

NPAF National Patient Advocate Foundation

The Patient's Voice | since 1996

EXECUTIVE BOARD

Nancy Davenport-Ennis

CEO, President

National Patient Advocate Foundation

Dennis A. Gastineau, MD

Board President

Director, Human Cell Therapy Laboratory

Divisions of Transfusion Medicine & Hematology

Mayo Clinic

Christian Downs, MHA, JD, MHA

Immediate Past President

Executive Director

Association of Community Cancer Centers

Leah Locke-Arnett, RN, BSN, MHCA

Board Secretary

John L. Murphy

Board Financial Officer

Saguenay Capital, LLC

Bruce Avery, MD

Hematology-Oncology Knoxville

Alan J. Balch, PhD

Vice President

Preventive Health Partnership

Martha E. "Meg" Gaines, JD, LL.M.

Clinical Professor of Law,

University of Wisconsin Law School

Lovell A. Jones, MD, PhD

Director, Center for Research on Minority Health

Department of Health Disparities Research

University of Texas

MD Anderson Cancer Center

Pearl Moore, RN, MN, FAAN

Jonathan B. Perlin, MD, PhD, MSHA, FACP, FACMI

President, Clinical Services & Chief Medical Officer

HCA / Hospital Corporation of America

Roy Ramthun, MSPH

President

HSA Consulting Services

Reed V. Tuckson, MD, FACP

Executive Vice President and

Chief of Medical Affairs

UnitedHealth Group

SCIENTIFIC ADVISORY COMMITTEE

Robert M. Rifkin, MD, FACP

Chair, Science Advisory Committee

Director, NMDP Collections

Rocky Mountain Blood & Marrow Transplant Program

Rocky Mountain Cancer Centers

Charles Balch, MD, FACS

Professor of Surgery and Oncology and Dermatology

Deputy Director, Johns Hopkins Institute for Clinical

and Translational Research

Johns Hopkins

Pamela S. Becker, MD, PhD

Associate Professor of Medicine/Hematology

Institute for Stem Cell and Regenerative Medicine

University of Washington

Al Benson III, MD, FACP

GI Medical Oncology (Professor of Medicine)

Northwestern University - Feinberg School of Medicine

David Brizel, MD

Professor of Radiation Oncology

Associate Professor of Head and Neck Surgery

Duke University Medical Center

Nicholas J. Petrelli, MD, FACS

Medical Director

Helen F. Graham Cancer Center

F. Marc Stewart, MD

Professor of Medicine, University of Washington

Fred Hutchinson Cancer Research Center

Lori Williams, PhD, RN, AOCN

University of Texas

MD Anderson Cancer Center

March 25, 2011

Donald M. Berwick, M.D.

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Hubert H. Humphrey Building, Room 445-G

200 Independence Avenue, SW

Washington, DC 21244-1850

Re: CMS -2337-P: Medicaid Program; Community First Choice Option

Dear Dr. Berwick:

National Patient Advocate Foundation (NPAF) would like to thank you for the opportunity to comment on the Community First Choice Option proposed rule published in the *Federal Register* on February 25, 2011.¹ NPAF is a non-profit organization dedicated to improving access to healthcare services through both federal and state policy reform. Its mission is to be the voice for patients who have sought care after a diagnosis of a chronic, debilitating or life-threatening illness. The advocacy activities of NPAF are informed and influenced by the experience of patients who receive direct, sustained case management services from our companion organization, Patient Advocate Foundation (PAF). In fiscal year 2010 (July 1, 2010 – June 30, 2011), PAF resolved 82,963 cases nationally and provided information to almost 4 million online contacts.

NPAF applauds the Community First Choice Program as it addresses the institutional bias in state implementation of the Medicaid program that has challenged disabled Medicaid beneficiaries for years. It represents a welcome improvement over the traditional Home and Community-Based Services (HCBS) waiver program by which many states provide services to disabled Medicaid beneficiaries. This comment letter highlights three noteworthy improvements and offers suggestions regarding how to assure the law's implementation remains patient-centric, as that is an identified goal.

Access The first important benefit of the Community First Choice option over the current HCBS waiver program relates to access. The Community First Choice option does not allow states to limit the number of beneficiaries it will serve although states can still define eligibility. This prevents states from limiting services to a numeric amount or to a geographic area. Thus, the result is increased access to home and community-based services by those in need. This change can only become patient-centric if CMS monitors state efforts to educate beneficiaries of this significant improvement. Some states may attempt to achieve a de-facto limitation of services by tailoring public relations activities such as limiting outreach efforts to certain geographic areas of the state.

¹ 76 Fed. Reg. 10736 (Feb. 25, 2011).

Eligibility Individuals will no longer have to meet an institutional level of care in order to qualify for Home and Community Based Services. This is an important change because it allows patients who might still benefit from these services to receive them. This allows patients to live and receive care in the community thereby preventing them from progressing to the stage of needing institutional services. Thus, the Community First Choice program option furthers the spirit of the Olmstead² decision, which affirmed the right of people with disabilities to receive public benefits and services in the most integrated setting appropriate to their needs. Once again, this important change in eligibility requirements can easily be misunderstood by patients. It allows a significant number of beneficiaries to be eligible for the very services that have been needed for some time. Once again, this change represents a significant change in the program and successful implementation will require targeted communication to specific populations.

Another important eligibility change is that of financial eligibility. States may now choose to provide services to individuals with income up to 300 percent of the Supplemental Security Income (SSI) Federal benefit rate (FBR). While individuals served in this new eligibility group must be eligible for HCBS under a 1915(c), (d), or (e) waiver or 1115 demonstration program, they do not have to be enrolled and receiving services in either waiver program. These eligibility changes directly impact patients who may forego services simply because they may not be aware that they now meet eligibility requirements. As stated above, this change, like the others will only become patient-centric if program education efforts are customized to the population that has heretofore been ineligible.

Scope of Services The range of services states are permitted to offer under the Community First Choice Option represents a final significant change. The Affordable Care Act allows states to offer case management, homemaker/home health aide, personal care, adult day health, habilitation, and respite care services. States may offer persons with chronic mental illness day treatment, other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility). A catch-all section of the law allows states to offer, “such other services requested by the State as the Secretary may approve.” As a result of this change, States will now be permitted to propose “other services” (not including room and board) in a 1915(i) State Plan Amendment Application for CMS to review.

These changes are complex ones that significantly change the expanse of the population eligible for home and community based services. NPAF suggests that CMS require states to spend an appreciable amount of resources in the education of Medicaid beneficiaries or their representatives about the changes in the law regarding the provision of community and home based services under Medicaid. CMS should also consider instructing States to partner with patient advocate groups to educate beneficiaries. Patient advocate groups enjoy a relationship with the beneficiary community characterized by trust. These groups have the unique ability to not only communicate with the provider groups in a manner that they will understand, but with a level of veracity necessary to encourage beneficiaries to learn more about and avail themselves of these new benefits.

Thank you once again for the opportunity to comment on these important regulations. Please do not hesitate to contact me directly should you have any questions or comments.

Sincerely,



Nancy Davenport-Ennis
CEO and President
National Patient Advocate Foundation

² 119 S. Ct. 2176