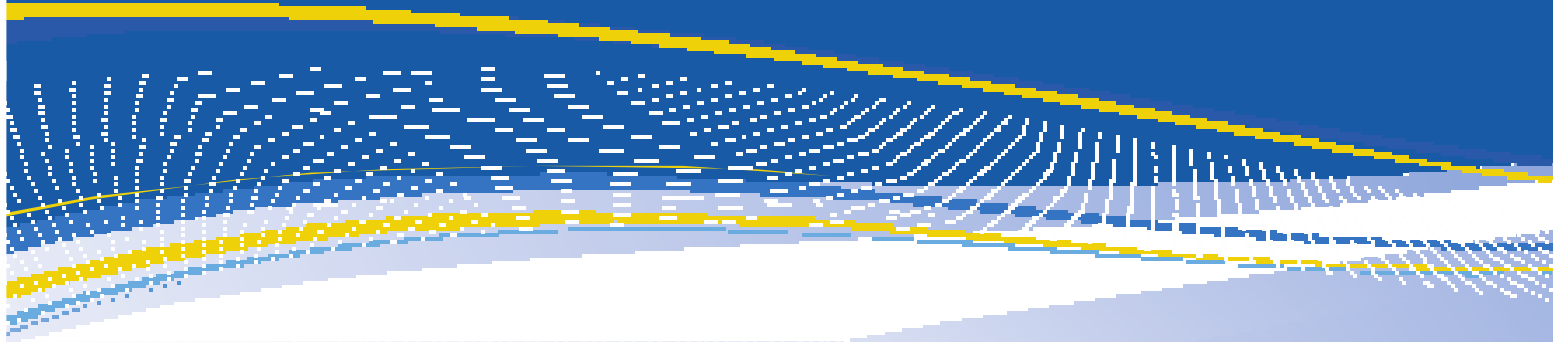# Home and Community-Based Settings Rule 2019 HCBS Conference Intensive

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

Agenda for Today's Session

- Overview of the HCBS Settings Rule

- Progress to Date

- Heightened Scrutiny Update

- State Challenges and Solutions

- Resources

- Q & A

2014 HCBS Final Rule

- Published January 2014 – Effective March 17, 2014
- Addressed CMS requirements across HCBS provided through:
  - 1915(c) waivers, 1915(i) state plan, 1915(k) Community First Choice, and 1115 Demonstration Waivers
- Some requirements were effective immediately, others were given a transition period in order to allow states sufficient time to come into compliance.
- Guidance issued in May 2017 extended the transition period for settings in existence as of the effective date of the final regulation from March 2019 to March 17, 2022. Extension of the transition period recognized the significant reform efforts underway and is intended to help states ensure compliance activities are collaborative, transparent and timely.
- This session does not cover all aspects of the Final Rule; in today's presentation we will focus specifically on the regulation's impact on home and community-based settings.

Key Themes

- The regulation is intended to serve as a catalyst for widespread stakeholder engagement on ways to improve how individuals experience daily life

- The rule is not intended to target particular industries or provider types

- Federal financial participation (FFP) is available for the duration of the transition period

- The rule provides support for states and stakeholders making transitions to more inclusive operations

- The rule is designed to enhance choice

Home and Community-Based Settings Criteria

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 HCBS

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Home and Community-Based Settings Criteria (cont.)

The setting options are identified and documented in the person-centered service plan

The setting options are based on the individual's needs, preferences, and, for residential settings, resources available for room and board

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

Provider-Owned or Controlled Settings: Additional Criteria (1 of 4)

- Unit/dwelling is a specific physical space 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

Provider-Owned or Controlled Settings: Additional Criteria (2 of 4)

- Each individual has privacy in their sleeping or living unit

- Units have entrance doors lockable by the individual, with only 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 of their choosing at any time

- Setting is physically accessible to the individual

Provider-Owned or Controlled Settings: Additional Criteria (3 of 4)

<u>Modifications of the additional criteria must be:</u>

- Supported by specific assessed need

- Justified in the person-centered service plan

- Documented in the person-centered service plan

Provider-Owned or Controlled Settings: Additional Criteria (4 of 4)

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

- Specific individualized assessed need

- Prior positive 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/supports will not cause harm

The Statewide Transition Plan (STP) (1 of 2)

- Each state providing Home and Community-Based Services (HCBS) under a Medicaid section 1915(c) waiver, section 1915(i) State Plan Amendment (SPA), section 1915(k) Community First Choice SPA, or 1115 Demonstration in effect on or before March 17, 2014, is required to file a STP.

- The STP is the public vehicle through which states:
  - Determine their state-level systemic compliance with the regulation's criteria;
  - Describe the assessment, validation and remediation strategies for each setting subject to the rule.

The Statewide Transition Plan (STP) (2 of 2)

o Outline the state's ongoing monitoring process to ensure continued compliance of all settings;

o Provide for how the state will communicate with beneficiaries who receive services in a setting that will not be in compliance with the rule at the end of the transition period; and

o Describe the state's process for submitting settings presumed to have institutional characteristics to CMS for heightened scrutiny review.

Steps for Final STP Approval (1 of 2)

1. Provide a summary of completed and validated site-specific assessments; validation of those assessment results, and inclusion of aggregate outcomes of these activities;

2. Include remediation strategies for settings, with timelines for resolution completed by March 17, 2022;

3. Identify the process for communicating with beneficiaries who are currently in settings that cannot or will not come into compliance by March 17, 2022.

Steps for Final STP Approval (2 of 2)

4. Describe the ongoing monitoring and quality assurance the state will conduct to ensure all settings will remain in compliance with the settings criteria; and

5. Include a detailed plan for identifying and evaluating those settings presumed to have institutional characteristics, in preparation for CMS' heightened scrutiny review.

State STP Approval Progress

As of August 15, 2019

- 45 States have initial approval: AL, AK, AZ, AR, CA, CO, CT, DE, DC, FL, GA, HI, IA, ID, IN, KS, KY, LA, MD, MI, MN, MO, MS, MT, NC, ND, NE, NH, NM, NY, OR, OH, OK, PA, RI, SC, SD, TN, UT, VA, VT, WA, WI, WV, WY

- 16 States have initial and final approval: AK, AR, CT, DE, DC, ID, KY, MN, ND, OK, OR, SD, TN, UT, WA, WY

State Milestone Data and Quarterly Reports

- CMS requests that states complete the milestones template with activities and timelines gleaned from the STP to assist with tracking implementation activities.

- To date 35/51 states have milestones in the Statewide Transition Plan website.

- To date 35/35 states have submitted quarterly reports and/or made progress updates on their milestones.

Milestone Progress (1 of 2)

- 34/35 states report completing their systemic assessment
- 9/35 states report completing the three (3) milestones related to the remedial actions to bring state standards into compliance
- 24/35 states report completing their site-specific assessments
- 6/35 states report completing 100% of residential provider remediation
- 8/35 states report completing 100% of non-residential provider remediation

Milestone Progress (2 of 2)

- 9/35 states report completing the four (4) milestones related to heightened scrutiny

- 6/35 states report completing the eight (8) milestones related to beneficiaries in non-compliant settings

- 11/35 states have submitted quarterly reports

Promising Practices (1 of 7)

- Stakeholder Engagement
  - Stakeholder work groups
    - AZ requires MCOs to participate in multi-stakeholder workgroups for each setting type.
  - Maintaining and updating website
    - OR requires each program area to update the program-specific pages within the website.
    - OH website contains links to all heightened scrutiny packages categorized as residential or non-residential and listed by county.

- Stakeholder engagement, cont.
  - Information dissemination
  - Providers engaging consumers, family members, and other advocates in self-assessments
    - TN requires that provider self-assessments include consumers, family members and advocates

Promising Practices (3 of 7)

- Assessment and Validation
  - Use of self-assessments
  - Validation through desk reviews, onsite visits and consumer feedback
    - ID conducted onsite visits for 100% of settings.
    - OK uses the Consumer-Focused Quality Care Review tool that includes a section for HCBS settings compliance and Member survey responses.
    - ND links consumer surveys with self-assessments to support successful validation

- Remediation and Technical Assistance
  - Offering one-on-one TA to providers
  - Conducting provider-wide, web-based training
    - CO required provider agencies and case management agencies to participate in webinars so that providers and case managers hear the same thing at the same time. Waiver participants, advocates, and others were also invited to join.
    - MN developed on-demand video training and created promising practices videos of settings across the state. MN is launching a web-based provider toolkit to assist with technical assistance efforts.

Promising Practices (5 of 7)

- Remediation and Technical Assistance, cont.
  - Using corrective action plans
    - GA uses "Solutions Focused Mapping", a tiered approach of education, technical assistance, and a corrective action plan (CAP)
    - NC uses web-based e-review tool that tracks plans and correspondence between providers and the local management entities (Managed Care Organizations).
    - SC and SD created easily digestible compliance summary reports and CAP templates to document and track remediation.

Promising Practices (6 of 7)

- Remediation and Technical Assistance, cont.
  - Using tools to emphasize person-centered planning
    - CT built LifeCourse planning tools into their Individual Plan documents
  - Restructuring payment methodologies
    - PA used a tiered rate structure to support providers in the transition from strictly facility-based services to more community-based services.
    - UT suspends provider payments when responses to requested information have passed deadlines. As soon as acceptable information is provided, those holds are released; it does not alter their reimbursement.

Promising Practices (7 of 7)

- Ongoing Monitoring
  - Leveraging quality assurance opportunities
    - UT incorporated staff from the quality assurance unit in planning to ensure staff familiarity and knowledge during ongoing monitoring.
  - Training service providers who conduct quarterly visits
    - WV trained service coordinators who conduct visits to verify compliance with the Settings Rule
- New Service Providers
  - Limiting number of participants
  - Integrating provider self-assessment tool into provider enrollment process

Heightened Scrutiny Pilot Project (1 of 2)

- CMS provided review and feedback to 6 states (MT, ND, NH, NV, OH, and OR) on the information submitted for residential settings that are in a public or private facility that provides inpatient treatment, or on the grounds of, or immediately adjacent to, a public institution.

- Lessons learned from the pilot produced a more efficient process for the review of <u>all</u> heightened scrutiny packages submitted by the states.

- The pilot process resulted in a Summary of Findings for each setting, which includes the following:
  - Support submitted by the state to demonstrate a setting's progress in overcoming its institutional presumption;
  - Initial determination of the setting's compliance by CMS;
  - Identification of additional information requested by CMS to confirm compliance with the regulation, linked to specific settings criteria.

Heightened Scrutiny Requirements (1 of 2)

- States' Responsibilities:
  - States need to identify settings that are presumed to be institutional;
  - To receive HCBS funding for individuals served in these settings, states must submit documentation for CMS approval that demonstrates how the setting overcomes the institutional presumption and complies with the provisions of the settings rule for all individuals served there.

Heightened Scrutiny Requirements (2 of 2)

o As part of its STP, states are required to identify, assess and validate compliance with the settings rule for all settings in which individuals will be receiving HCBS.

o For settings that don't meet HCBS settings characteristics, a state can propose necessary changes for each of those settings, with a timeline and milestones to comply, and/or

o Submit evidence to CMS for a heightened scrutiny review of those settings presumed to be institutional to show that they have overcome the presumption and meet settings requirements.

Heightened Scrutiny - FAQs

Frequently Asked Questions: Heightened Scrutiny Guidance

Heightened Scrutiny Reviews of Presumptively Institutional Settings

The HCBS settings regulations describe three categories of residential or non-residential settings that are presumed to have the qualities of an institution requiring a heightened scrutiny review:

- Settings that are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

- Settings that are in a building located on the grounds of, or immediately adjacent to, a public institution;

- Any other settings that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

What is a Setting that Isolates? (1 of 3)

- CMS will take the following factors into account in determining whether a setting may isolate Medicaid HCBS beneficiaries from the broader community:
  - o Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities* for interaction in and with the broader community, including individuals not receiving Medicaid-funded HCBS;
  - o The setting restricts a beneficiary's choice to receive services or to engage in activities outside of the setting; or

What is a Setting that Isolates? (2 of 3)

o The setting is located separate and apart from the broader community without facilitating beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary's person-centered plan.

*Opportunities, as well as identified supports, that provide access to and participation in the broader community, should be reflected in both the individuals' person-centered plans and the policies and practices of the setting in accordance with the regulations.

What is a Setting that Isolates? (3 of 3)

- This new guidance in the FAQs revises prior guidance published on this criteria which was originally found at: https://www.medicaid.gov/medicaid/hcbs/downloads/settings-that-isolate.pdf

- The new guidance eliminates specific examples of settings that isolate.

How Can States Bring Settings that Isolate into Compliance without a Heightened Scrutiny Review?

- March 17, 2022: The end of the transition period for <u>all</u> settings to come into compliance with the settings rule.

- <u>For settings that isolate individuals from their broader community:</u> The state can work with these settings to complete remediation to come into compliance by July 1, 2020.

  - If the setting complies with the settings rule to the state's satisfaction by July 1, 2020, then there is no need to submit those settings for a heightened scrutiny review.

  - These settings should be identified in a state's STP and/or identified in information disseminated separate from the STP.

What if a Setting that Isolates Cannot Complete Remediation by July 1, 2020?

- If a state determines that an isolating setting can implement remediation before March 17, 2022

And

- Also determines that the isolating setting can achieve compliance with the settings criteria,

Then

- The state should submit to CMS those isolating settings that have <u>not</u> completed remediation for heightened scrutiny review.

- CMS strongly encourages these settings to be submitted to CMS by the end of October 2020.

HIPAA Related Privacy Concerns and Settings that Isolate

- For those settings that have the effect of isolating individuals, the FAQs identified HIPAA related privacy concerns when posting settings for public comment, preventing the public disclosure of protected health information (PHI);

- Guidance is provided on how to disclose information to adhere to federal and state privacy laws and regulations; and

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HIPAA Related Privacy Concerns and Settings that Isolate (cont.)

- Information is provided on the extent to which stakeholders may receive notice and provide comment on these settings.

  - <u>Note:</u> Question 7 of the FAQs replaces prior guidance to account for HIPAA implications.

- Contact your state HIPAA compliance officer for guidance specific to your state or local rules on who will make the final determination of what information can be disclosed.

Beginning the Heightened Scrutiny Review Process

- The state submits a numbered list of settings identified for each category of presumptively institutional settings;

- CMS will use the list to compile a random sample of settings to review, including any setting the state requests CMS to review and any setting that generated significant public comment in opposition to the state's assessment;

- CMS will notify the state as to which settings should be formally submitted. This should include the remediation plan for the setting if applicable and the public comments received.

- Evidence should focus on the qualities of the setting and how it is integrated in and supports access of individuals into the broader community via the organization's policies and procedures, and how the setting supports individuals consistent with their individual person-centered service plans.

- Exploratory questions in the Toolkit can help determine the type of information to include. See: https://www.medicaid.gov/medicaid/hcbs/guidance/settings/index.html.

- Description of the proximity to and scope of interactions in and with the broader community demonstrated by mechanisms such as:

  o Description of the state's review of a sample of individuals' daily activities, person-centered service plans, and/or interviews to see if there is variation in the scope, frequency and breadth of interactions and engagement in and with the broader community;

  o A copy of procedures and services provided that indicate evidence of access to and demonstrated support for beneficiary integration in the broader community activities consistent with individuals' person-centered service plans;

o Descriptions of processes in place or actions taken by direct support professionals to support, monitor, improve, and enhance individual beneficiary integration in and with the broader community over time;

o A summary of examples of how schedules are varied according to individual preferences and the need to integrate into the local community at times when the general community attends an activity;

o Procedures to routinely monitor individual access to services and activities of the broader community as identified in the person-centered service plans;

- Description of how staff are trained and monitored in the settings criteria and the role of person-centered planning, consistent with state standards described in the waiver or state plan amendment or in community training policies and procedures established by the state;

- Description of the setting's proximity to public transportation and how transportation is facilitated;

- Attestation that the state reviewed/concluded through an onsite visit and/or a sample of consumer interviews, or person-centered service plan reviews, that any modifications to the settings criteria in provider-owned or controlled settings are documented in the person-centered services plans.

    - **Note:** while there is no number or percentage of individuals that states must sample in this context, states should demonstrate a sample size sufficient to obtain data that is representative of the overall experiences of individuals in the setting.

- Description of the setting's remediation plan to achieve compliance by March 2022, including the state's oversight to ensure completion of actions;

- Summary or other description of stakeholder comments received in response to the state's solicitation of public feedback; and

- Other information the state deems helpful to demonstrate the setting overcomes the institutional presumption, such as:

  o Photos of the setting, not including beneficiaries or other identifying information;

  o Attestation that the setting has been selected by the individual from among settings options including non-disability specific settings.

CMS Actions (1 of 2)

- The state will receive an initial determination letter that will indicate CMS' preliminary decision regarding whether or not the state has demonstrated that the setting overcomes its institutional presumption;

- The state will also receive a Summary of Findings for each setting submitted by the state that includes:

  o The support submitted by the state to demonstrate the setting's progress in overcoming the institutional presumption;

  o The areas where additional information will be needed to clearly articulate that the setting meets the HCBS criteria and has overcome any institutional presumption.

CMS Actions (2 of 2)

- The final determination letter and the Summary of Findings will be posted to the www.Medicaid.gov website.

- The state will receive notification before these documents are posted to the website.

Heightened Scrutiny Review of Newly Constructed Presumptively Institutional Settings

- CMS released an Informational Bulletin (CIB) on August 2, 2019 in response to follow-up inquiries received on how heightened scrutiny will be applied to newly constructed presumptively institutional settings.

- 2016 Guidance stated that CMS would only be able to determine whether a setting overcame its institutional presumption after the facility was operational and occupied by Medicaid beneficiaries who were receiving services in the setting.

- The new guidance allows the state to submit a setting to CMS for a heightened scrutiny review while only non-Medicaid beneficiaries are receiving services in the new setting.

Heightened Scrutiny Review of Newly Constructed Presumptively Institutional Settings, cont.

- The CIB clarifies the following:
  - With respect to newly constructed facilities, CMS can perform a heightened scrutiny review based on how non-Medicaid beneficiaries are receiving services in the new setting at the time a state conducts and submits information for a heightened scrutiny review.

  - Three examples of when Federal Financial Participation (FFP) is available for Medicaid-funded HCBS should CMS determine that a new presumptively institutional setting overcomes that presumption and adheres to the home and community-based settings criteria.

- For new settings, when CMS agrees that the setting overcomes its institutional presumption without requiring any additional information, or when additional information is needed from the state describing how the setting fully complies with the regulatory criteria without requiring additional remediation, FFP will be available for expenditures associated with dates of service beginning on the date the state determined the setting complied with the regulatory criteria.

- For new settings in which states submit information to CMS for a heightened scrutiny review based on an assessment of how the setting provides services to non-Medicaid beneficiaries, and the state is able to confirm that all Medicaid regulatory requirements either were met or would have been met if the services had been furnished to Medicaid beneficiaries, FFP will be available for expenditures associated with dates of services beginning on the date the setting began providing services to Medicaid beneficiaries.

FFP Timeline 3 of 3

- For new settings which CMS determines that additional remediation is necessary for the setting to comply with the regulatory criteria, FFP will be available for expenditures associated with dates of service beginning on the date the state confirmed all remediation was completed and that the setting demonstrates compliance with the regulation.

Promising Practices to Remediate Settings that Isolate (1 of 5)

- CMS is collaborating with federal partners in the Administration for Community Living (ACL) to develop a comprehensive set of promising practices.

- Overarching goals:

  o Transforming the long-term services and supports systems to fully implement person-centered thinking, planning, and practices (the foundation of the HCBS settings rule).

Promising Practices to Remediate Settings that Isolate (2 of 5)

o Increasing engagement with the broader community by:

- Developing partnerships with community-based entities, resulting in inclusion of individuals receiving HCBS in the broader community;

- Establishing a community-based advisory group.

Promising Practices to Remediate Settings that Isolate (3 of 5)

o Implementing a broad range of services and supports, programming and multiple daily activities to facilitate access to the broader community so individuals can select an array of options and control their own schedule. Such activities should:

- Promote skills development and facilitate training to attain and expand opportunities for community-based integration;

- Expose beneficiaries to community activities/situations comparable to those in which individuals not receiving HCBS routinely engage;

- Encourage families/friends to participate regularly with the beneficiary onsite and in the broader community; and /or
- Promote greater HCBS beneficiary independence and autonomy.

o Implementing organizational changes that:

- Assure required staffing and transportation options to offer both group and individualized options that facilitate community engagement based on individual preferences in the person-centered service plan; and/or

Promising Practices to Remediate Settings that Isolate (5 of 5)

- Decentralize staff structures to promote flexibility and encourage staffing focused on individuals' access to/participation in the broader community, rather than staff models focused around a specific facility/site.

o Expanding strategies for increasing beneficiary access to transportation options through existing means; could include providing transportation to promote ease of access and optimize individuals' ability to select their own options and make decisions about their services and supports.

➢ Regulation and policy alignment:

- Align regulations, administrative rules, policy and procedural directives;

- Take action with executive and legislative branches;

- Break down silos and work across agencies:

  o State Medicaid Agencies working with Operating Agencies to bring the spirit of the rule to life.

- Educate policy makers on critical issues.

HCBS System Transformation: Suggested Strategies (2 of 5)

➢ Stakeholder engagement including ongoing education, training and technical assistance:

- <u>ID</u>: Working through Community NOW!, Idaho is trying to change attitudes and how services are provided, focusing on outcomes from the adult's perspective and how their rights and choices are supported.

- <u>CT:</u> The state hires Self-Advocacy Coordinators; their self-advocates have developed several training programs including Prevention of Abuse and Neglect and Developing Healthy Relationships.

HCBS System Transformation: Suggested Strategies (3 of 5)

➢ Capacity building:

- Identify necessary supports and services that could be added to further beneficiary integration into the community;

- Consider ways to build capacity to meet changing models of service delivery, including identifying systemic ways to ensure that non-disability specific options are adequate and being expanded;

- Consider changes in transportation models/partnerships to facilitate community inclusion;

- Identify efficiencies in current operating systems.

HCBS System Transformation: Suggested Strategies (4 of 5)

➤ Value-based payment reform:

- Consider reforms to incentivize payments for increased time in the community, for more individualized choices, or for increased personal autonomy;

- Create tiered models to make gradual changes;

- Incentivize competitive integrated employment models;

- Incentivize Case Management models that emphasize individualization;

- Reward exceptional implementation of person-centered thinking, planning and practice.

➤ TN: Design and implementation of a new reimbursement approach.

HCBS System Transformation: Suggested Strategies (5 of 5)

➢ Ongoing monitoring and quality assurance:

- Monitor systems change to ensure ongoing compliance;

- Develop strategies and processes to synthesize components of the rule across all systems;

- Design methods to ensure services are delivered in accordance with person-centered service plans;

- Ensure that Managed Care Organizations (MCOs) are fully utilized to assist in system change;

- Utilize new/evolving methods to improve quality;

- Incorporate system change into Quality Assurance process.

➤ Lease/Residency Agreements:

- Each participant must have a lease, residency agreement or other form of written agreement in place with the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city or other entity.

- What must be included in a residency agreement?

- Questions

  - Subleasing implications

  - What happens when the provider cannot meet changing needs of the individual?

➢ Provider-owned or controlled settings:

- A setting is provider-owned or controlled when the setting in which the individual resides is a physical place that is owned, co-owned, and/or operated by a provider of home and community-based services.

- CMS has provided guidance on this: if the individual leases directly from the third party that has no direct or indirect financial relationship with the provider, this would not be provider-owned or controlled.

- If the HCBS provider leases from a third party or owns the property, this would be considered provider-owned or controlled.

- If the provider does not lease or own the property, but has a direct or indirect financial relationship with the property owner, CMS presumes that the setting was provider controlled unless the property owner or provider establishes that the nature of the relationship did not affect either the care provided or the financial conditions applicable to tenants.

Source: Home and Community-Based Requirements Q & A document published on June 26, 2015 at https://www.Medicaid.gov/Medicaid/hcbs/downloads/home-and-community-based-setting-requirements.pdf.

➢ The other defining factor in categorizing whether a setting is provider-owned or controlled considers:

- Whether the selection of a setting limits the participant to a specific HCBS provider of services.
  - o This is most often found in assisted living, senior housing, supportive housing and group home living arrangements.

➢ Foster care:

- It is also critical that a state is informed about the status of the relationship between the participant and the person who owns the home in foster care or shared living settings.

- If the caregiver receives funding from an HCBS authority, and is not a family member of the HCBS participant, then the setting is provider-owned or controlled.

➢ Modification of the conditions/restrictions for provider-owned or controlled settings must be documented in the person-centered service plan:

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

- Documentation includes:

  o Identification of a specific assessed need;

  o The positive interventions and supports used prior to any modification of the person-centered plan.

Operational Awareness: Provider Owned or Controlled Residential Setting (7 of 7)

- A clear description of the condition that is directly proportionate to the specific assessed need;
- Regular collection and review of data to measure the ongoing effectiveness of the modifications;
- Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- The informed consent of the individual to ensure s/he understands what they are agreeing to;
- An assurance that interventions will cause no harm.

Operational Awareness: General Issues

- Administration changes

- Staff turnover

- General delays

- Heightened scrutiny implications

- Assessment/Validation/Remediation approaches

Website Resources: Settings

➤ Home & Community-Based Services Overview
  https://www.medicaid.gov/medicaid/hcbs/index.html

➤ Home & Community-Based Services and Settings Final Regulation (published in 2014)
  https://www.medicaid.gov/medicaid/hcbs/guidance/hcbs-final-regulation/index.html

➤ Extension of Deadline for Compliance with Home & Community Based Settings Criteria-CMCS Informational Bulletin announcing the extension of the transition period from March 17, 2019 to March 17, 2022: https://www.medicaid.gov/federal-policy-guidance/downloads/cib050917.pdf

Website Resources: Statewide Transition Plan

➤ Statewide Transition Plans:

https://www.medicaid.gov/medicaid/hcbs/transition-plan/index.html

➤ Home & Community-Based Settings Requirements Compliance Toolkit: https://www.medicaid.gov/medicaid/hcbs/guidance/settings/index.html

➤ Statewide Transition Plan printable toolkit (2014): https://www.medicaid.gov/medicaid/ltss/downloads/statewide-transition-plan-toolkit.pdf

Website Resources: Heightened Scrutiny (1 of 2)

➢ 42 CFR 441.301(c)(5) found in the Electronic Code of Federal Regulations at:

https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=f54d3cb1d2cc9ce8ac60a9b25b0ed5d5&ty=HTML&h=L&mc=true&n=pt42.4.441&r=PART#se42.4.441_1301

Website Resources: Heightened Scrutiny (2 of 2)

➢ CMS's *Home & Community Based Settings Requirements Compliance Toolkit* provides helpful information at: https://www.medicaid.gov/medicaid/hcbs/guidance/settings/index.html

➢ The Toolkit includes March 2019 Updated Frequently Asked Questions on Heightened Scrutiny Provisions which can also be accessed at https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf

➢ CMS's Home & Community Based Services Training Series at: https://www.medicaid.gov/medicaid/hcbs/training/index.html

Website Resources: Ongoing Monitoring

➢ CMS's Medicaid.gov HCBS Training Series website: https://www.medicaid.gov/medicaid/hcbs/training/index.html

- • "Monitoring of Compliance with the Home and Community-Based Settings Requirements" https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-monitoring-slides.pdf

➢ HCBS Statewide Transition Plan Website's Training Page: Module 5: "The Process for Final Approval: Ongoing Monitoring" https://www.neweditions.net/stptraining

Training

➢ HCBS Training Series: Webinars presented as part of a CMS-State TA series:

https://www.medicaid.gov/medicaid/hcbs/training/index.html

➢ Training Modules (2018): The Statewide Transition Plan: The Process for Final Approval: https://www.neweditions.net/stptraining

Technical Assistance

➢ Requesting One-on-One TA:
https://www.medicaid.gov/medicaid/hcbs/technical-assistance/index.html, or by emailing the TA contractor at:
HCBSettingsTA@neweditions.net

➢ Small Group Discussions & Access to STP Database:
Contact the TA help desk,
HCBSSTPHelpdesk@neweditions.net

Additional Resources

➢ CMS Central Office Contact—Division of Long-Term Services and Supports:

HCBS@cms.hhs.gov

➢ ACL's web page on Community Living:

https://acl.gov/about-community-living

Questions and Answers