

Medicaid Managed Long Term Services and Supports

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What is MLTSS?

- Managed Long Term Services and Supports (MLTSS) – the delivery of long term services and supports through capitated Medicaid managed care program
- Can be a managed care organization, pre-paid inpatient health plan, pre-paid ambulatory health plan

Authority to Provide MLTSS

Managed Care Authorities	LTSS Authorities
<ul style="list-style-type: none">• 1115(a) Demonstration• 1915(b) Waiver• 1915(a) Contract Authority• 1932(a) State Plan Amendment (SPA)	<ul style="list-style-type: none">• 1905(a) State Plan services• 1115(a) Demonstration• 1915(c) Waiver• 1915(i) SPA• 1915(k) SPA• 1915(j) SPA

Growth of MLTSS

- Use of managed care for delivery of LTSS is growing rapidly
 - Number of states with MLTSS programs increased from 8 in 2004 to 16 in 2012
 - Estimated that 26 states will have MLTSS program by 2014
- The most common authorities being used by states for MTLSS are a 1915(b)/1915(c) combination or through an 1115 demonstration

MLTSS Guidance Development

- CMS released a guidance document which outlines our expectations for states using either the 1915(b) waiver or 1115 demonstration for their MLTSS programs on May 21, 2013 at: (<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html>)
- Along with the guidance document, CMS also posted tools for states, namely:
 - A suggested timeline for MLTSS planning, design and implementation
 - An issue brief addressing incorporation of traditional HCBS providers into MLTSS programs.

MLTSS Guidance Development

- Conducted site visits with states to gain knowledge of existing MLTSS programs
- Used national studies, reports from advocacy and stakeholder groups
- Composed workgroups with expertise in all areas of MLTSS to review final guidance recommendations

CMS approach for principle use

- CMS is using the principles to guide our review and approval of MLTSS programs using section 1115 demonstration and 1915(b) managed care authorities
- Standard Terms and Conditions (STCs) are being added to all new section 1115 demonstration approvals
- Performance requirements will be added for new MLTSS programs using 1915(b) managed care authority
- Questions about these principles will be developed and asked during review of MLTSS programs using other types of managed care authorities

MLTSS Principles

- Adequate planning and transition strategies
- Stakeholder engagement
- Enhanced provision of HCBS
- Alignment of payment structures with MLTSS programmatic goals
- Support for beneficiaries
- Person-centered processes
- Comprehensive and integrated service package
- Qualified providers
- Participant protections
- Quality

Adequate Planning and Transition Strategies

- States should use a thoughtful and deliberative planning process with enough time to outline a clear vision for the program.
- Elements:
 - Solicitation and consideration of stakeholder input;
 - Education of program participants,
 - Assessment of readiness at both the state and managed care plan level, and
 - Development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition to and effective ongoing implementation of MLTSS.

Stakeholder Engagement

- Stakeholders, including beneficiaries, providers and advocacy groups of all impacted LTSS populations, can provide significant insight to the state's planning, implementation, and ongoing oversight of the MLTSS program.
- Stakeholder engagement and collaboration are critical pieces to ensure the smooth and efficient transition to managed care for these populations.
- Elements:
 - Provider and beneficiary educational tours,
 - Multiple educational mailings,
 - Transparency in design and oversight of the program, and
 - State and managed care plan advisory groups

Enhanced Provision of HCBS

- Per Americans with Disabilities Act and Olmstead v. L.C., 527 U.S. 581 beneficiaries are entitled to receive services in the most integrated setting.
- Services should be delivered in settings that meet the home and community based characteristics and that offer opportunities for active community and workforce participation.
- Elements:
 - Consistency of goals with ADA and Olmstead plans in place prior to transition
 - Monitoring of individuals moving between community and institutions
 - Working with MCOs and provider community on HCBS characteristics

Alignment of Payment Structures with MLTSS Programmatic Goals

- Payment to managed care plans should support the goals of MLTSS programs that include these essential elements and support the goals of improving the health of populations, improving the beneficiary experience of care, and reducing costs.
- Elements:
 - A capitation rate that encourages the delivery of services in home and community-based settings,
 - Performance-based incentives tied to outcome measures, and
 - Penalties for poor performance or contract non-compliance.

Alignment of Payment Structures with MLTSS Programmatic Goals

- The basis for the creation of a capitated rate may be found in the Fee for Service System.
- Sound rate methodology in the Fee for Service System will facilitate the process.

Support for Beneficiaries

- All beneficiaries, particularly those most vulnerable, need support and education throughout their experience in the MLTSS program.
- Support is more readily accepted and trusted from an independent and conflict-free source.
- Common support resources for beneficiaries provided by the state at no cost to the beneficiary are:
 - Enrollment/disenrollment services, including choice counseling and education on additional opportunities for disenrollment, and
 - An advocate or ombudsman to help understand a beneficiary's rights, responsibilities and how to handle a dispute with the managed care plan or state.

Person-Centered Processes

- Ensuring beneficiaries' needs are met and they have the quality of life and level of independence they desire within the MLTSS program are fundamental components of person-centered processes.
- Elements:
 - Active participation by the beneficiary, or his/her designee, in the service planning and delivery process,
 - Meaningful choices of service alternatives,
 - Holistic service plans based on a comprehensive needs assessment, and
 - Opportunity to self-direct community-based services with assurances of appropriate supports.

Person-Centered Plans

- Section 2402(a) of the Affordable Care Act – Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Services Programs.
- Final Rule CMS 2249-F and CMS 2296-F - Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice (Section 1915(k) of the Act) and Home and Community-Based Services (HCBS) Waivers (Section 1915(c) of the



Comprehensive and Integrated Service Package

- CMS urges states to make benefit packages through the MCOs as comprehensive as possible.
- When all services are not covered through the MLTSS plan, states should include contract provisions on coordination and referral to ensure that the beneficiary's service plan is holistic and person-centered.
- Benefits of comprehensive service package:
 - MCOs have greater ability to monitor changing needs of beneficiary
 - Service plans are more comprehensive
 - Incentives on the MCOs to keep enrollees in the community or another integrated setting

Qualified Providers

- MLTSS plans must have an adequate network of qualified providers to meet the needs of their enrolled beneficiaries.
- CMS expects states to assure that MCO networks meet the needs of MLTSS beneficiaries, including adequate provider capacity and expertise to provide services that support community integration.
- During transition, states can establish continuity of care standards as well as mandate the managed care plans to provide training and technical assistance to providers.

Qualified Providers

- LTSS Service Provider pools.
- Impact of lack of availability of LTSS Service Provider on individual.
- Potential need to reprioritize service provider selection (home and job v. primary treating physician).

Participant Protections

- The elderly and those with disabilities are at greater risk of abuse, neglect and exploitation, and health disparities.
- Robust health and welfare protections and monitoring the transition and ongoing operation of the MLTSS program are critical.
- Elements to include in contracts:
 - Health and welfare assurances
 - Critical Incident management system with pathways for reporting known to all entities involved
 - Strong appeals process expectations allowing continuation of services while appeals are pending

Participant Protections

- 1915(c) HCBS Health and Welfare Assurance: The State demonstrates it has designed and implemented an effective system for assuring waiver participants health and welfare.
 - Subassurance 1: The State demonstrates that on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.
 - Subassurance 2: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Participant Protections

- 1915(c) HCBS Health and Welfare Assurance: The State demonstrates it has designed and implemented an effective system for assuring waiver participants health and welfare.
 - Subassurance 3: State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.
 - Subassurance 4: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Quality

- States should base their MLTSS quality framework on **existing LTSS quality systems** and **managed care quality systems**.
- Merging these two systems may provide a state with more sophisticated data capabilities and provide a new opportunity to think holistically about beneficiary outcomes.
- A comprehensive quality strategy and oversight structure that takes into consideration the acute care, behavioral health, as well as LTSS needs can provide a framework for states to incorporate more meaningful goals into the program that focus on quality of care and quality of life for the beneficiary.

Quality

- CMS March 12, 2014 Information Bulletin, “Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers”.
 - All new waiver applications and renewals submitted after June 1, 2014 must incorporate these modifications.

What's Next?

- We will continue to use our technical assistance resources to develop additional issue briefs and toolkits to assist States in addressing these principles.
 - How to use an External Quality Review Organization in review of MLTSS programs
 - White papers on quality, network and other policy areas within MLTSS

Questions?

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Public Notice Requirements in the Final Regulation

Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services



Background and Overview

Final Regulation became effective on March 17, 2014

- Covers 1915(c) waivers and 1915(i) state plan programs, including regulations on:
 - Home and community-based (HCB) settings
 - Allows Transition Plans on programs approved prior to March 17, 2014 to bring HCB Settings into compliance with the regulation by March 16, 2019
 - Person-centered planning
 - Conflict of interest

Background and Overview (cont'd)

- The final regulation also includes Home and community-based settings requirements for the 1915(k) State Plan authority (SPA).
- All 1915(k) programs approved after March 17, 2014 must fully comply with the rule.

Background and Overview (cont'd)

- Public Notice Requirements for 1915(k) SPAs:
 - States must follow the standard public notice requirements described in § 447.205, which requires states to provide public notice of any significant proposed change in its methods and standards for setting payment rates for services.
 - The final rule did not change the public notice requirements for 1915(k) SPA submissions.

Key Points

- Transition Plans are only allowed on existing programs as of the effective date of the regulation (March 17, 2014)
 - All new proposals must have HCB settings fully compliant with the regulation at time of approval
- Transition plans are only allowed for HCB Settings compliance
 - All other regulation provisions are expected to be met immediately

Public Notice Requirements

- Public Notice is required for the following:
 1. 1915(c) waiver and 1915(i) state plan specific transition plans
 2. A statewide transition plan, and
 3. A new or renewal 1915(c) waiver, and any amendment that includes a substantive change including, but not limited to:
 - I. Change in rate methodology
 - II. Change in provider qualifications,
 - III. Elimination or reduction in the scope, amount or duration of services
 - IV. Constriction in the eligible population

1915(c) Waiver Specific, 1915(i) State Plan Specific and Statewide Transition Plans

- The public notice requirements are the same:
 - There must be at least a 30 day public notice and comment period
 - The state must at minimum provide 2 statements of public notice and public input procedures
 - The state must assure that the full transition plan(s) is available to the public for comment
 - The state must consider and modify the transition plan, as the state deems appropriate, to account for public comment

1915(c) Waiver Specific, 1915(i) State Plan Specific and Statewide Transition Plans

- The submission of the proposed transition plan to CMS must include:
 - Evidence of the public notice required,
 - A summary of the comments received during the public notice period,
 - Reasons why comments were not adopted,
 - Any modifications made to the transition plan based upon those comments

1915(c) Waiver Specific, 1915(i) State Plan Specific and Statewide Transition Plans

- Upon approval by CMS, the State will begin implementation of the transition plans.
- The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation

1915(c) Waiver Modifications

- Waiver modifications may be made effective retroactive to the first day of a waiver year, or another date after the first day of a waiver year, in which the amendment is submitted, **unless** the amendment has substantive changes as determined by CMS
- Substantive changes include, but are not limited to:
 - Elimination or reduction of services
 - Reduced scope, amount and duration of any service
 - Change in provider qualifications
 - Change in rate methodology, and
 - Constriction in the eligible population

1915(c) Waiver Modifications with Substantive Change(s)

- A request for an amendment that involves a substantive change, may only take effect on or after the date when the amendment is approved by CMS.
- The amendment must be accompanied by information on how the State has assured smooth transitions and minimal effect on individuals adversely impacted by the change.

New 1915(c) Waivers, Renewals or Amendments with Substantive Change

- The public notice process must be used for existing waivers that have substantive changes proposed, either through the renewal or the amendment process, and new waivers.
- This process must be completed at a minimum of 30 days prior to submission of the proposed change to CMS,
- This process must include consultation with Federally-recognized Tribes, and in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5), Indian health programs and Urban Indian Organizations

New 1915(c) Waivers, Renewals or Amendments with Substantive Change

- The public notice and input process must be sufficient to reach the individuals receiving services, those who could be eligible and other stakeholders.

Summary

- The public notice process has been substantially strengthened with the new HCBS Regulation
- States may want to combine the transition plan and waiver public notices when both are needed at the same time
 - However, must call out in the public notice that both are present, and where each is located for review

For Further Information

For Questions contact:
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Final Rule Medicaid HCBS

Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services



Final Rule

CMS 2249-F and CMS 2296-F

Published in the Federal Register on 01/16/2014

Title:

Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice (Section 1915(k) of the Act) and Home and Community-Based Services (HCBS) Waivers (Section 1915(c) of the Act)

Intent of the Final Rule

- To ensure that individuals receiving long-term care services and supports through home and community based service (HCBS) programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate
- To enhance the quality of HCBS and provide protections to participants

Input to the Final Rule

The final rule reflects:

- Combined response to public comments on two proposed rules published in the Federal register –
 - May 3, 2012
 - April 15, 2011
- More than 2000 comments received from states, providers, advocates, employers, insurers, associations, and other stakeholders

Highlights of the Final Rule

- Defines, describes, and aligns home and community-based setting requirements across three Medicaid authorities
- Defines person-centered planning requirements for persons in HCBS settings under 1915(c) HCBS waiver and 1915(i) HCBS State Plan authorities
- Implements regulations for 1915(i) HCBS State Plan benefit

Highlights of the Final Rule

- Provides option to combine multiple target populations within one 1915(c) waiver
- Provides CMS with additional compliance options for 1915(c) waiver programs
- Establishes five-year renewal cycle to align concurrent authorities for certain demonstration projects or waivers for individuals who are dual eligible
- Includes a provider payment reassignment provision to facilitate certain state initiatives

Home and Community-Based Setting Requirements

- The home and community-based setting requirements establish an outcome oriented definition that focuses on the nature and quality of individuals' experiences
- The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting

Home and Community-Based Setting Requirements

The final rule establishes:

- Mandatory requirements for the qualities of home and community-based settings including discretion for the Secretary to determine other appropriate qualities
- Settings that are not home and community-based
- Settings presumed not to be home and community-based
- State compliance and transition requirements

Home and Community-Based Setting Requirements

The Home and Community-Based setting:

- Is integrated in and supports access to the greater community
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services

Home and Community-Based Setting Requirements

- Is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
 - Person-centered service plans document the options based on the individual's needs, preferences; and for residential settings, the individual's resources

Home and Community-Based Setting Requirements

- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports, and who provides them

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

Additional requirements:

- Specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement
- Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity
- If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- Setting is physically accessible to the individual

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

Modifications of the additional requirements must be:

- Supported by specific assessed need
- Justified in the person-centered service plan
- Documented in the person-centered service plan

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

Documentation in the person-centered service plan of modifications of the additional requirements includes:

- Specific individualized assessed need
- Prior interventions and supports including less intrusive methods
- Description of condition proportionate to assessed need
- Ongoing data measuring effectiveness of modification
- Established time limits for periodic review of modifications
- Individual's informed consent
- Assurance that interventions and supports will not cause harm

Settings that are NOT Home and Community-Based

- Nursing facility
- Institution for mental diseases (IMD)
- Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Hospital

Settings PRESUMED NOT to Be Home and Community-Based

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

Settings PRESUMED NOT to Be Home and Community-Based-Heightened Scrutiny

These settings (slide 18) may NOT be included in states' 1915(c), 1915(i) or 1915(k) HCBS programs unless:

- A state submits evidence (including public input) demonstrating that the setting does have the qualities of a home and community-based setting and NOT the qualities of an institution; AND
- The Secretary finds, based on a heightened scrutiny review of the evidence, that the setting meets the requirements for home and community-based settings and does NOT have the qualities of an institution

Transition

- For NEW 1915(c) HCBS waivers or 1915(i) HCBS State Plan benefits to be approved, states must ensure that HCBS are only delivered in settings that meet the new requirements

Transition

For renewals and amendments to existing HCBS 1915(c) waivers submitted within one year of the effective date of final rule:

- The state submits a plan in the renewal or amendment request detailing any actions necessary to achieve or document compliance with setting requirements for the specific waiver or amendment
- Renewal or amendment approval will be contingent upon inclusion of an approved transition plan

Transition

For renewals and amendments to existing 1915(i) state plan benefits submitted within one year of the effective date of final rule:

- The state submits a plan in the State Plan Amendment (SPA) or renewal (for 1915(i)s that target) request detailing any actions necessary to achieve or document compliance with setting requirements for the specific waiver or amendment
- SPA approval or renewal of the 1915(i) will be contingent upon inclusion of an approved transition plan

Transition

For ALL existing 1915(c) HCBS waivers and 1915(i) HCBS State Plan benefits in the state, the state must submit a plan:

- Within 120 days of first renewal or amendment request detailing how the state will comply with the settings requirements in ALL 1915(c) HCBS waivers and 1915(i) HCBS State Plan benefits
- The level and detail of the plan will be determined by the types and characteristics of settings used in the individual state

Transition

When a state DOES NOT renew or amend an existing 1915(c) HCBS waiver or 1915(i) HCBS State Plan benefit for HCBS within one year of the effective date of the final rule, the plan to document or achieve compliance with settings requirements must:

- Be submitted within one year of the effective date of the final rule
- Include all elements, timelines, and deliverables as required

Transition Public Comment Period

The state must provide a 30-day public notice and comment period on the plan the state intends to submit to CMS -

- Provide minimum of two statements of public notice and public input procedures
- Ensure the full transition plan is available for public comment
- Consider public comments
- Modify the plan based on public comment, as appropriate
- Submit evidence of public notice and summary of disposition of the comments

Transition

- Implementation of the plan begins upon approval by CMS
- Failure to submit an approvable plan may result in compliance actions
- Failure to comply with the terms of an approved plan may result in compliance actions

Final Rule Changes to Address Major Comments of Concern in NPRMs

- *Disability specific complex* – Phrase replaced with “any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS ...”
- *Rebuttable presumption* – Settings presumed to have institutional characteristics will be subject to heightened scrutiny allowing states to present evidence that the setting is home and community-based
- *Choice of provider in provider owned and operated settings* – Clarified that choice of provider is intrinsic to the setting

Final Rule Changes to Address Major Comments of Concern in NPRMs

- *Private rooms/roommate choice* – Needs, preferences, and resources are relevant to option of private versus shared residential unit. Providers must offer roommate choice for shared rooms.
- *Application of setting requirements to non-residential settings* – Rule applies to all settings where HCBS are delivered, not just to residential settings and CMS will provide additional information about how states should apply the standards to non-residential settings

Person-Centered Service Plans

Final rule includes changes to the requirements regarding person-centered service plans for HCBS waivers under 1915(c) and HCBS state plan benefits under 1915(i) -

- Identical for 1915(c) and 1915(i)
- The person-centered service plan must be developed through a person-centered planning process

1915(c) and 1915(i) Home and Community-Based Services Person-Centered Service Plans

- The person-centered planning process is driven by the individual
- Includes people chosen by the individual
- Provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- Is timely and occurs at times/locations of convenience to the individual

1915(c) and 1915(i) Home and Community-Based Services Person-Centered Service Plans

- Reflects cultural considerations/uses plain language
- Includes strategies for solving disagreement
- Offers choices to the individual regarding services and supports the individual receives and from whom
- Provides method to request updates

1915(c) and 1915(i) Home and Community-Based Services Person-Centered Service Plans

- Conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare
- Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual

1915(c) and 1915(i) Home and Community-Based Services Person-Centered Service Plans

- May include whether and what services are self-directed
- Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others

1915(c) and 1915(i)

Home and Community-Based Services

Written Person-Centered Service Plan Documentation

- Risk factors and measures in place to minimize risk
- Individualized backup plans and strategies when needed
- Individuals important in supporting individual
- Individuals responsible for monitoring plan

1915(c) and 1915(i)

Home and Community-Based Services

Written Person-Centered Service Plan Documentation

- Distributed to the individual and others involved in plan
- Includes purchase/control of self-directed services
- Exclude unnecessary or inappropriate services and supports

1915(c) Home and Community-Based Services Waivers

Other 1915(c) provisions in the final rule -

- Allows states to serve more than one target group in a single waiver
- Clarifies timing of amendments and public input process when states propose modifications
- Describes strategies available to CMS to assist states with compliance
- Clarifies guidance regarding effective dates of waiver amendments particularly in the area of substantive changes

1915(c) Home and Community-Based Services Target Groups

- States, under prior regulation, had ability to serve only one of three target groups
- A state may combine target groups within one waiver -
 - Individuals who are aged and disabled, or both
 - Individuals with intellectual disabilities or developmental disabilities, or both
 - Individuals with mental illness
- The state must assure that the waiver meets the needs of each individual regardless of target group.

1915(c) Home and Community-Based Services Duration, Extension, and Amendment of a Waiver

- Final rule clarifies guidance regarding effective dates of waiver amendments and the influence of substantive changes
 - Substantive changes include changes in eligible populations, constriction of service, amount, duration or scope, or other modifications as defined by the Secretary

1915(c) Home and Community-Based Services Duration, Extension and Amendment of a Waiver

- Waiver amendments with changes that are substantive (as described in the rule) may take effect only on or after the date of CMS approval
- The state must provide public notice when proposing significant changes to its methods and standards for setting payment rates for services
- The state is required to establish a public input process specifically for HCBS changes that are substantive in nature (slide 43)

1915(c) Home and Community-Based Services Strategies to Ensure Compliance

- The final rule describes additional strategies CMS may employ to ensure state compliance with the requirements of a waiver, short of termination or non-renewal, such as freezing enrollment, deferring payment for a service or other actions as determined necessary by the Secretary

1915(i) State Plan HCBS Benefit

Section 1915(i) of the Act -

- Was established by Deficit Reduction Act of 2005 and was effective January 1, 2007
- Is an option to amend state plan to offer HCBS
- Is an unique type of state plan benefit with similarities to 1915(c) HCBS waivers
- Breaks the “eligibility link” between HCBS and institutional care required under 1915(c) waivers

1915(i) State Plan HCBS Benefit

The Affordable Care Act of 2010 amended 1915(i) by –

- Adding a new optional categorical eligibility group for individuals to provide full Medicaid benefits to certain individuals who will be receiving HCBS
- Authorizing states to waive comparability

1915(i) State Plan HCBS Benefit

The final rule implements the laws and requires state plan home and community based services to meet -

- Home and community-based settings requirements
- Needs-based eligibility requirement
- Minimum state plan HCBS requirement (one service at a frequency established by the state)
- Applicable targeting criteria
- Nonapplication, i.e., option to not apply certain requirements (medically needy, comparability) when determining eligibility

1915(i) State Plan HCBS Benefit

The final rule implements the laws and requires the state to establish –

- Needs-based criteria and evaluation
- Independent assessment for each individual determined to be eligible for the benefit
- Person-centered service plan
- Provider qualifications
- Definition of individual's representative
- Self-directed services
- State responsibilities and quality improvement

1915(i) State Plan HCBS Benefit – Needs-Based Criteria and Evaluation Requirement

- State establishes needs-based criteria for determining eligibility under state plan for HCBS benefit
- Needs-based criteria are factors used to determine an individual's requirements for support and may include risk factors
- State must have more stringent institutional and waiver needs based criteria
- State may modify needs-based criteria in certain situations
- Individual independent evaluation to determine eligibility with periodic redeterminations

1915(i) State Plan HCBS Benefit – Needs-Based Criteria and Evaluation Requirement

- Needs-based criteria are NOT-
 - Descriptive characteristics of the person, or diagnosis
 - Population characteristics
 - Institutional levels of care

1915(i) State Plan HCBS Benefit - Independent Assessment of Needs

- For each individual determined eligible
- Conducted at least every 12 months and, as needed, when an individual's support needs or circumstances change significantly
- Service plan is updated accordingly

1915(i) State Plan HCBS Benefit – Provider Qualifications Requirements

The state defines -

- Standards for agency and individual providers
- Standards for agents conducting evaluations, assessment, and service plan development
- Conflict of interest standards to assure independence
(Note: Conflict of interest standards apply to public and private individuals and entities)

1915(i) State Plan HCBS Benefit - Definition of Individual's Representative and Responsibilities

- Legal guardian or other person authorized under state law to make decisions regarding the individual's well-being
- Any other person authorized to represent the individual including parent, family member or advocate
- State has policies describing authorization process, extent of decision-making and safeguards
- State must meet person-centered planning process including assuring that the process provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible

1915(i) State Plan HCBS Benefit – Self-Directed Services

- Services that are planned and purchased under the direction and control of the individual (or representative)
- Services include the amount, duration, scope, provider, and location
- Person-centered service plan must meet additional requirements when individual chooses to direct some/all HCBS
- Person-centered service plan specifies employer authority, limits to authority, and parties responsible for functions outside individual authority

1915(i) State Plan HCBS Benefit

State Plan HCBS Administration

State responsibilities and quality improvement-

- Provide CMS with projected numbers of individuals to be enrolled and actual numbers from previous year
- Grant access to all HCBS needed to eligible individuals per person-centered service plan
- Implement HCBS quality improvement strategy that includes continuous quality improvement process, measures of program performance, and experience of care

For more information

More information about the final regulation is available:

<http://www.medicaid.gov/HCBS>

A mailbox to ask additional questions can be accessed at:

hcbs@cms.hhs.gov

Medicaid and HCBS Basics: 1915(c), 1915(i), and HCBS in Managed Care

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Center for Medicaid and CHIP Services
Disabled and Elderly Health Programs Group

Purpose of Session

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- Provide an overview of different approaches available through the Medicaid program that States may use to provide home and community-based services and supports

Medicaid Authorities that include HCBS

95

- Medicaid State Plan Services – Section 1905(a) of the Social Security Act (the Act)
- Medicaid Home and Community Based Services Waivers (HCBS)– Section 1915(c)
- Medicaid HCBS State Plan Option – 1915(i)
- Medicaid Self-directed Personal Assistance Services State Plan Option - 1915(j)
- Medicaid Community First Choice Option– 1915(k)

Medicaid Authorities for HCBS (cont'd.)

96

- **Medicaid Managed Care Authorities**
 - Section 1915(a)
 - Section 1915 (b)
 - Section 1115
- **Section 1115 demonstration programs**

Medicaid in Brief

97

- States determine their own unique programs
- Each State develops and operates a State plan outlining the nature and scope of services; the State Plan and any amendments must be approved by CMS
- Medicaid mandates some services, States elect to provide other services (“optional services”)
- States choose eligibility groups, services, payment levels, providers

Medicaid State Plan Requirements

98

- States must follow the rules in the Act, the Code of Federal Regulations (generally 42 CFR), the State Medicaid Manual, and policies issued by CMS
- States must specify the services to be covered and the “amount, duration, and scope” of each covered service
- States may not place limits on services or deny/reduce coverage due to a particular illness or condition.

Medicaid State Plan Requirements (cont'd.)

99

- Services must be *medically necessary*
- Third party liability rules require Medicaid to be the “payor of last resort”
- Generally, services must be available Statewide
- Beneficiaries have freedom of choice of providers

Medicaid State Plan Requirements (cont'd.)



- State establishes provider qualifications
- State enrolls all willing and qualified providers
- Establishes payment for services (4.19-B pages)
- Reimbursement methodologies must include methods/procedures to assure payments are consistent with economy, efficiency, and quality of care principles

Medicaid State Plan Services

101

MANDATORY

- Physician services
- Laboratory & x-ray
- Inpatient hospital
- Outpatient hospital
- EPSDT
- Family planning
- Rural and federally-qualified health centers
- Nurse-midwife services
- NF services for adults
- Home health

OPTIONAL

- Dental services
- Therapies – PT/OT/Speech/Audiology
- Prosthetic devices, glasses
- Case management
- Clinic services
- Personal care, self-directed personal care
- Hospice
- ICF/IID
- PRTF for <21
- Rehabilitative services
- 1915(i) State plan HCBS
- Inpatient hospital services [other than those provided in an Institution for Mental Diseases (IMD)]
- Services for individuals 65+ in IMDs
- 1915(k) Community First Choice Option

HCBS under the State Plan

102

Some HCBS are Available through the regular State plan:

- Personal Care
- Home Health (nursing, medical supplies & equipment, appliances for home use, optional PT/OT/Speech/Audiology)
- Rehabilitative Services
- Targeted Case Management
- Self-directed Personal Care

Medicaid Waivers

103

- Title XIX permits the Secretary of Health & Human Services - through CMS - to waive certain provisions required through the regular State plan process:

For 1915(c) HCBS waivers, the provisions that can be waived are related to:

- Comparability (amount, duration, & scope)
- Statewideness
- Income and resource requirements

1915(c) HCBS Waivers

104

- 1915(c) HCBS waiver services complement and/or supplement the services that are available through:
 - ❖ the Medicaid State plan
 - ❖ other Federal, state and local public programs
 - ❖ supports from families and communities

Medicaid HCBS Waivers -1915(c)

105

- Is the major tool for meeting rising demand for long-term services and supports
- Permits States to provide HCBS to people who would otherwise require Nursing Facility (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) or hospital Level of Care
- Serves diverse target groups
- Services can be provided on a less than statewide basis
- Allows for participant-direction of services

Basic 1915(c) Waiver Facts

106

- There are more than 315 Waivers in operation across the country.
- 1915(c) waivers are the primary vehicle used by States to offer non-institutional services to individuals with significant disabilities.
- Package of HCBS is designed as an alternative to institutional care, supports community living & integration and can be a powerful tool in a State's effort to increase community services.

Final Rule CMS 2249-F

107

- CMS published Final Regulations on January 16, 2014, that became effective on March 17, 2014, to implement changes in the current regulations for 1915(c) waivers.
- Changes in the current regulations for 1915(c) waivers, including option to combine multiple target groups in one waiver, home and community-based settings, person-centered planning, public notice, and additional compliance options for CMS.
- More information about the final regulation is available at:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

Section 1915(c) HCBS Waivers: Permissible Services

108

- Home Health Aide
- Personal Care
- Case management
- Adult Day Health
- Habilitation
- Homemaker
- Respite Care

For chronic mental illness:

- **Day Treatment/Partial Hospitalization**
- **Psychosocial Rehabilitation**
- **Clinic Services**

- **Other Services**

1915(c) HCBS Waiver Requirements

109

- **Costs:** HCBS must be “cost neutral” as compared to institutional services, on average for the individuals enrolled in the waiver.
- **Eligibility & Level of Care:** Individuals must be Medicaid eligible, meet an institutional level of care, and be in the target population(s) chosen & defined by the state.
- **Assessment & Plan of Care:** Services must be provided in accordance with an individualized assessment and person-centered service plan.
- **Choice:** Not waived under 1915(c) - HCBS participants must have choice of all willing and qualified providers.

1915(c) HCBS Waiver Processing

110

- **Processing:**

- CMS approves a new waiver for a period of 3 years. States can request a period of 5 years if the waiver will include persons who are dually eligible for Medicaid & Medicare.
- States may request amendments at any time.
- States may request that waivers be renewed; CMS considers whether the State has met statutory/regulatory assurances in determining whether to renew.
- Renewals are granted for a period of 5 years.

HCBS Waiver Quality

111

- States must demonstrate compliance with waiver statutory assurances
- States must have an approved Quality Improvement Strategy: an evidence-based, continuous quality improvement process

Quality in HCBS Waivers

112

1915(c) Federal Assurances

- Level of Care
- Service Plans
- Qualified Providers
- Health and Welfare
- Administrative Authority
- Financial Accountability

HCBS Waiver Application and Instructions

113

- Waiver applications are web-based: *Version 3.5 HCBS Waiver Application*
- The application has a robust set of accompanying instructions: *Instructions, Technical Guide, and Review Criteria*
- Available at
<https://wms-mmdl.cdsvdc.com/WMS/faces/portal.jsp>

1915(i) State Plan HCBS — Key Features

114

- Section 1915(i) established by DRA of 2005; became effective January 1, 2007
- State option to amend the state plan to offer HCBS as a state plan benefit
- Unique type of State plan benefit with similarities to HCBS waivers
- Breaks the “eligibility link” between HCBS and institutional care now required under 1915(c) HCBS waivers

1915(i) State plan HCBS

115

- Modified under the Affordable Care, effective October 1, 2010:
 - Added state option to add a new Medicaid categorical eligibility group to provide full Medicaid benefits to individuals with incomes up to 150% of the FPL, and/or with incomes up to 300% of SSI FBR and who are eligible for a waiver
 - Added state option to disregard comparability (target populations) for a 5 year period with option to renew with CMS approval, and states can have more than one 1915(i) benefit
 - Expanded the scope of HCBS states can offer
 - Removed option for states to limit the number of participants and disregard state-wideness

1915(i) Services

116

Any of the statutory 1915(c) services:

- Case management
- Homemaker
- Home Health Aide
- Personal Care
- Adult Day Health
- Habilitation
- Respite Care
- For Chronic Mental Illness:
 - Day treatment or Partial Hospitalization
 - Psychosocial Rehab
 - Clinic Services
- Other Services necessary to live in the community

Who May Receive State plan HCBS?

117

- Individuals eligible for medical assistance under the State plan; and
 - Meet state-defined **needs-based criteria**; and
 - Reside in the community; and
 - Have income that does not exceed 150% of FPL .
-
- States also have the option to add a new Medicaid categorical eligibility group to provide full Medicaid benefits to individuals with incomes up to 150% of the FPL, and/or with incomes up to 300% of SSI FBR and who are eligible for a HCBS waiver.

1915(i) Needs-Based Criteria

118

- Determined by an individualized evaluation of need (e.g., individuals with the same condition may differ in ADLs)
- May be functional criteria such as ADLs
- May include State-defined risk factors
- Needs-based criteria are not:
 - descriptive characteristics of the person, or diagnosis
 - population characteristics
 - institutional levels of care

1915(i) Needs-Based Criteria

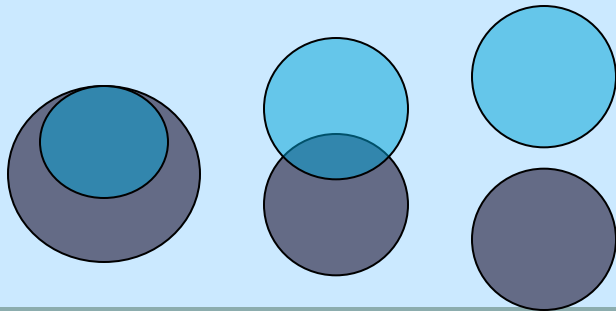
119

- The lower threshold of needs-based eligibility criteria must be “less stringent” than institutional and HCBS waiver LOC.
- But there is no implied upper threshold of need. Therefore the universe of individuals served:
 - Must include some individuals with less need than institutional LOC
 - and May include individuals at institutional LOC, (but not in an institution)

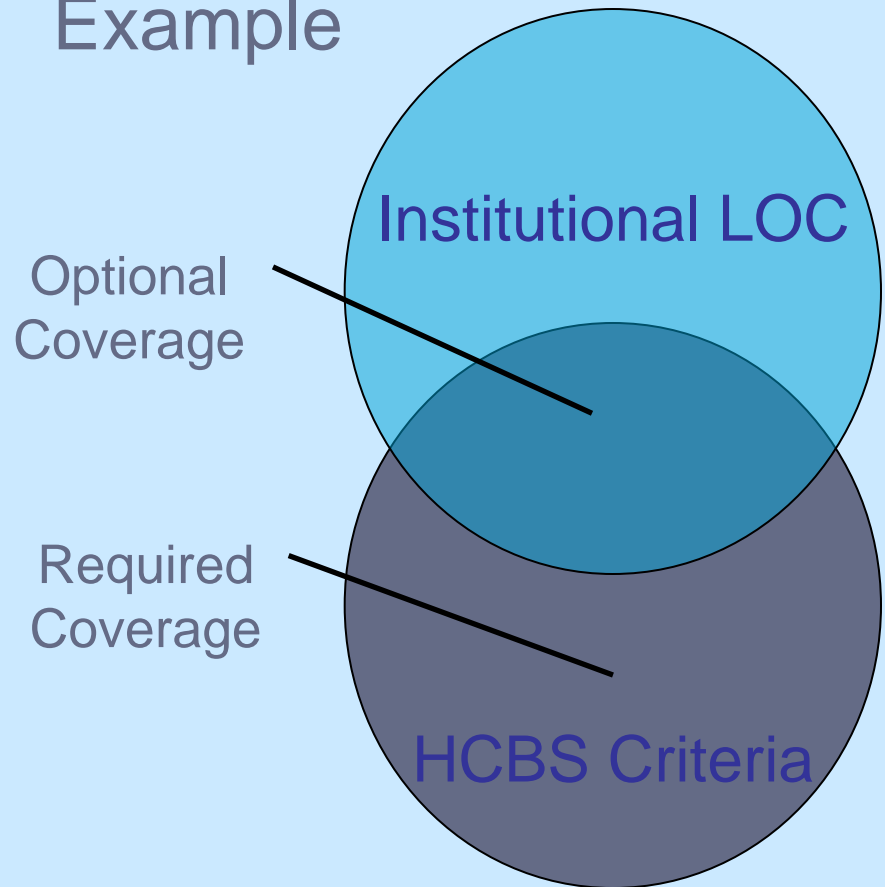
1915(i) Needs-Based Criteria

120

- Eligibility criteria for HCBS benefit may be narrow or broad
- HCBS eligibility criteria may overlap all, part, or none, of the institutional LOC:



Example



1915(i) State plan HCBS: Requirements

121

- Independent Evaluation to determine program eligibility
- Individual Assessment of need for services
- Individualized Person-Centered Service Plan
- Projection of number of individuals who will receive State plan HCBS
- Payment methodology for each service
- Quality Improvement Strategy: States must ensure that HCBS meets Federal and State guidelines
- Home and Community-Based Setting Requirements

Self-Direction in 1915(i)

122

- State Option to include services that are planned and purchased under the direction and control of the individual (or representative)
- May apply to some or all 1915(i) services
- May offer budget and/or employer authority
- Specific requirements for the service plan: must include the self-directed HCBS, employment and/or budget authority methods, risk management techniques, financial management supports, process for facilitating voluntary and involuntary transition from self-direction

Final Rule CMS 2249-F

123

- New Regulations for 1915(i) State plan HCBS were published on January 16, 2014
- Effective date: March 17, 2014
- More information about the final regulation is available at:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

Medicaid HCBS Provided in a Managed Care Delivery System

124

- HCBS are usually provided as “fee for service” – service is delivered, a claim is filed, and payment made
- HCBS can also be provided as part of a managed care delivery system, which generally offers a capitated payment arrangement, using one of several Medicaid authorities:
 - 1915(a) – contracting option
 - 1915(b) – waiver
 - 1115 – demonstration authority

Medicaid Managed Care Authorities

125

- Section 1915(a) – voluntary contract with a managed care organization that agrees to provide certain State plan services, including HCBS in a capitated arrangement
- Section 1915(b) waiver – managed care delivery system for State plan services that may restrict providers, use selective contracting, use locality as central broker, use “savings” to provide additional services generated through savings

Section 1115 Demonstration Projects

126

- Section 1115 authority may be used when a State seeks to demonstrate whether a new service or intervention would lead to a change in Medicaid policy.
- The Secretary may waive compliance with any of the requirements of section 1902 of the Social Security Act.
- Services may be reimbursed as fee-for-service or under a managed care arrangement.



Person-Centered Planning

Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services



Regulatory Requirement

- Required for both the 1915(c) and the 1915(i)
- For the 1915(c)
 - Requirements for the person-centered planning process can be found at 441.301(c)(1)(ix)
 - Requirements for the person-centered service plan can be found at 441.301(c)(2)(xiii A through H)
 - Requirements for review of the person-centered plan can be found at 441.301(c)(3)

Regulatory Requirements

- For the 1915(i)
 - Requirements for the person-centered process and plan can be found at 441.725(a) and (b)
- The process and plan requirements are the same for both authorities.

Process and Plan

- Each individual will be engaged in a person-centered planning process, which will lead to the development of their person-centered service plan.

Person-Centered Planning Process

Leading

- The individual will lead the person-centered planning process where possible.
- The process should provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

Person-Centered Planning Process

Leading

- The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative.
 - All references to individuals include the role of the individual's representative.
- The planning process should only include people chosen by the individual.

Person-Centered Planning Process *Requirements*

The person-centered planning process should be characterized by the following:

- Is timely and occur at times and locations of convenience to the individual.
- Reflects cultural considerations of the individuals.
- Is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

Person-Centered Planning Process

Conflict Resolution

- The person-centered planning process should include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

Person-Centered Planning Process

Conflict-of-Interest

- Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan.
- Exceptions to this will only be granted when the State demonstrates that the only willing and qualified entity to provide case management or develop person-centered service plans in a geographic area also provides HCBS.

Person-Centered Planning Process

Conflict-of-Interest

- In these cases the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS.
- Individuals must be provided with a clear and accessible alternative dispute resolution process.

Person-Centered Planning Process

Informed Choices & Updates

The planning process must:

- Offer informed choices to the individual regarding the services and supports they receive and from whom.
- Record the alternative home and community-based settings that were considered by the individual.
- Include a method for the individual to request updates to the plan as needed.

Person-Centered Service Plan

- The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and support.
- The written plan must reflect that the setting in which the individual resides is chosen by the individual.

Person-Centered Service Plan

Community Access

- The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including:
 - Opportunities to seek employment and work in competitive integrated settings
 - Engage in community life
 - Control personal resources
 - Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

Person-Centered Service Plan *Requirements*

The person-centered service plan must:

- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs as identified through an assessment of functional need.
- Include individually identified goals and desired outcomes.
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

Person-Centered Service Plan

Services & Supports

The person-centered service plan must:

- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and providers of those services and supports, including natural supports.
 - Natural supports are unpaid supports that are provided voluntarily to the individual voluntarily in lieu of 1915(c) HCBS waiver services and supports.

Person-Centered Service Plan

Services & Supports

The person-centered service plan must:

- Include those services, the purpose or control of which the individual elects to self-direct.
- Prevent the provision of unnecessary or inappropriate services and supports.

Person-Centered Service Plan

Understandability

- The person-centered service plan must be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.
- At a minimum, for the written plan to be understandable, it must be written in plain language, and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

Person-Centered Service Plan

Monitoring, Finalizing, & Distributing

The person-centered service plan must:

- Identify the individual and/or entity responsible for monitoring the plan.
- Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individual and providers responsible for its implementation.
- Be distributed to the individual and other people involved in the plan.

Person-Centered Service Plan *Modifications*

- Any modifications of these conditions must be supported by a specific assessed need and justified in the person-centered service plan.

Person-Centered Service Plan *Modifications*

The following requirements must be documented in the person-centered service plan:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.

Person-Centered Service Plan *Modifications*

The following requirements must be documented in the person-centered service plan:

- Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include informed consent of the individual.
- Include an assurance that interventions and supports will cause no harm to the individual.

Person-Centered Service Plan *Review*

- The person-centered service plan must be reviewed, and revised upon reassessment of functional need at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.



Statewide Transition Plan Alignment with HCB Settings Regulation Requirements

Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services



Overview

- Introduction to the Statewide Transition Plan
- Assessment Process
- Remedial Strategy
- Public Input Process
- Other Components
- Summary

Introduction to the Statewide Transition Plan

Regulatory Requirement

When to Submit

What is a Statewide Transition Plan

Snapshot of Main Components

Regulatory Requirement

- Each state that operates a 1915(c) waiver or a Section 1915(i) state plan benefit that was in effect on or before March 17, 2014 is required to file a Statewide Transition Plan.
- The regulatory requirement can be found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2).

When to Submit

- Triggered by the state's first 1915(c) waiver or 1915(i) SPA that is renewed or amended between March 17, 2014 and March 16, 2015.
 - A Statewide Transition Plan must be submitted within 120 days after the submission date of the first renewal or amendment.
 - If a state does not submit an amendment or renewal between March 17, 2014 and March 16, 2015, the state must submit a Statewide Transition Plan no later than **March 17, 2015**.

What is a Statewide Transition Plan

- The vehicle through which states determine their compliance with the regulation requirements for home and community-based settings in 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2).
- Describes to CMS how the state will comply with the new regulations.
- States must be in full compliance with the federal requirements by the time frame approved in the Statewide Transition Plan but no later than **March 17, 2019**.

Snapshot of the Main Components

- ***Assessment Process:*** Includes the state's assessment of the extent to which its regulations, standards, policies, licensing requirements, and other provider requirements ensure settings comport with the regulation.
- ***Remedial Strategy:*** Describes actions the state proposes to assure initial and on-going compliance with the HCBS settings requirements, with specific timeframes for identified actions and deliverables.
- ***Public Input:*** Subject to public input, as required in 42 CFR Section 441.301(6)(B)(iii) and 42 CFR Section 441.710(3)(iii).

Assessment Process

Systemic Review

Site Specific Assessments

Provider Assessments

Settings Presumed Not to be HCB

Summary

Assessment Process

- To determine whether state transition actions are needed for compliance, states must first determine their current level of compliance with the settings requirements.
- A written description of the assessment should be submitted to CMS, which includes:
 - The state's assessment of the extent to which its standards, rules, regulations, or other requirements comply with the HCBS settings requirements.
 - A description of the state's oversight process to ensure continuous compliance.
- The state may also assess individual settings/types of settings to further document their compliance.

Systemic Review

- Upon conducting its compliance assessment, a state may determine that:
 - Existing state standards meet the federal settings requirement, and
 - The state’s oversight process is adequate to ensure ongoing compliance,
 - therefore, any settings currently approved under the state’s standards meet the federal settings requirement.
- The state describes its process for conducting the compliance review and the outcomes of that review.

Systemic Review (cont'd)

- The state determines that its standards may not meet the federal settings requirements.
- The state includes in its Statewide Transition Plan:
 1. Specific remedial action(s) to come into compliance, which may include:
 - a) Proposing new state regulations or revising existing ones
 - b) Revising provider requirements
 - c) Conducting statewide provider training on the new state standards.

Systemic Review (cont'd)

2. Time frame for completing these actions, and
3. estimate of the number of settings that likely do not meet the federal settings requirement.

Site Specific Assessment

- In situations where the state standards do not coincide with the federal standards, it is possible that specific settings are in compliance with the federal requirements.
- In this case, a state may choose to assess individual sites to determine which are/are not in compliance with the federal standard.
- Such an assessment may impact the time frames proposed to bring settings into compliance; if so, the Statewide Transition Plan should include these additional actions and timeframes.

Site Specific Assessment (cont'd)

- States may conduct specific site evaluations through standard processes such as licensing reviews, provider qualification reviews, support coordination visit reports, etc.
- States may engage individuals receiving services and representatives of consumer advocacy entities (long-term care ombudsman programs, protection and advocacy systems, etc.) in the assessment process.

Site Specific Assessment (cont'd)

- Evaluations may be conducted by entities such as:
 - state personnel
 - case managers that are **not** associated with the agency operating the setting providing services
 - Licensing entities.
 - Managed Care Organizations.
 - Individuals receiving services themselves and/or
 - Representatives of consumer advocacy entities such as long-term care ombudsman programs and/or protection and advocacy systems.

Site Specific Assessments (cont'd)

- States may perform on-site assessments of a statistically significant sample of settings.
- When states do not have full knowledge of the settings in their system, CMS strongly encourages, at a minimum, a sampling approach to onsite reviews.
- Assessment of individual settings is not a substitute for ensuring that state standards, regulations, policies, and other requirements are consistent with federal requirements and that the state has an oversight system in place to assure ongoing compliance with the requirements.

Provider Assessments

- States may also administer surveys of providers.
- In this instance, providers of the settings could “self-assess” their compliance with the federal requirements or provide information required by the state to make a determination of compliance.
- States should include a validity check against the self evaluation
- If the assessment indicates settings do not meet the new requirements, states must include remediation strategies in the Statewide Transition Plan.

Settings Presumed Not to be Home and Community-Based

- Where the state is submitting evidence that a setting presumed not to be home and community-based is in fact home and community-based and does not have the qualities of an institution, evidence of a site visit will facilitate the heightened scrutiny process.

Summary

If the state determines on the basis of its review of current state regulations, standards, and policy that its settings are consistent with federal settings requirements, the state should describe:

- The process of the assessment,
- The basis for the conclusion(s), and
- The oversight (monitoring) process

Summary (cont'd)

- If the process of assessment is not yet complete and will require greater than six (6) months for review the state must submit justification for the additional time frame.

Summary (cont'd)

If the assessment is based on state standards, the state needs to provide their best estimate of the number of settings that:

1. Fully align with the federal requirements,
2. Do not comply with the federal requirements and will require modifications,
3. Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals, and

Summary (cont'd)

4. Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)
 - CMS would expect an on-site assessment that supports the state's assertion.

Summary(cont'd)

If the state conducts site specific evaluations, the state needs to provide the same information as required for an assessment based on state's standards.

Remedial Strategy

State Level Remedial Actions

Provider Level Remedial Actions

Settings Presumed Not to be HCB

Relocation of Beneficiaries

Remedial Strategy

- Statewide Transition Plans should include a detailed description of the remedial actions the state will use to assure full compliance with the HCB settings requirements, including timelines, milestones and monitoring process.

State Level Remedial Actions

Might include, but are not limited to:

- New requirements promulgated in statute, licensing standards or provider qualifications.
- Revised service definitions and standards.
- Revised training requirements or programs.
- Plans to relocate individuals to settings that are compliant with the regulations.

Provider Level Remedial Actions

Might include, but are not limited to:

- Changes to the facility or program operation to assure that the Medicaid beneficiary has greater control over critical activities like:
 - Access to meals
 - Engagement with friends and family
 - Choice of roommate
 - Access to activities of his/her choosing in the larger community, including the opportunity to seek and maintain competitive employment.

Settings Presumed Not to be HCB

- If the state determines it will submit evidence to CMS for the application of heightened scrutiny for settings that are presumed not to be home and community-based, the Statewide Transition Plan should include evidence sufficient to demonstrate the setting does not have the characteristics of an institution and *does* meet the HCB setting requirements.

Settings Presumed Not to be HCB (cont'd)

- Evidence of a site visit by the state, or an entity engaged by the state, will facilitate the heightened scrutiny process.
- CMS will consider input from the state, information collected during the public input process, and information provided by other stakeholders in conducting heightened scrutiny.
- CMS may conduct its own site visits as well.

Relocation of Beneficiaries

- When relocation of beneficiaries is part of the state's remedial strategy, the Statewide Transition Plan should include:
 - An assurance that the state will provide reasonable notice to beneficiaries and due process to these individuals;
 - A description of the timeline for the relocation process;
 - The number of beneficiaries impacted; and

Relocation of Beneficiaries (cont'd)

- A description of the state's process to ensure beneficiaries, through the person-centered planning process, are given the opportunity, the information and the supports to make an informed choice of an alternate setting that aligns, or will align, with the regulation and that critical services/supports are in place in advance of the individual's transition.

Time Frame & Milestones

- Submitted Statewide Transition Plans must include a time frame and milestones for state actions, including assessment and remedial actions.
- If state standards must be modified in order to effect changes in the state system, the state should propose a reasonable time frame for making the modifications.

Time Frame & Milestones (cont'd)

- If the state intends to conduct an assessment after adopting new standards, the state should provide information on how, in the interim, it will communicate the need for change, educate providers, inform individuals and families, and establish a time frame for the activities.
- The state must also include a complete timetable for coming into full compliance.

Summary of Comments & Modifications

- When filing its Transition Plan with CMS, the state must provide:
 - A summary of public comments, including the full array of comments whether in agreement or not with the state's determinations of the state's determination of the system-wide compliance and/or compliance of specific settings/types of settings;
 - A summary of modifications to the Transition Plan made in response to public comment;

Summary of Comments & Modifications (cont'd)

- When filing its Transition Plan with CMS, the state must provide:
 - In the case where the state's determination differs from public comment, the additional evidence and the rationale the state used to confirm its determination (e.g. site visits to specific settings).

Public Posting

- At the time the state files the Transition Plan with CMS, it must simultaneously post the submitted plan on the state website.
- The URL for that posting should be included in the Transition Plan document submitted to CMS.
- The state must also provide an assurance that the Statewide Transition Plan, with any modifications made as a result of public input, is posted for public information no later than the date of submission to CMS, and that all public comments on the Transition Plan are retained and available for CMS review for the duration of the transition period or approved waiver, whichever is longer.

Public Input

Access

Public Notice

Timeframe

Public Input Process

Summary of Comments & Modifications

Public Posting

Waiver Specific Transition Plans

Changes in Public Input Process Initiated by this Regulation

Substantive Changes

Ongoing Transparency and Public Input

Public Input (cont'd)

- Prior to filing with CMS, a state must seek input from the public for its proposed Statewide Transition Plan.
- The public input period must be no less than a 30-day period.
- CMS encourages states to seek input from a wide range of stakeholders representing consumers, providers, advocates, families, and other stakeholders.

Public Input (cont'd)

- The state must retain all public comments on the Statewide Transition Plan to be made available for CMS review for the duration of the transition period or approved waiver, whichever is longer.

Access

- The process for individuals to submit public comment should be convenient and accessible for all stakeholders, particularly individuals receiving services.
- CMS requires states to post the Statewide Transition Plans on their website in an easily accessible manner and include a website address for comments.
- At least one additional option for public input, such as public forums, is required.

Public Notice

- The Statewide Transition Plan must include evidence of two statements of public notice and requests for public input
- To accomplish this, the state could include in the Transition Plan the processes used for providing the public notice (e.g., publication in newspapers, announcement via websites, etc...)

Timeframe

- The Statewide Transition Plan should include evidence of the timeframe for public input, which verifies that a minimum of 30-days was afforded for public review and comment.
- To accomplish this, the state could include in the Transition Plan the actual date of the public notice requests for public input.

Public Input Process

- The Statewide Transition Plan should include a description of the public input process.
- To accomplish this, the state could include in the Transition Plan how public input was received (e.g., testimony, web response, etc...).

Waiver Specific Transition Plans

- States filing waiver renewals or amendments to existing 1915c waivers require a public input process in addition to the public input process for the embedded waiver specific Transition Plan.
- A state could use one public input process to meet both requirements.

Changes in Public Input Process Initiated by this Regulation

- States must ensure the document is posted and, in the case of public forums, available or distributed for comment.
- States must ensure the full Transition Plan is available to the public for public comment, including individuals receiving services, individuals who could be served, and the full stakeholder community.
- Summary statements or documents may be helpful but in and of itself will not constitute public notice.
- Meetings held with selected representatives of types of stakeholder will not be sufficient to demonstrate adequate notification or input.

Substantive Changes

- Substantive changes in a Transition Plan will require public comment.
- When a state submits an amendment or modification to a Transition Plan where additional assessment has resulted in a change in the findings or where the state adds more specific remedial action and milestones, the state must incorporate the public notice and input process into that submission.

Ongoing Transparency and Public Input

- CMS believes it would be very helpful for the states to use public input in the assessment of the state's progress on the milestones approved in the Transition Plan.
- States are strongly encouraged to describe their process for ensuring ongoing transparency and input from the stakeholders on the process of the Transition Plan.