



**Center for Medicaid and State Operations**

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JUN 10 2009

Suellen Galbraith  
Director for Government Relations  
American Network of Community Options and Resources  
1101 King Street, Suite 380  
Alexandria, VA 22314-2944

Dear Ms. Galbraith:

Thank you for your letter regarding ANCOR providers' concerns about the H1N1 Influenza A virus. The letter clearly reflects your members' dedication to providing quality Medicaid supports and services to our nation's citizens of all ages with disabilities. We commend your actions to provide information to your nationwide provider network and appreciate your expressed need for clear channels of communication with our agency, including guidance and clarification of Medicaid policies under public health emergency circumstances.

Your letter clearly articulates the challenges that a potential pandemic flu emergency places on an already financially strained delivery system. We recognize your request for us to review and adjust Medicaid requirements in light of a potential emergency. We sincerely appreciate your constructive recommendations.

On the important issue of coordination and communication, you recommend that the Centers for Medicare & Medicaid Services (CMS) help public health, education, and local officials to coordinate communications with providers of all public services. You specifically encourage us to sponsor a nationwide webinar or conference call(s) as well as a public and devoted Web site as means to continually update guidance and information to our partners in the case of a pandemic emergency. We are committed to establishing and maintaining open channels of communication with our stakeholders, including ANCOR, so that you are prepared to fulfill your mission of providing appropriate guidance and information to direct support professionals as well as informing and educating individuals with disabilities and their families, and/or representatives.

To that end, we invite you to participate in some existing forums that we believe will accomplish our common goals of communication and emergency preparedness. Please join us in our regular teleconferences of the Emergency Preparedness Stakeholder Communication Forum. The purpose of these teleconferences is to disseminate information, gather input and recommendations, and extract lessons learned for improving the overall health care system's emergency preparedness status. The stakeholders include a variety of perspectives: State Survey Agencies (SAs), accrediting organizations, provider associations (all types), patient and resident advocates, quality and safety organizations, and other HHS operating divisions. Susan Larsen, the Survey & Certification Emergency Preparedness Lead facilitates these teleconferences. Please contact her at [Susan.Larsen@cms.hhs.gov](mailto:Susan.Larsen@cms.hhs.gov) and provide ANCOR'S representative's contact information.

In addition, we have an Emergency Preparedness Web site to provide State Agencies, health care providers, and other partners with helpful tools and resources, such as the emergency preparedness checklists, Public Health Emergency All-Hazards FAQs, as well as links to other relevant Federal emergency preparedness Web sites. Updates, new documents and resource links are posted on a regular basis. We encourage you to access the Survey and Certification Emergency Preparedness Web site at: <http://www.cms.hhs.gov/SurveyCertEmergPrep/>

You also raised a number of important policy and operational issues of concern to you. We understand the expressed need for clear guidance to States on issues related to hospital stays and reimbursement rates. One tool that may assist providers with this issue is the personal assistance retainer, authorized through Olmstead letter #3 (and further detailed in Attachment 3e). This provision allows, at the State's election, payment for the retention of services while an individual is temporarily absent due to hospitalization or family visitation. In Version 3.5 of the Instructions, Technical Guide and Review Criteria for Section 1915(c) Home and Community Based Services (HCBS) waivers, published in January 2008, CMS clarified that this option was also available for habilitation services, particularly since individuals with disabilities often receive personal assistance as a component of their habilitation service. This tool assists with one side of the issue you identify. There remains a regulatory prohibition at 42 CFR 441.301(b)(1)(ii) to providing services to inpatients of hospitals. CMS is considering remedies to this situation that are in accord with governing statute and regulation but that afford individuals with disabilities and individuals who are aging the essential support they need during their hospital stay, support that frequently requires a person-specific, person-driven skill set.

We understand your concerns related to hospital stays and the prohibition against payment for agency direct support under 1915(c) home and community-based waivers. We appreciate that direct support staff are often in the best position to support people with disabilities given their familiarity and relationships. Please be assured that we will continue work to identify resolution to this longstanding challenge.

With regard to your concern related to hospital stays and multiple individuals with disabilities who are supported by the same agency, we believe that a State could elect to use the personal assistance retainer to defray the burdens to providers should situations of this type arise. While States must indicate their intent to utilize the personal assistance retainer (or habilitation retainer) within their approved waiver document, States are able to amend these documents retroactively to the beginning of the waiver year when the proposed changes do not result in a constriction of services for individuals served. In other words, if a situation arises necessitating the employment of this tool, States are free to implement immediately and provide the needed documentation to CMS when feasible.

You shared that ANCOR providers have reported that they were "considered a health-care facility," required to provide 24-hour nursing services, and therefore could not admit individuals to a hospital in a pandemic. You urged us to clarify if this is true and if so, revisit and reassess the requirement so that there might be a "waiver" or "suspension" during a pandemic emergency. We are not aware of any policy or regulation that prohibits ICFs/MR from admitting individuals to a hospital during a pandemic. Therefore we see no need for a waiver or suspension to be granted during a pandemic emergency.

It should not be presumed in a pandemic flu situation that all residents would be better served and protected in the hospital setting. The ICF/MR regulations at 42 CFR § 483.460(a)(3) require that the facility provide or obtain preventative and general medical care for each client.

Your letter also raised the issue of the need for guidance to address higher utilization rates and increased costs to providers if community or public activities were suspended and there was a need for increased in-home supports beyond what is currently approved. We are pleased to share that states have the authority, within the plan of care, to authorize such services. In fact, when there are limits on amounts, duration or service scopes within waivers, or when States apply cost limits by levels of support or individual cost limits for purposes of entry into the waiver, States must indicate the safeguards they have in place to address extraordinary needs when they arise in order to assure individual health and welfare. Increased utilization or costs resulting from individual or systemic circumstances could certainly be used at the States' discretion to address these issues without need for amendment. An amendment would only become necessary if it becomes apparent that the measures taken will need to be sustained for prolonged (more than one year) periods of time.

Thank you for your recommendation that we should consider waiving applicable State plan requirements that currently disallow Medicaid-funded day program employees from working in homes and/or Medicaid facilities. Because States establish provider qualifications and establish the parameters under which providers render service, this issue may be best addressed at the State level. There is no Federal prohibition related to the issue you describe in Section 1915(c) waivers.

Lastly, on the issue of access to and coordination with public health resources, you urged us to ensure that public health systems coordinate fair access to medical and drug resources on behalf of individuals with disabilities. We certainly share your interest in preventing individuals with disabilities from being discriminated against in obtaining necessary medical care and treatment. While we feel that we have limited influence in this area, we will keep this concern in mind when and if we are involved in Department initiatives to address an impending flu pandemic.

Sincerely,



Thomas E. Hamilton  
Director  
Survey and Certification



Terry Pratt  
Acting Director  
Disabled and Elderly Health Programs Group