NASUAD Overview

• Founded in 1964 to represent state agencies on aging.

• In 2010, changed name in recognition of the fact that most state agencies served aging and disability populations.

• 56 members Represents State and Territorial Agencies on Aging and Disabilities.

• Board of Directors – Executive Officers, 10 regional representatives and 10 regional alternate reps.
Key Resources

- NASUAD.org
- HCBS.org
- NASUADiQ.org
- Friday Update
- Integration Tracker
- Expansion Tracker
CMS HCBS Regulation

Key Issues and concerns
What the rule includes:

- Defines and describes state plan home and community based services under 1915(c)/(i)/(k)
- Establishes regulations implementing section 1915(i)
- Defines person-centered planning
- Provides states with option of combining coverage for multiple target populations
- Allows states to use a 5 year renewal cycle to align state plan and waivers serving Medicaid/Medicare recipients
- Provides exception to the general requirement that payment for services under a SPA must be made directly to the individual practitioner
- Provides CMS with additional compliance options beyond waiver termination
Effective Date

• The Regulation became effective March 17, 2014;
• For Transition plans:
  – A waiver-specific plan must be provided in conjunction with the first amendment/renewal submitted after March 17, 2014;
  – A statewide transition plan must be submitted 120 days after the first amendment/renewal or by March 17, 2015 – whichever is first.
HCBS definition

- Moves away from defining HCBS based on setting location, geography, or physical characteristics
- Instead defines HCBS by the nature and quality of participants’ experiences
- Outcome-oriented definition
All HCBS settings must meet certain qualifications

- Setting is integrated in and supports full access to the greater community to the same degree as individuals not receiving Medicaid HCBS;
- Is selected by the individual from among setting options that include non-disability specific settings and an option for a private unit in a residential setting;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and service providers.
Additional requirements for provider owned settings

- Individual has a lease or other legally enforceable agreement providing similar protections
- Individual has privacy in their unit including lockable doors, choice of roommates and freedom to decorate or furnish the unit
- Individual controls his/her own schedule including access to food at any time
- Individual can have visitors at any time
- The setting is physically accessible
Settings that are NOT considered home and community based

- Nursing facilities
- Institutions for mental disease
- Intermediate care facilities for individuals with intellectual disabilities
- Hospitals
Opportunity for Modifications

• Modifications to any of the requirements for provider-owned homes and community-based residential settings:
  – Must be supported by specific assessed need
  – Must be justified and documented in the person-centered service plan
Other settings that are not home and community based

- Provides inpatient treatment (regardless if publicly/privately owned);
- On the grounds of, or immediately adjacent to, a public institution;
- Has the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.
Transition process to ensure compliance

- NEW HCBS 1915 (c) waivers or 1915 (i) plans must meet the new requirements to be approved;
- States must evaluate the settings in their 1915 (c) waivers and 1915 (i) plans to evaluate if they meet the new settings requirement:
  - If not, states should work with CMS to develop a plan to bring the programs into compliance;
  - CMS will allow states a maximum of a one year period to submit a transition plan for compliance;
  - Once the transition plans are approved, states will have up to five years to be in full compliance;
  - Public will have an opportunity to comment on states’ transition plans.
Two Types of Transition Plans

• A waiver specific transition plan:
  – used to describe how one specific HCBS program will be brought into compliance with the regulation;
  – must be submitted with any “action” performed on the option, which includes a renewal or an amendment;
  – renewal and/or amendment will not be approved until the waiver-specific transition plan is approved.

• A statewide transition plan:
  – used to describe how every HCBS option will come into compliance with the requirements;
  – must be submitted by whichever comes first:
    • Within 120 days of the first HCBS action in the state; or
    • March 17, 2015.

• CMS guidance: [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Statewide-Transition-Plan-Toolkit.pdf](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Statewide-Transition-Plan-Toolkit.pdf)
Additional Clarifications

• Disability specific complex—“any other setting that has the effect of discouraging integration of individuals from the broader community”

• Rebuttable presumption—while certain settings are presumed to have institutional characteristics and will be subject to heightened scrutiny, the rule allows states to present evidence to the contrary

• Choice of provider — when an individual chooses to receive HCBS in a provider-owned setting where the provider is paid a single rate for a bundle of services, the individual is choosing that provider and can’t choose an alternate provider to deliver other services within the bundle
Additional Clarifications

• Private rooms/roommate choice — States, as opposed to individual providers, have the responsibility for ensuring that individuals have options available for both private/shared residential units.
• Individual’s needs, preferences, and resources are relevant to his/her options for shared v. private residential units.
• Provider owned/operated residential settings will be responsible for facilitating individual’s choice regarding roommate selection.
Additional Clarifications

• Application of HCBS settings to non-residential settings
  – Rule applies to all settings where HCBS are delivered, not just to residential settings (i.e. ADULT DAY)
  – CMS has specifically expressed concerns about:
    • Sheltered employment settings;
    • Adult day health and other day programs that are provided in hospitals or other facilities.
  – CMS intends to issue further guidance on nonresidential settings, but the timeline is unclear.
Nonresidential Settings

• Concerns exist regarding how non-residential settings will be assessed for compliance:
  – The regulation largely focuses on residential issues;
  – Non-residential services must meet the requirements:
    • FAQ is in HHS clearance;
    • CMS encourages states to perform an assessment using the regulatory standards;
    • Focus would be on “settings that isolate” as well as whether facilities are attached to an excluded setting.
Person-Centered Plan

• Will assist individual in achieving personally defined outcomes
  • Most integrated community setting
  • Ensures delivery of services in a manner that reflects preferences and choices
  • Contributes to the assurance of health and welfare
• Person-centered plan must be reviewed every 12 months
• CMS will provide additional guidance on operationalizing person-centered planning in order to bring programs into compliance
  – ACL issued guidance based on section 2402 of the ACA, which we believe will closely match CMS guidance
  – NASUAD/ACL conference call held on August 22; visit http://www.nasuad.org/initiatives/information-and-referralassistance/monthly-calls
Person-Centered Planning

• Service planning for 1915 (c) and 1915 (i) must be developed through a person-centered planning process
  – The plan should reflect:
    • Services and Supports (paid/unpaid)
    • Who provides the LTSS
    • If the participant is self-directing
  – The plan should include goals and preferences for:
    • Community participation
    • Employment
    • Income and savings
    • Health care and wellness
    • Education and others
  – The plan should be directed by the individual with LTSS needs
    • May include a representative chosen by the individual
Person-Centered Planning Process

• Includes people chosen by the individual
  – Conflict of interest-providers of HCSB may not develop the person-centered plan unless the state can demonstrate appropriate conflict of interest protections
• Provides necessary info to support the individual as he/she directs the process
• Is timely and occurs at times/locations convenient to the individual
• Reflects cultural considerations
• Includes conflict solving strategies
• Offers informed choices to the individual
• Includes a method to request updates to the plan
Conflict-free Case Management

• Creates requirements regarding case management services provided under Medicaid HCBS programs:
  – Case managers must be free from any conflict of interest, such as:
    • Financial conflicts due to provision of other services or financial interest in the individual and/or service providers;
    • Conflicts due to relationships by blood or marriage to the individuals or service providers.
  – In limited instances where provider availability is limited, some service providers can perform CM functions if certain “firewall” protections exist.
More info available

- Questions or comments?:
  - Martha Roherty mroherty@nasuad.org
  - Damon Terzaghi dterzaghi@nasuad.org

- www.nasuad.org