February 21, 2013

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-2334-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

Re: Comments on Proposed Regulations for Medicaid Cost Sharing;
78 Fed. Reg. 4594 (January 22, 2013)

Submitted Electronically through www.regulations.gov;
Document ID CMS-2013-0012-0005

Dear Administrator Tavenner:

The National Association of Area Agencies on Aging (n4a) appreciates the opportunity to comment on the proposed Medicaid regulations related to cost sharing. n4a is the leading voice on aging issues on behalf of our members: Area Agencies on Aging (AAAs) and Title VI Native American aging programs. Through advocacy, training and technical assistance, we support the national network of 629 AAAs and 246 Title VI programs that provide critical home and community-based services to millions of older adults and persons with disabilities in every community in the country. With many states increasingly shifting from fee-for-service Medicaid programs to capitated managed care models, AAAs will continue to be an asset to consumers, providers and government alike in the coordination of Medicaid home and community-based services.

n4a has several initial thoughts in response to your cost-sharing query in the proposed Medicaid rules and will share additional feedback as the discussion progresses. As
always, we look forward to continuing the CMS and stakeholder dialogue to further explore all the issues surrounding home and community-based services (HCBS) and long-term services and supports (LTSS).

Our main points are as follows:

- HCBS is distinct from other services and should be treated as such;
- Cost sharing for HCBS may have adverse effects on consumer access and health outcomes; and
- HCBS should be exempted from cost sharing in all states.

CMS correctly recognizes that community-based LTSS is different from most other outpatient services, as it is “furnished over an extended period of time pursuant to a coordinated plan of care.” 78 Fed. Reg. 4594, 4658 (Jan. 22, 2013). Services that a Medicaid beneficiary would receive under an HCBS waiver are not parallel to acute or other outpatient services for many reasons. Long-term services and supports are just that: frequent services over a long period of time that provide the means for people with chronic diseases, functional disabilities and/or other conditions to live with dignity and as independently as possible.

In most cases, community-based LTSS is authorized by a care plan that is 1) based on an assessment of the beneficiary’s condition and needs, and 2) developed by a care team that includes relevant health care professionals. Though the proposed rule cautions states to be aware of their obligations under the Supreme Court’s Olmstead ruling and the Americans with Disabilities Act (ADA) when exercising their options with respect to cost sharing, the establishment of cost sharing for consumers receiving HCBS may have adverse effects on consumer access to services and may lead to poor health outcomes resulting in higher costs due to hospitalization and institutionalization. See 78 Fed. Reg. at 4659-60.

Given the care planning process, there is no reason for HCBS to be discouraged by imposition of cost sharing. Especially as care coordination expands through the health reform process, cost sharing should not be imposed in a way that impedes the demonstrated efficacy of care coordination in LTSS. Given that HCBS are often provided every day, and at a minimum several times weekly, even nominal cost sharing imposed on a per-episode basis creates an undue incentive for beneficiaries to forego the services, even considering seemingly reasonable limits based on income.

Furthermore, cost sharing should only be employed in situations where it leads beneficiaries to choose more cost-effective alternatives. For example, cost sharing is more likely appropriate to the extent that it induces beneficiaries to receive necessary non-emergency care in a clinic rather than an emergency room. When applied to LTSS, however, cost sharing has the perverse effect of favoring use of more expensive nursing facility services, which generally will not be subject to cost sharing. One of the
The major benefits of providing LTSS in a community-based setting is that it offers the means for older adults and individuals with disabilities to live as independently as possible without incurring the costs of more expensive institutional care.

The consequences of foregoing HCBS can be severe. If beneficiaries do not receive HCBS, they are likely to suffer serious health consequences. Adverse outcomes may include falls, uncontrolled blood sugar levels, pressure ulcers and infections, which can lead to hospitalizations, nursing facility admissions, and other costly interventions. In fact, most AAAs provide evidence-based disease prevention and health promotion programs, such as falls prevention and chronic disease self-management, which result in lower health costs and better health outcomes.

The proposed regulations essentially exempt nursing facility residents from co-payments and premiums, and give states the option to extend a comparable exemption to recipients of community-based LTSS. In discussing the application of the exemption to community-based LTSS, CMS notes the law’s comparability requirements and, on the previous page of the Federal Register discussion, emphasizes a state’s obligations under the ADA and the Supreme Court’s Olmstead ruling. See 78 Fed. Reg. at 4659-60. These legal authorities support the humane and cost-effective policy to treat community-based LTSS equivalent to facility-based LTSS in the exemption from cost sharing and premiums.

**n4a recommends that the exemption from cost sharing for community-based LTSS be made mandatory.** States should not be given the option to implement a policy that discriminates unjustifiably against beneficiaries who prefer to receive LTSS while living in the community.

Thank you for the opportunity to provide our initial comments on these important policy questions and proposed regulations. We are grateful for CMS’s leadership in developing and improving home and community-based LTSS, and urge CMS to develop the cost-sharing rules in a way that does not discourage Medicaid beneficiaries from receiving LTSS at home or in the community nor penalize those that do.

Sincerely,

Sandy Markwood  
Chief Executive Officer