NASUAD
National Association of States United for Aging and Disabilities

2014: Medicaid and HCBS

November 12, 2014

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

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?:

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- www.nasuad.org