law establishes nursing homes as comprehensive, all-inclusive services that provide total care including housing and nutrition. In order for a nursing home to receive Medicare or Medicaid payments, State inspectors must certify that the nursing home meets CMS-established regulatory requirements that address over 180 aspects of care based on expectations that Congress set forth in law. Through the Federally–funded Survey and Certification program, CMS contracts with the survey agency in each State to certify that nursing homes meet these requirements. Health and fire safety inspections of these certified nursing homes take place about once a year, but may be done more often to investigate complaints or if the nursing home is performing poorly.

Licensing of assisted living facilities (and other HCBS providers), on the other hand, is a State responsibility, and there are no Federally-established standards. Monitoring of such facilities is also generally a State responsibility. Lacking a basis in law or practice, CMS does not have a direct role to define or oversee "assisted living facilities" as a category or provider type. However, CMS does require certain standards for any services offered under State Medicaid programs, particularly for 1915(c) waivers, under which the majority of services in assisted living facilities are covered in the Medicaid program. CMS requires States to specify and define services to be offered under each 1915(c) waiver and to identify the qualifications of providers who may bill for those services. If a State proposes to reimburse for supportive services provided in assisted living facilities, a State must demonstrate that it has adequate provider licensure requirements and oversight systems in place.

Efforts to Ensure Participant Health and Well-Being in Section 1915(c) Waivers

State Waiver Assurances

While there are no specific licensure requirements for HCBS providers, section 1915(c) and its implementing regulations require that the State demonstrate several "assurances" regarding their waiver programs. As specified in 42 CFR 441.302, these assurances relate to participant health and welfare, appropriate level of care needs, effective evaluation of need, adequate service plans, availability of qualified providers, and financial accountability. CMS is committed to safeguarding the health and safety of Medicaid beneficiaries.

In its waiver application, a State must demonstrate that it is prepared to protect participants in a number of ways, including by:

- Specifying the qualifications of waiver providers and verifying that providers continuously meet these qualifications;
- Periodically monitoring the implementation of the service plan and participant health and well-being;
- Identifying and responding to alleged instances of abuse, neglect and exploitation that involve waiver participants; and,
- Instituting appropriate safeguards concerning practices that may cause harm to the participant or restrict participant rights.

Quality Improvement Process

In addition to detailing how it will accomplish these tasks, a State must specify how it monitors performance in assuring health and well-being by preparing and submitting a Quality Improvement Strategy that, on an on-going basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.

The Quality Improvement Strategy is a process that involves continuous monitoring of the implementation of each waiver assurance, methods for remediation or addressing identified individual problems and areas of noncompliance, and processes for a) aggregating collected information on compliance and remediation activities, and b) prioritizing and implementing needed systems changes to improve care.

The Reporting Process

To satisfy Federal monitoring requirements, States must submit evidence that they are meeting the statutory and regulatory assurances, as well as annual reports that include information on the health and well-being of HCBS participants and a final report in the year prior to the expiration of the waiver. Combined with information obtained by the CMS regional office throughout the waiver period, the regional office makes a determination about the State's performance and communicates it through the draft report, discussed in more detail below.

In certain circumstances, including when the health and well-being of waiver participants may be jeopardized, CMS may find it necessary to conduct special or focused on-site or off-site review activities. The results of this type of review may necessitate the State's preparing and implementing a corrective action plan.

The Renewal Process

Continuation of a waiver beyond its initial three-year or five-year approval period requires that the State submit a five-year waiver renewal application and a determination by CMS that, while the waiver has been in effect, the State has satisfactorily met the waiver assurances and other Federal requirements, including the submission of a mandatory annual waiver report (the CMS-372(S) report). The Affordable Care Act allows waivers for services provided to individuals who are dually eligible for Medicare and Medicaid to have five-year initial and subsequent approval periods, subject to the Secretary's discretion.

At least one year in advance of the expiration date of an approved waiver, the CMS regional office will issue a draft report to the State summarizing its findings and conclusion. If the draft report concludes that one or more requirements of the waiver are not met, then the regional office must provide the basis for the conclusion. In its response to the draft report, the State may dispute the regional office findings or propose a course of action to remediate the problem, either immediately or by implementing a corrective action plan. If the State does not propose a satisfactory course of action, CMS may not approve the State's HCBS waiver renewal application. Because waiver termination could have a significant detrimental impact on all participants receiving waiver services, CMS works diligently with States to achieve full compliance.

In response to State feedback and Federal concerns, CMS has recently engaged with our State partners in a review of the waiver quality improvement and reporting process in order to identify opportunities to improve the effectiveness and efficiency of State and Federal efforts to improve care and assurance of safety of waiver participants.

Rulemaking on HCBS Waivers

CMS has been engaged in the development of updated regulations regarding section 1915(c). In the June 22, 2009 Federal Register (74 FR 29453), CMS published the Medicaid Program HCBS advance notice of proposed rulemaking (ANPRM) that proposed to initiate rulemaking on a number of areas within the section 1915(c) program. The purpose of the ANPRM was to solicit input from a broad array of stakeholders regarding opportunities to improve the quality of HCBS offered under the 1915(c) programs. CMS received 313 comments from States, health care and community support providers and associations, consumer groups, social workers, and others, plus held teleconferences with stakeholders to solicit additional feedback. CMS followed up with a notice of proposed rulemaking (NPRM), CMS–2296–P (42 CFR Part 441), which was published in the Federal Register on April 15, 2011, with a 60-day comment period. These proposed regulations address key issues raised in the ANPRM, including improvements in person-centered planning, clarifying characteristics of home and community-based settings, and providing improved tools for CMS to use to assure compliance with health and well-being expectations.

Person Centered Planning and Clarifying the Characteristics of HCBS Settings

Underpinning all aspects of successful HCBS is the importance of a complete and inclusive person-centered planning process that addresses health and long-term services and support needs. In recognition of the importance of person-centered planning, CMS–2296–P proposes requirements for elements of person-centered planning and approaches to service delivery. The planning process would be conducted in a manner that reflects both what is important for the individual to meet identified clinical and support needs, determined through a person-centered functional needs assessment process, and what would reflect personal preferences and choices and contribute to the assurance of health and well-being. The plan resulting from this process would include individually identified goals, the services and supports that will assist the individual in achieving these goals, and identify risk factors and measures in place to minimize them.

Through CMS–2296–P, CMS also proposed to improve the assurance that HCBS are truly "home and community-based" in nature and provide a meaningful alternative to an institutional experience of care. Setting characteristics that may not be home and community based include regimented meal and sleep times, limitations on visitors, lack of privacy, and other attributes that limit an individual's ability to engage freely in the broader community. In addition, encouraging "aging in

place," or allowing individuals to remain where they live as they age and/or support needs change, is a proposed requirement for assisted living settings for the elderly.

CMS Strategies to Ensure Compliance with Statutory Assurances

At present, if CMS identified serious quality issues, such as potential harm to individual health and well-being or significant financial concerns, and States failed to take appropriate remedial action, the only enforcement options addressed in the regulations would be for CMS to refuse to renew a State's waiver or terminate the waiver.[2] Such action could have a significant detrimental impact on the individuals served (for example, loss of waiver services or Medicaid eligibility).

CMS is interested in working with States to achieve full compliance without having to resort to termination of a waiver. Specifically, in CMS-2296-P CMS proposed to add language describing additional strategies CMS may employ to ensure State compliance with the requirements of a waiver, short of a waiver termination or non-renewal. CMS's proposed regulation at the new section 441.304(g) reflects an approach to encourage State compliance.

These strategies include use of a moratorium on waiver enrollments or withholding of a portion of Federal payment for waiver services or for administration of waiver services in accordance with the seriousness and nature of the State's noncompliance (that is, health and well-being concerns and significant financial issues). These strategies could continue, if necessary, as the Secretary determines whether termination is warranted. CMS' primary objective is to use such strategies rarely, only after other efforts to resolve issues have not succeeded as necessary to ensure the health and well-being of individuals served.

Once CMS employs a strategy to ensure compliance, the State must submit an acceptable corrective action plan in order to resolve all areas of noncompliance. The corrective action plan must include details on the actions and timeframe the State will take to correct each area of noncompliance, including necessary changes to the quality improvement strategy and a detailed timeline for the

[2] This authority and the process for termination of waivers are currently addressed in the regulations at sections 441.304(d), 441.307, and 441.308.

completion and implementation of corrective actions. CMS will determine if the corrective action plan is acceptable.

CMS invited comment on the discussion of characteristics of HCBS and compliance strategies in proposed rule CMS–2296–P during the 60-day comment period that ended on June 14, 2011. CMS is currently reviewing over 1600 comments received during the comment period on the proposed rule. Over half of these comments addressed the proposed characteristics of home and community based settings, indicating support for many provisions as well as opposition to those same provisions. Comments raised issues regarding the importance of allowing services and settings to reflect the specialized needs of individuals (e.g., those with cognitive or memory care needs) and raised questions regarding the meaning and impact of certain proposed standards. CMS is reviewing all comments closely and is committed to continuing a dialogue with all interested stakeholders on issues related to designing services and supports that meet individual needs, and that offer meaningful opportunities for individuals to be served in the most integrated community settings appropriate to their needs and preferences.

Conclusion

Thank you for the opportunity to draw attention to CMS efforts to provide Medicaid beneficiaries with quality services in their homes and communities, including in assisted living environments. Regardless of the care setting or payer, all Americans need access to high-quality, flexible, and personalized long-term care supports and services. CMS is committed to continuing our current efforts to engage consumers, caregivers, providers, and States in this effort to better support the design and delivery of long-term care supports and services that enable individuals with cognitive and physical impairments to have access to quality long-term care in their homes and communities.