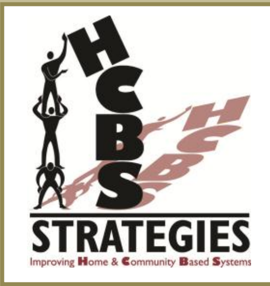

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On April 15, 2011, the Centers for Medicare and Medicaid Services (CMS) issued proposed rules that would make significant changes to Medicaid 1915(c) Home and Community Based Services (HCBS) waivers. The ***Federal Register*** announcement for this notice can be found at: http://www.gpo.gov/fdsys/pkg/FR-2011-04-15/pdf/2011-9116.pdf. Because these waivers fund the majority of publicly funded HCBS, these changes could potentially have substantial implications for how states operate these waivers.

The bulk of HCBS Strategies work is supporting state agencies as they try to build and improve the operations of the HCBS delivery systems. Thus, our bias is to view these proposed regulations from the perspective of how they may impact states.

Below, HCBS Strategies provides an annotated version of the proposed changes to the regulations along with comments about possible implications. We are providing this information to States so that they can make informed decisions about the comments that they wish to provide to CMS. As we obtain more information and input, we may update this document and post it at www.HCBS.info.

The draft notice includes a preamble that provides more information about how CMS may interpret these regulations. The section of the ***Federal Register*** notice that would be of greatest importance are the proposed changes to the regulatory language that would be included in the Code of Federal Regulations (CFR). Thus, our analysis, and any state analysis, should focus on that language which is included at the end of the Federal Register notice. However, we have referenced sections of the preamble and states should review it because CMS staff often reference it when giving guidance and reviewing waiver applications, etc.

Our intent is not to criticize the proposed changes. We commend CMS for the leadership it has provided helping to shift power to individuals. Our purpose is to help states understand the potential implications for their current operations. We also note that interpreting regulation is not an exact science and our interpretation may differ from others. We hope that this effort will contribute to a dialogue that will ultimately result in final regulations that will improve HCBS without putting undue burden on states.

We have also set up a blog at hcbspolicy.com to facilitate an informed dialogue about these proposed rules. We invite states and other stakeholders to react to our comments and identify other potential issues.

Proposed Changes to Code of Federal Regulations

This notice would make changes to Code of Federal Regulations Title 42, Part 441. For the current rules, click http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR&searchPath=Title+42%2FChapter+IV%2FSubchapter+C%2FPart+441%2FSubpart+G&oldPath=Title+42%2FChapter+IV%2FSubchapter+C%2FPart+441&isCollapsed=true&selectedYearFrom=2010&ycord=2263

PART 441--SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO

SPECIFIC SERVICES

1. The authority citation continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

Subpart G--Home and Community-Based Services: Waiver Requirements

2. Section 441.301 is amended by--

A. Revising paragraphs (b)(1)(i) and (b)(6).

B. Adding new paragraph (b)(1)(iv).

The revisions and addition read as follows:

§441.301 Contents of request for a waiver.

* * * * *

(b) * * *

(1) * * *

(i) Under a written services and support plan (also called plan of care) that is based on a person-centered approach and is subject to approval by the Medicaid agency.

> The changes appear to mandate the inclusion of person-centered principles into assessment and care planning.
>
> While most states are moving in this direction, this could become mandatory.

(A) Person-Centered Planning Process. In addition to being led by the individual receiving services, the person-centered planning process:

> CMS should clarify the criteria that determine that the individual led the process and circumstances when it is acceptable for someone else to lead the process (e.g., severe cognitive impairment & no representative.

(1) Includes people chosen by the individual.

(2) Provides necessary support to ensure that the individual has a meaningful role in directing the process.

> Many states will need to build capacity to support individuals with cognitive impairments and other disabilities so that they can play a more active role. This could include making assessment tools and other tools easier to understand, self-advocacy training, and peer mentoring. CMS should clarify expectations regarding recommended operations and infrastructure.

(3) Occurs at times and locations of convenience to the individual.

(4) Reflects cultural considerations of the individual.

(5) Includes strategies for solving conflict or disagreement within the process, including any conflict of interest concerns.

> States may want greater guidance on what is an acceptable strategy.

(6) Offers choices to the individual regarding the services and supports they receive and from whom.

(7) Includes a method for the individual to request updates to the plan as needed.

> The preamble discussed updating the support plan whenever the individual requests it be done. States may want flexibility to limit this in some extreme cases (e.g., someone asks for an update every month).

(B) The Person-Centered Plan. The person-centered plan must reflect the services that are important for the individual to meet individual services and support needs as assessed through a person-centered functional assessment as well as what is important to the person with regard to preferences for the delivery of such supports.

Commensurate with the level of need of the individual, the plan must:

(1) Reflect the individual's strengths and preferences.

(2) Reflect clinical and support needs as identified through a person-centered functional assessment.

> CMS will need to define the criteria a functional assessment will need to meet to be considered person-centered.

(3) Include individually identified goals, which may include, as desired by the individual, items related to relationships, community living, community participation, employment, income and savings, health care and wellness, education, and others.

(4) 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.

(5) Reflect risk factors and measures in place to minimize them, including back-up strategies when needed.

(6) Be signed by all individuals and providers responsible for its implementation.

(7) Be understandable to the individual receiving services and the individuals important in supporting him or her.

(8) Include a timeline for review.

(9) Identify the individual and/or entity responsible for monitoring the plan.

(10) Be distributed to everyone involved (including the participant) in the plan.

(11) Be directly integrated into self-direction where individual budgets are used.

(12) Prevent the provision of unnecessary or inappropriate care.

* * *

Many states will need to update assessment and support plan formats to collect more information and address these components in the support plan.

Support plans will need to include measurable goals that are individualized.

CMS will need to clarify if the support plan will need to be updated and signed each time someone changes a provider. This could become especially burdensome for participant-directed services.

The preamble says, "The plan should act as the basis for the building of an individual's budget, and the individual's ability to make decisions regarding the resources available to him or her." CMS should clarify if budgets not based on person-centered assessments and support plans, including budgets based on case mix or other populations characteristics would also be acceptable.

(iv) Only in settings that are home and community based, integrated in the community, provide meaningful access to the community and community activities, and choice about providers, individuals with whom to interact, and daily life activities. A setting is not integrated in the community if it is:

(A) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment or custodial care; in a building on the grounds of, or immediately adjacent to, a public institution; or a housing complex designed expressly around an individual's diagnosis or disability, as determined by the Secretary; or

(B) Has qualities of an institutional setting, as determined by the Secretary.

* * * * *

(6) Be limited to one or more of the following target groups or any subgroup thereof that the State may define:

(i) Aged or disabled, or both.

(ii) Individuals with Intellectual or Developmental Disabilities, or both.

(iii) Mentally ill.

CMS is proposing a substantial change to what can be paid for under a HCBS waiver. This could mean that many residential settings, such as group homes and some types of assisted living will no longer be eligible for Medicaid.

A key distinction will be what CMS considers a "housing complex." When (if ever) would a group home or other residential setting for individuals with DD be considered a "housing complex."

The preamble excludes residential settings that support American Indians who have a cultural preference for shared meals. The preamble also states that assisted living facilities may qualify if the assisted living facilities meet certain criteria such as not discharging people who become more impaired and allowing visitors at any hour.

This definition could vary substantially across regional offices, CMS staff, and federal administrations. The preamble states, "Such qualities may include regimented meal and sleep times, limitations on visitors, lack of privacy and other attributes that limit individual's ability to engage freely in the community." This suggests that many group homes would not qualify for Medicaid without substantial changes. Some may have to convert into ICF-MRs to be Medicaid eligible.

If CMS is proposing a change that would require major changes to state systems, providers' operations, and/or eliminating certain types of providers, CMS should propose a phase-in time.

3. Section 441.302 is amended by adding paragraphs (a)(4) and (a)(5) to read as follows:

§441.302 State Assurances.

* * * * *

(a) * * *

(4) Assurance that the State is able to meet the unique service needs that particular target groups may present when the State selects to serve more than one target group under a single waiver, as specified in §441.301(b)(6) of this subpart.

(5) Assurance that services are provided in home and community based settings, as specified in §441.301(b)(1)(iv) of this subpart.

* * * * *

CMS is adding the ability to include multiple populations in a single waiver. This is a voluntary option that may be of great help to some states.

4. Section 441.304 is amended by--

A. Revising the section heading as set forth below.

B. Redesignating paragraph (d) as new paragraph (g).

C. Adding new paragraphs (d), (e), and (f).

D. Revising newly designated paragraph (g).

The additions and revisions read as follows:

§441.304 Duration, extension, and amendment of a waiver.

* * * * *

(d) The agency may request that waiver modifications be made effective retroactive to the first day of a waiver year, or another date after the first day of a waiver year, in which the amendment is submitted, unless the amendment involves substantive changes as determined by CMS.

This could be helpful, in that states will have more time in submitting minor changes such as changes to forms that do not affect level of care.

(1) Substantive changes may include, but are not limited to, revisions to services available under the waiver including elimination or reduction in services, and changes in the scope, amount, and duration of the services. Substantive changes may also include a change in the qualifications of service providers, changes in rate methodology or a change in the eligible population.

(2) A request for an amendment that involves a substantive change as determined by CMS, may only take effect on or after the date when the amendment is approved by CMS, and must be accompanied by information on how the State has assured smooth transitions and minimal adverse impact on individuals impacted by the change.

Currently changes can be implemented on the 1st day of the quarter in which an amendment is submitted (however, they run the risk of having FFP denied if the change is disapproved). This provision could greatly increase the timeframe for implementing changes to waivers.

(e) The agency must provide public notice of any significant proposed change in its methods and standards for setting payment rates for services in accordance with §447.205 of this chapter.

(f) The agency must establish and use a public input process, for any changes in the services or operations of the waiver.

(1) This process must be described fully in the State's approved waiver application and be sufficient in light of the scope of the changes proposed, to ensure meaningful opportunities for input for individuals served, or eligible to be served, in the waiver.

Public notice requirements for waivers are greatly increased, including a requirement to consult with Tribes.

(2) This process must include consultation with Federally-recognized Tribes, and in accordance with section 5006(e) of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5), Indian health programs and Urban Indian Organizations.

(g)(1)If CMS finds that the Medicaid agency is not meeting one or more of the requirements for a waiver contained in this subpart, the agency is given a notice of CMS' findings and an opportunity for a hearing to rebut the findings.

(2) If CMS determines that the agency is substantively out of compliance with this subpart after the notice and any hearing, CMS may employ strategies to ensure compliance as described in §441.304(g)(1) of this paragraph or terminate the waiver.

(3)(i) Strategies to ensure compliance may include the imposition of a moratorium on waiver enrollments, other corrective strategies as appropriate to ensure the health and welfare of waiver participants, or the withholding of a portion of Federal payment for waiver services until such time that compliance is achieved, or, ultimately, termination. When a waiver is terminated, the State must comport with §441.307 of this subpart.

(ii) CMS will provide States with a written notice of the impending strategies to ensure compliance for a waiver program. The notice of CMS' intent to utilize strategies to ensure compliance would include the nature of the noncompliance, the strategy to be employed, the effective date of the compliance strategy, the criteria for removing the compliance strategy and the opportunity for a hearing.

CMS is increasing their enforcement capabilities.