Friday Morning Collaborative Webinar

Implementation of the Home and Community Based Services Settings Rule

Friday June 20, 2014

National Council on Aging

Friday Morning Collaborative

- American Association on Health and Disability
- American Association of People with Disabilities
- AARP
- Alliance for Retired Americans
- American Federation of State, County and Municipal Employees (AFSCME)
- American Network of Community Options and Resources
- The Arc of the United States
- Association of University Centers on Disabilities
- Alzheimer's Association
- Bazelon Center for Mental Health Law
- Center for Medicare Advocacy
- Community Catalyst
- Direct Care Alliance
- Disability Rights Education & Defense Fund
- Easter Seals
- Families USA
- Health and Disability Advocates
- Leading Age
- Lutheran Services in America
- National Association of Area Agencies on Aging
- National Association of Councils on Developmental Disabilities
- National Association for Home Care and Hospice
- National Committee to Preserve Social Security and Medicare
- National Council on Aging
- National Council on Independent Living
- National Consumer Voice for Quality Long-Term Care
- National Disability Rights Network
- National Health Law Program
- National PACE Association
- National Senior Citizens Law Center
- Paralyzed Veterans of America
- Paraprofessional Healthcare Institute
- Service Employees International Union
- United Cerebral Palsy
- United Spinal Association
- VNAA –Visiting Nurse Associations of America

Support From

For more information visit: www.TheSCANFoundation.org

Community Living Policy Center
University of California, San Francisco

Funding from the National Institute on Disability and Rehabilitation Research (grant number H133B130034) in partnership with the Administration for Community Living

Power Point

- Can I get a copy of the Power Point?
- Will an Archive of the webinar be available?

YES! YES! YES!

- You will receive copies in a follow up e-mail early next week. Please share with others!
- www.ncoa.org/HCBSwebinars

Questions and Comments

All Lines Will Be Muted During the Call
To Ask A Question Use the Chat Function

Webinar Overview

- Introduction
  - Joe Caldwell and Kata Kertesz (National Council on Aging)
- Speakers:
  - Ralph Lollar (Director, Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group, CMS)
  - Pat Nobbie (Program Specialist, Center for Disability and Aging Policy, Administration for Community Living)
  - Eric Carlson (Directing Attorney, National Senior Citizens Law Center)
  - Rachel Patterson (Policy Analyst, Association of University Centers on Disabilities)
- Questions and Answers (20 – 30 minutes)

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

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)

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

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

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

HCBS Settings Rule

Person-centered Services Planning:
From Assessment to Review

PCP in Official Regulations

- Person-centered planning has been incorporated in the delivery of services to older adults and people with disabilities for many years. For the first time, the HCBS settings rule puts the requirements for person-centered planning into regulation – known in the HCBS rule as “person centered service planning.”

Coherence with ACA

- On June 6, 2014 Secretary Sebelius signed guidance to HHS agencies on standards for person-centered planning and self-direction of HCBS that should be embedded in all HHS funded HCBS programs as appropriate. The guidance is consistent with the final rule from the Centers for Medicare & Medicaid Services on Medicaid HCBS, and meets the requirement in section 2402(a) of the Affordable Care Act for a more consistent administration of policies and procedures across programs. This guidance is the Department's first step in implementing section 2402(a).

ACA 2402(a)

- Section 2402(a) of the Affordable Care Act requires the Secretary to ensure all states receiving federal funds develop service systems that are responsive to the needs and choices of beneficiaries receiving home and community-based long-term services (HCBS), maximize independence and self-direction, provide support coordination to assist with a community-supported life, and achieve a more consistent and coordinated approach to the administration of policies and procedures across public programs providing HCBS.

2402(a)

- Outlines the standards for person-centered planning (PCP) and self-direction (SD) that should be reflected in all HHS programs that fund or provide HCBS.
- The standards in this guidance should be used in future program regulations, program policies, funding opportunities, technical assistance contracts, grant opportunities, and other programs funding HCBS.

2402(a)

- The guidance for the steps in the PCP process, as well as the steps that must be taken when a person's services are modified in any way mirror the steps in the HCBS settings rule.
- The settings rule and the 2402(a) guidance can go a long way toward establishing coherence and consistency in person-centered planning and self-direction for all individuals benefitting from HHS services.

HCBS Settings Rule: STEPS

- **The person-centered plan process has 5 steps:**
- Independent evaluation and determination of eligibility (for state plan services (i)
- An independent assessment (for state plan services)
- The person-centered service planning meeting
- Writing the person-centered service plan
- Reviewing the plan

Independent Evaluation / Eligibility

- Evaluation of the individual's eligibility for the state plan benefit is performed by an agent that is qualified and independent.
- Applies the needs-based criteria the state has established under 441.715(a) (individual's need for support)
- Includes consultation with the individual and / or the individual's representative
- Uses current and accurate information from existing records
- Must be re-determined at least every 12 months

Independent Assessment

- The supports and services the individual needs, how much they need, and how long they need them is discovered during an independent assessment.
- May include a standardized functional needs assessment.
- The agent doing the assessment must be qualified and independent of the service provider
- The assessment must be face to face, or through the use of health technology provided certain conditions are met.

Independent Assessment

- Includes an opportunity for the individual to identify other persons to be consulted such as spouse, guardian, family, and other treating professionals
- Examines the individual's relevant history
- Includes assessment of mental and physical health, needs for support in areas of cooking, shopping or banking, where the individual wants to live, their goals, who they would like to provide services, etc
- If unpaid caregivers will be relied upon to implement any elements of the plan, a caregiver assessment.

Independent Assessment

- Information from the assessment helps the team and the individual plan services and supports.
- During the planning process the team should find creative ways to help the individual meet their goals whether or not there are specific services and supports available.
- The individual must be given the option to self-direct their services, including getting training or education on how to self-direct.

Person-Centered Planning Meeting

- The individual can invite anyone they want. Interpreters or communication device should be provided if needed.
- Meeting must be held in a manner that respects the individual's culture and is conducted in a language the individual understands.
- It should be clear how conflicts or differences among team members will be resolved.

Plan Process

- The process should offer the individual choices about the types of services they want, where they want them delivered, information on residential options, where they spend their day, and why those choices were made.
- Include who will provide services, including day service and living options that are not only with other people with disabilities.
- The plan can be changed or updated at the individual's request, but must be renewed at least annually.

The written plan should include:

- Options presented to the individual about where to live and what was chosen and why.
- Where the individual chose to receive other services, like supported employment.
- The individual's strengths, preferences and needs.
- The supports needed, both paid and unpaid.
- Things the individual wants to accomplish (goals) and how they will know they have achieved them (outcomes).

The plan must also:

- Note any risks the individual might encounter and plans to deal with them.
- Include the name of the person responsible for making sure the plan is followed.
- Be written in plain language that the individual understands.
- Include the signatures of everyone who participated, and everyone should get a copy.

A plan can be modified at any time, at the individual's request, or if their circumstances change.

When a person, service or setting must be modified

- Sometimes, in order for a person with a disability to be well-supported and safe in the community, there must be some modifications made. For example, some people cannot have unlimited access to food because of the risk to their health. If an individual needs special supports or modifications where they live or receive services, those need to be written into their person-centered plan under a special set of rules.

Requirements for Modifying an HCBS Setting

- The PCP must identify the specific and individual assessed need.
- The PCP must document the interventions and supports that were tried prior to modifying the plan.
- The PCP must describe less intrusive methods of meeting the need that were tried but did not work.
- The plan must include a clear description of the condition that is directly proportionate to the specific assessed need.

Requirements for Modifying an HCBS Setting

- The plan is reevaluated regularly to review whether the changes in the individual's plan are working to help them meet their goals (data collection and review of data).
- The plan must include time limits on the restrictions on the individual's freedoms. The changes should only stay in their plan for as long as they are needed.
- The plan must explain to the individual in language they can understand what the changes are, why the changes are being made and the individual's informed consent must be included in the plan.
- The plan must include assurances that the changes will not harm the individual.

For More Information:

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http://HCBSadvocacy.org
www.cms.gov

June 20, 2014

Implementation of Medicaid HCBS Settings Rule

Eric Carlson

The National Senior Citizens Law Center is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. For more information, visit our Web site at www.NSCLC.org.

Resources from NSCLC.org

- Just Like Home: An Advocate's Guide to Consumer Rights in Medicaid HCBS
- Just Like Home: An Advocate's Guide for State Transitions under the New Medicaid HCBS Rules (released this week)

Transition Plans

Transition Plans Should Have Broad Coverage

- Must "detail[] how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section."
  - Including, e.g, identifying settings that isolate.
  - Identifying settings that have HCBS qualities.
  - Establishing systems that enforce new standards.

Service Planning in Transition Plan

- Regulations refer to transition plan relating to “home and community-based settings” and to compliance with “this section” (which includes service planning.
- Good opportunity for state to address service planning in HCBS.
  - E.g., PA OLTL Transition Plan addresses service planning.

Some States Have Little Time

- If state has waiver renewal or amendment, transition plan for entirety of state's HCBS must be submitted within 120 days of request for renewal or amendment.

- Plus, public must have 30-day comment period prior to submission of transition plan to CMS.

Some States' "Transition Plans" Look Like Work Plans Instead

- e.g., Iowa
  - "Transition Plan" out for comment in May 2014
  - Includes state activities for assessment, remedies, and public comment, with estimates of hours needed to complete activities.
  - Programmatic rules to be revised from August 2014 through July 2015.
  - Assumes multiple iterations of transition plan, but with public comment, stakeholder forums, etc., concentrated in May 2014.

Wyoming's Transition Plan Also Looks Like Work Plan

- "State Plan for Assessing HCB Settings Compliance" out for comment from April 18 through May 22, 2014.
- Plan identified as meeting requirement for 30-day comment period.
- But "Draft transition plan to submit for state and federal approval" scheduled for 12/1/14 to 1/15/15, with no mention of public input.

Public Must Be Allowed to Comment on Substance of Transitions

- Full transition plan(s)" must be available for public comment.

- Submission to CMS must include:
  - Summary of comments received.
  - Reasons why comments were not adopted.
  - Any modifications based upon comments.

Deadlines Presumably Leading to Incomplete Plans

- Difficult to evaluate system and develop recommendations within a month or two.
  - Deadlines may be unrealistic.

- Better to take more time and involve public, rather than rush through "transition plans" that don't address substance of state's system.

Excluding Settings that Tend to Isolate Consumers

Presuming Isolation

- Presumption of isolation if:
  - Sharing building with facility providing inpatient institutional treatment.
  - On grounds of, or adjacent to, public institution.
  - Effect of isolating HCBS consumers from broader community.

Important to Take Isolation Question Seriously

- In reality, many current HCBS settings probably are isolative.
  - *But see* PA OLTL Transition Plan
    - "Adult Daily Living Centers are assumed to be in compliance" with no-isolation rule.
    - Centers also assumed to be compliance with rule requiring full access to greater community.

How to Identify Potentially Isolative Settings

- Numbers of HCBS consumers?
- % of HCBS consumers?
- Transportation options?
- Internet access?
  - *See, e.g.*, CMS's Exploratory Questions for potential considerations.

What If Setting Is Isolative?

- HCBS reimbursement allowed if "setting does not have the qualities of an institution and … does have the qualities of home and community-based settings."

Is This Test Circular?

- Is having HCBS qualities, and not having institutional qualities, equivalent to meeting "regular" HCBS standards?
  - Related question – if state develops standards specifically to improve matters in settings that tend to isolate, should those same standards also be applied to all HCBS settings?

Suggestion – Higher Standards Should Ensure Access to Community

- Because isolation is the problem, the standards for HCBS qualities (*aka* non-institutional qualities) should address access to the community.

Rejecting Payment Source Discrimination

Qualifying Setting Should Honor Standards Regardless of Consumer's Payment Source

- Would a non-institutional setting discriminate by payment source?
  - e.g., Access to food at any time.
  - Right to receive visitors.
  - Lockable doors.

Interpretation Supported by Regulatory Language

- Regulations generally referring to "individual" or "individuals."

- Provision pertaining to written lease-type agreements applies specifically to "each HCBS participant."

HCBS Regulations Apply Broadly

- Focus on non-institutional *setting* even though payment is for *services*.
  - E.g., setting relevant even when services provided outside of setting.
    - 79 Fed. Reg. at 2,960.

- Treatment of other consumers is relevant to whether or not the HCBS consumer is in an institutional environment.

Need to Get Beyond Nursing Facility "Distinct Part" Mindset

- Payment source discrimination is common in the nursing facility model.
  - Facilities will have to improve their standards if they expect to be reimbursed for services that are defined as home and community-based.

Enforcing Standards

How Will Rules Be Enforced?

- To great extent, no existing mechanism.
  - States make assurances to CMS regarding beneficiaries' health and welfare.
    - For residential care facilities, states often reference existing state licensure standards.

Many Questions to Be Answered Re: Enforcement

- Consumers will need some enforcement mechanism to make these standards a reality.
  - Amendment of existing licensure rules may make sense for residential care facilities.

Enforcement Needs Strong Advocacy

- Otherwise, it will be easy for this issue to be ignored in transition plans.
  - Enforcement not addressed in regulations themselves or in CMS guidance.

Questions?

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Implementation of the HCBS Settings Rule: Resources for Advocates

Rachel Patterson

Association of University Centers on Disabilities

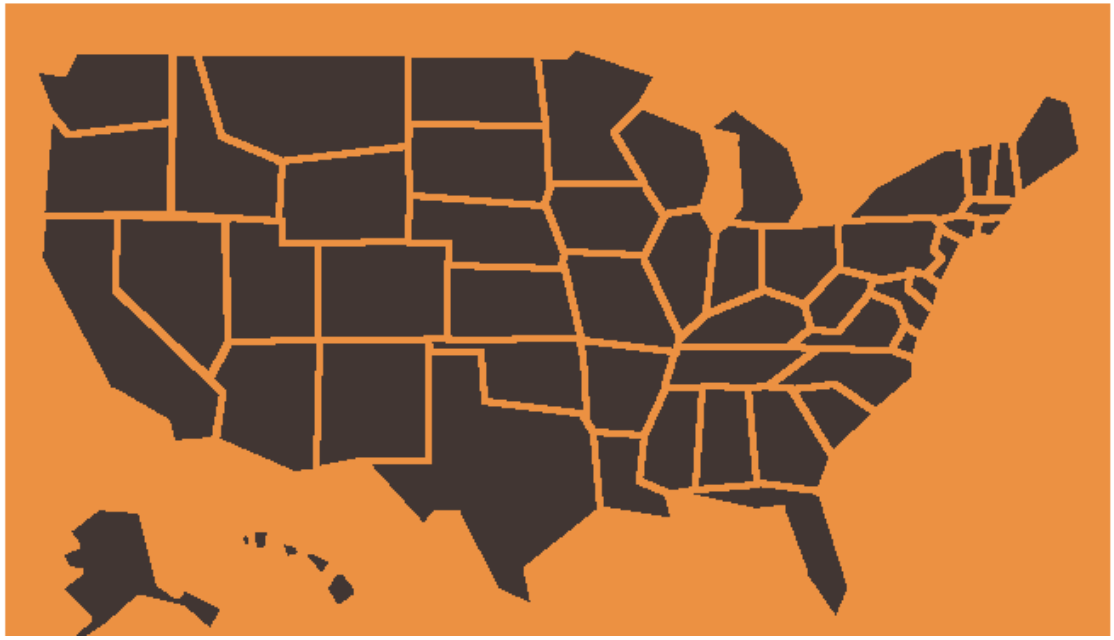
HCBS Advocacy

Information for advocates about the new home and community-based services rules

State Resources

HCBSadvocacy.org is a platform for the aging and disability communities to post information and resources regarding the new HCBS settings rule and steps each state is making to comply with the new rule. Click on a state or choose from the list below to see resources, dates and deadlines, state documents, news, and other information from that state. This site is a work in progress that relies on state and national partners to find information and share resources. Have news or resources to post? Send them to hcbsadvocacy@gmail.com.

Please click on the state you are interested in to view that state's information:



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Key Dates & Deadlines

Comment Deadlines:

Pennsylvania: Comments on the transition plan were due June 16, 2014

Tennessee: Comments on the concept paper are due June 30, 2014

Expected Waiver Renewal Submission Dates: 1915(c) Waiver Renewal Dates Through April 2015

States with waivers expected to be submitted June 30, 2014: These states must include a transition plan with this waiver submission if they have not yet already submitted a plan.

Alabama

Connecticut

Iowa

Indiana

New Mexico

HCBSadvocacy.org

Tips for Advocates

- Work in coalition
  - Olmstead coalitions or task forces
  - Protection & Advocacy
  - DD Council
  - University Centers
  - Area Agencies on Aging
  - Mental Health America or NAMI local
  - Centers for Independent Living
  - AARP local chapter

Tips for Advocates

- Build on Existing Reform Work in the State
  - Olmstead Settlements
  - Medicaid reform
    - 1115 waivers
    - Managed Care
    - Community First Choice Option
    - Balancing Incentive Program
    - 1915(i) HCBS State Plan Amendments

→ *Leverage these and other opportunities for increased stakeholder engagement*

Tips for Advocates

- Learn About the Rule
- Spread the Word
- Get Involved
  - Public Comment
  - Stakeholder Committees
  - Town halls
- Advocate
  - Improved Stakeholder Engagement


Tom Harkin on April 7, 2014
to 700 Disability Policy Seminar attendees in DC
"EARLY TO BED, EARLY TO RISE,
WORK LIKE HELL AND ORGANIZE!"

Questions