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 and Home and Community-Based Services (HCBS) Waivers
[42CFR Parts 430, 431, 435, 436, 440, 441 and 447]

The rule was filed on January 10, 2014. The rule will be published on January 16, 2014 and it will be effective on March 17, 2014. This rule will impact all of the DD HCBS waivers.

Waiver	*# of Individuals Enrolled at 1/2/14*	*Renewal Date*	*Transition Plan Due to CMS**	*Transition Period for Rule Compliance**
Individual Options	17,601	7/1/14	10/28/14 – 6/30/15	6/30/15 – 6/30/19
Level One	12,963	7/1/16	6/30/15	6/30/15 – 6/30/19
SELF	220	7/1/15	6/30/15	6/30/15 – 6/30/19
Transitions DD	2,951	7/1/15	6/30/15	6/30/15 – 6/30/19
*These timelines are our best estimates, as there remains some question about the transition plan process requirements. CMS will likely issue subregulatory guidance on this soon.				

The rule applies to all HCBS waiver services, not just residential-related services. CMS will work with individual states to determine the applicability of the rule's requirements to each state's waiver system. There will be a "heightened review process" whereby states may ask CMS for subregulatory guidance on specific HCBS waiver services/settings. States will have up to 5 years to come into compliance, but may only be given 1 year at the discretion of CMS.

The new rule defines both what an acceptable HCBS setting is and what it is not. There are general requirements, plus requirements for settings with provider-controlled/owned housing. Some HCBS service settings in Ohio may need to change, for example, Institutional Respite and Adult Day Services (particularly when these services isolate people with IDD from the broader community). For additional information on the new HCBS setting requirements, please see the attached HCBS Setting Fact Sheet from CMS and pages 330 - 333 of the rule document.

In addition to the definition of community settings, the rule allows states to combine target populations for HCBS waivers. This includes: aged and/or disabled; IDD; and mental illness. We are not aware of any intention by the State of Ohio to combine IDD waivers with another target population.

The rule also requires "person-centered planning" that focuses on outcomes over process. This is consistent with the waiver pilot that includes OPRA, OACB, and DODD.

For additional information on the rule, go to www.medicaid.gov/HCBS. A webinar is being offered by CMS to the general public on January 23rd and 30th, 1:00 – 3:00pm EST both days. It will be the same webinar – identical on both days. Registration information will be posted at the aforementioned

website soon. We encourage interested parties to check the website and register as soon as registration is available, as this webinar is expected to be in high demand.

There is no requirement for the implementation of this rule to be budget neutral, nor is there any presumption by CMS that they will make a major investment in this implementation. There will be no grant money available from CMS for the implementation. States may use the balanced incentive payment program, or the money-follows-the-person program to help fund any transition (Ohio is doing both).

CMS welcomes input from any interested parties. OPRA will collect input and "bundle" it for CMS. Please send any comments or questions directly to Mark Davis at mdavis@opra.org.

Primary Components of the Rule

- Provides HCBS setting requirements for all waiver services
- Allows states to combine target populations for HCBS waivers including aged and/or disabled, IDD, and mental illness
- Requires "person-centered planning" that focuses on outcomes over process
- 5 year demonstration period for dual-eligibles (Medicaid and Medicare) with 1115, 1915 (b), (c), and (d) waivers
- Provides additional limited exception to the general requirement that payment for services under a state plan must be made directly to the individual practitioner providing a service when the Medicaid program is the primary source of reimbursement for a class of individual practitioners

HCBS setting requirements

The rule provides characteristics of settings that <u>are</u> and <u>are not</u> community-based settings.

<u>General characteristics of all community-based settings (includes all HCBS waiver services, not just residential)</u>

"Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

i. "The setting 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, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

ii. "The setting 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. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

iii. "Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

iv. "Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

v. "Facilitates individual choice regarding services and supports, and who provides them."

Characteristics of community-based settings that are in a provider-owned or controlled residential setting

A. "The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

B. "Each individual has privacy in their sleeping or living unit:

1) "Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

2) "Individuals sharing units have a choice of roommates in that setting.

3) "Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

C. "Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

D. "Individuals are able to have visitors of their choosing at any time.

E. "The setting is physically accessible to the individual.

F. "Any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

1) "Identify a specific and individualized assessed need.

2) "Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

3) "Document less intrusive methods of meeting the need that have been tried but did not work.

4) "Include a clear description of the condition that is directly proportionate to the specific assessed need.

5) "Include regular collection and review of data to measure the ongoing effectiveness of the modification.

6) "Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7) "Include the informed consent of the individual.

8) "Include an assurance that interventions and supports will cause no harm to the individual."

*Settings that are **not** community-based*

i. "A nursing facility;

ii. "An institution for mental diseases;

iii. "An intermediate care facility for individuals with intellectual disabilities;

iv. "A hospital; or

v. "Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings."

These new requirements for community settings may impact Ohio's ability to use HCBS waiver funds to provide Institutional Respite, Nonmedical Transportation and some Adult Day Services. For example, the rule specifically excludes ICFs as an HCBS setting, but in the CMS comments, Institutional Respite is specifically allowed (for comments, see pages 40, 47, and 252 of the rule document). CMS has specifically said they will issue subregulatory guidance on the application of these new requirements adult day services.

Residential providers may need to revise policies on meals, visitation, access to individual's private areas, outings, lease agreements with individuals, home furnishing, general schedule of other activities, having multiple provider organizations working in one residential setting.

Combination of target populations for HCBS waivers

The rule allows states to combine target populations for HCBS waivers including aged and/or disabled, IDD, and mental illness. There is no indication that Ohio will combine aged and/or disabled waivers with IDD waivers. Ohio has no waivers for individuals with mental illness.

OPRA remains concerned about what combining target waiver groups would mean for resources available to serve people with IADD. Many of the people with IADD served on HCBS waivers are potentially higher needs individuals than other target groups discussed (aged, mentally ill). OPRA is concerned that combining groups might result in a lowering of rates for HCBS waivers that address the needs of the people with IADD resulting in insufficient resources and support to appropriately serve these individuals.

Person-centered planning

This requires "person-centered planning" that focuses on outcomes and where possible is "led by the individual receiving services and supports (which includes the 'individual's representative'), unless the person has a legal guardian who has decision-making authority."

Additional person-centered planning requirements:

i. "Includes people chosen by the individual.

ii. "Provides 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.

iii. "Is timely and occurs at times and locations of convenience to the individual.

iv. "Reflects cultural considerations of the individual and 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, consistent with §435.905(b)" – that states: (b) Such information must be provided to applicants and beneficiaries in plain language and in a manner that is accessible and timely to –

    1) "Individuals who are limited English proficient through the provision of language services at no cost to the individual; and

    2) "Individuals living with disabilities through the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act."

v. "Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

vi. "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, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. 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.

vii. "Offers informed choices to the individual regarding the services and supports they receive and from whom.

viii. "Includes a method for the individual to request updates to the plan as needed.

ix. "Records the alternative home and community-based settings that were considered by the individual."

The 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 supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

i. "Reflect that the setting in which the individual resides is chosen by the individual. 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, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

ii. "Reflect the individual's strengths and preferences.

iii. "Reflect clinical and support needs as identified through an assessment of functional need.

iv. "Include individually identified goals and desired outcomes.

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

vi. "Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

vii. "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, consistent with §435.905(b) of this chapter.

viii. "Identify the individual and/or entity responsible for monitoring the plan.

ix. "Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

x. "Be distributed to the individual and other people involved in the plan.

xi. "Include those services, the purpose or control of which the individual elects to self-direct.

xii. "Prevent the provision of unnecessary or inappropriate services and supports.

xiii. "Document that any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered service plan.

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

A) "Identify a specific and individualized assessed need.

B) "Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

C) "Document less intrusive methods of meeting the need that have been tried but did not work.

D) "Include a clear description of the condition that is directly proportionate to the specific assessed need.

E) "Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

F) "Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

G) "Include informed consent of the individual.

H) "Include an assurance that interventions and supports will cause no harm to the individual.

"The person-*centered service plan must be reviewed, and revised upon reassessment of functional need* as required by §441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual."

Ohio will need to analyze the existing statute, rules and practices of the service planning process. We may need to examine: a focus more on outcomes, assurances of conflict-free case management, the location of the ISP meetings, the parties included in the service planning process, and the assessment process used as part of the ISP process.

Other provisions

- 5 year demonstration period for dual-eligibles (Medicaid and Medicare) with 1115, 1915 (b), (c), and (d) waivers

- Provides additional limited exception to the general requirement that payment for services under a state plan must be made directly to the individual practitioner providing a service when the Medicaid program is the primary source of reimbursement for a class of individual practitioners

- Provides CMS with additional compliance options beyond waiver termination for 1015(c) HCBS waiver programs

Review the final rule here. The rule document is 371 pages. Check out the table below to help focus your attention on certain rule requirements. These are not the only parts of the document that relate to the topic, but they contain the gist of the requirements.

Topic	Starts on Page	Ends on Page
Definition of Community	330 338	333 342
Person-Centered Plan	327	330
Target Populations	326	326
State's Compliance, Transition, Assurances	333	336
Duration, extension or amendment of a waiver	336	338

Again, CMS welcomes input from any interested parties. OPRA will collect input and "bundle" it for CMS. Please send any comments or questions directly to Mark Davis at mdavis@opra.org. OPRA will continue to digest the rule; will work with our national partners, ANCOR and CMS on necessary subregulatory guidance; and will release further information on the rule as it becomes available.

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