



June 28, 2010

Cindy Mann, J.D.
Deputy Administrator and Director
Center for Medicaid, CHIP and Survey & Certification
Centers for Medicare & Medicaid Services
7500 Security Boulevard, MS C5-22-23
Baltimore, Maryland 21244-1850

Dear Ms. Mann:

The National Association of State Units on Aging (NASUA) applauds the Centers for Medicare & Medicaid Services' (CMS) development of MDS 3.0 Section Q (Return to Community Referral). As the national representative of the 56 officially designated state and territorial agencies on aging, NASUA supports the successful implementation of MDS 3.0 Section Q. We believe that it will contribute to existing initiatives to rebalance the long-term services and supports system in the United States and to facilitate a person-centered care approach. However, NASUA is concerned that the implementation of MDS 3.0 Section Q by October 1, 2010 as an unfunded mandate will place a hardship on "Local Contact Agencies" or LCAs. NASUA urges CMS to issue a one year delay of the implementation of MDS 3.0 Section Q to address the states' needs for adequate funding of this mandate.

As you are aware, CMS has classified LCAs as "community contact agencies that can provide individuals with information about community living options and available supports and services." LCAs may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities. Service providers such as ADRCs and AAAs are experiencing budget cuts and personnel layoffs that make it difficult to provide information, referral, and assistance (I&R/A) to seniors, persons with disabilities, family caregivers, and health care providers. However, the demand for I&R/A services has continued to increase during the past year for these agencies. NASUA firmly believes that this coupled with the implementation of the unfunded MDS 3.0 Section Q roll out will jeopardize the state and local providers' ability to maintain quality services.

CMS has acknowledged that it has not designated any funding specifically to support the activities of a LCA, but notes "multiple funding streams that currently support functions that would be performed by the LCA, including the Money Follows the Person (MFP) initiative, Medicaid administrative matching funds. Medicaid targeted case management

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benefits, Older Americans Act (OAA) Title III funding, Rehabilitation Act funding, and others.” NASUA believes that this description of funding sources fails to acknowledge that a significant number of skilled nursing facility (SNF) residents could not be served through these funding streams. Further, some of the funding noted would need to be redirected to this effort, thereby actually reducing existing home and community based (HCB) services being provided. More specifically:

- The care of approximately 35% of SNF residents is paid for privately or by Medicare. MFP or any other Medicaid funding sources could not be used to pay for the actual LCA transition assistance to non-Medicaid residents (beyond outreach and education).
- Initial SNF resident assessments must be completed within 14 days of admission. If a resident expressed an interest in transitioning to community living, a referral to the LCA must occur within 10 days. CMS recommends that the LCA should provide a telephone response within 3 days and an on-site visit within 10 days, if needed.¹ MFP funding can only be accessed if the resident has been in the facility for 90 days or longer (and this period will be even longer if their rehabilitation care was originally paid for by Medicare). So within the MFP program, no funding could be used to reimburse actual LCAs transition work between day 30 and day 90 (beyond outreach and education), a crucial time period when residents may still have housing and social supports that would facilitate the transition. Most transition pilots have clearly identified that once these supports are lost, the ability for residents to move to independent living becomes increasingly more difficult.
- Medicaid administrative activities and targeted case management funding have also been identified as potential sources of LCA funding. This narrow funding source could only be used by governmental agencies, i.e., cities and/or counties, to recruit or assist Medicaid beneficiaries. Further, this process would require the LCA to absorb 50% of the cost of providing service only to be reimbursed in the following year. It is not realistic, particularly in this fiscal environment, to anticipate that LCAs could absorb the up-front staffing and administrative costs.
- While OAA Act Title III has been suggested as a potential LCA funding source, redirecting already inadequate Title III HCB service funds to pay for LCA transition services both decreases the HCB services currently supporting other older adults to avoid SNF placement and decreases the HCB supports available to SNF residents seeking to transition to community living.
- Aging and Disability Resource Centers (ADRCs) have also been identified as potential LCAs. CMS and the U.S. Administration on Aging (AoA) have publicized that there are “290 ADRC pilot sites operating—at varying stages of development—across the country covering roughly 45% of the U.S. population.”² While

¹ CMS MDS 3.0 Section Q Implementation Questions and Answers from Informing LTC Choice Conference and E-Mails, June 7, 2010, p. 3.

² U.S. Department of Health & Human Services, “Implementing the Affordable Care Act: Making It Easier for Individuals to Navigate Their Health and Long-Term Care through Person-Centered

conceptually, NASUA and the State Units on Aging are very supportive of the ADRC model, we believe that CMS and AoA are overstating both the geographic reach and the capacity of ADRCs to take on new responsibilities with no additional resources. Currently \$11 million in federal funding is being used nationwide to sustain/expand ADRCs expansion. While some states may have had additional funding to previously support ADRCs, most states are struggling to maintain their optional Medicaid services and are dramatically reducing general fund supported program because of budget deficits. ADRCs, which rely primarily on these federal seed grants and the existing Medicaid and OAA funding, simply do not have unspent funds or available staff that can be redirected to take on LCA responsibilities in addition to the comprehensive set of expectations CMS and AoA have already articulated for a fully functioning ADRC.

- The MDS 3.0 Pilots, conducted in several states in 2009 and 2010, and prior SNF transition pilots clearly identified that time is required to build a rapport between the SNFs and the LCAs and that this rapport is crucial to success. However, building these relationships takes time which is likely to be in short supply given the lack of LCA dedicated funding for this work.
- Beyond the LCA role in transitioning these residents back into the community, many of these individuals, given their health and other support needs, will require on-going care coordination to avoid re-institutionalization. It is simplistic to believe that if residents are transitioned to the community, the budgetary resources to pay for the increased care coordination and HCB services will follow. Many HCB Medicaid waivers have waiting lists. Many of these individuals are not Medicaid eligible so the cost of their on-going care coordination and needed HCB services would either need to be paid for by the state or the individual on a private pay basis. Potential LCAs will need clarity on the scope of their responsibilities. With or without that, they will be in the difficult role of having to terminate services to these clients after a certain point in the transition process because the agency cannot absorb on-going staffing costs with no reimbursement.

While the goal of the MDS 3.0 Section Q changes is laudable, the significant unfunded costs involved in implementing these changes will result in unachieved expectations. In California, for example, there are approximately 275,000 new admissions in over 1,000 freestanding SNFs each year. If only 5% of those new residents wanted to discuss HCB service options with an LCA, that would equate to 13,750 contacts. Assuming, conservatively, that this required the LCA to spend 9 hours per resident in assessing their needs, providing education, identifying community service providers, coordinating with the SNF staff, and assisting the client in accessing needed services, the cost would be approximately \$12.4 million annually. Even if \$8 million of those LCA costs could be paid for by Medicaid, OAA or Rehabilitation Act funding can hardly cover the \$4.4 million in LCA cost for assisting non-Medicaid residents, without decimating the existing services being provided with through those limited funding streams.

Systems of Information, Counseling and Access,” Program Announcement and Grant Application, p. 9.

NASUA firmly believes that a dedicated funding stream is necessary to support the implementation and sustainability of MDS 3.0 Section Q in order to achieve tangible outcomes for nursing home residents seeking help in transitioning to the community. NASUA is very willing to advocate with Congress for passage of additional funding to perform LCA functions. In the meantime, NASUA urges CMS to delay the October 1, 2010 implementation by one year while CMS identify federal funds to support states' implementation of the mandate.

We welcome the opportunity to discuss this matter further with you. Should you have any questions or desire technical assistance on this matter, please do not hesitate to contact John Thompson of my staff at 202-898-2578.

Respectfully,

A handwritten signature in blue ink that reads "Martha Roherty". The signature is written in a cursive, flowing style.

Martha Roherty

cc: Kathy Greenlee
Assistant Secretary for Aging
U.S. Administration on Aging

Henry Claypool
Director, Office on Disability
U.S. Department of Health and Human Services