Final Regulation CMS-2249-F/CMS-2296-F
Home and Community-based Settings and Person-Centered Planning Provisions

Overview:

- The rule reflects the Centers for Medicare and Medicaid's (CMS) intent to ensure that persons receiving Home and Community-Based Services (HCBS) have access to the benefits of **community living** and receive services in the **most integrated** setting.
- The rule creates a more outcome-oriented definition of home and community-based settings, rather than a definition based on the settings location, geography or physical characteristics.
- The rule defines Person-Centered Planning.
- All states must submit to CMS a plan for transitioning their current HCBS system into compliance with the new rule by March 17, 2015. States submitting a 1915(c) waiver renewal or amendment before March 17, 2015 must include a transition plan in that submission. States then have 120 days from that submission date to submit a transition plan for the remainder of their HCBS system.

Home and Community-Based Settings:

- The final rule creates a single definition of a home and community-based setting for 1915(c), 1915(i), and 1915(k) HCBS. The rule describes home and community-based settings as having the following qualities:
    - The setting is integrated in the greater community, and includes opportunities to seek employment in competitive integrated settings and engage in the community.
    - The setting is selected by the individual.
    - The setting ensures individual rights of privacy, dignity, and respect; and freedom from coercion and restraint.
    - The setting optimizes individual initiative, autonomy, and independence in life choices.
    - The setting facilitates individual choice regarding services and supports, including who provides them.
- The definition and qualities **apply to all settings**: residential, employment, adult day, and prevocational training.
- For provider-owned or controlled residential settings, the rule states the following additional requirements:
    - Units or rooms must be a specific physical place, the kind that could be owned or rented in a typical landlord-tenant agreement.
    - Individuals have privacy in their living or sleeping units, meaning that:
        - Units have lockable doors and entrances, with only appropriate staff having keys to doors;
        - Individuals who share rooms have a choice of roommate in that setting;
        - Individuals can furnish and decorate their own units within the limits of the lease agreement;
        - Individuals control their own schedules, including access to food at any time;

    - Individuals can have visitors at any time; and
    - The setting is physically accessible to the individual.
- The rule states that the following are never home and community-based settings:
    - Nursing facilities
    - Institutions for mental diseases
    - Intermediate care facilities for people with intellectual disabilities
    - Hospitals

Person-Centered Planning:

- Providers of HCBS for the individual, or those who have an interest in or are employed by a provider for HCBS for the individual, must not develop the person-centered plan.
- Process for plan development must be driven by individual.
- Process must be conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.
- Plan must address key areas:
    - Strengths
    - Preferences
    - Clinical Needs
    - Support Needs
    - Desired Goals and Outcomes
- Written plan must reflect:
    - The setting is chosen by the individual and is integrated in, and supports full access to, the greater community.
    - The individual has opportunities to seek employment and work in competitive integrated settings.
    - The individual has opportunities to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.

To Learn More:

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 rule: www.HCBSadvocacy.org

The Final Rule is available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

CMS HCBS Settings Rule
Non-residential Settings

Background: The home and community-based settings rule established a definition of HCBS settings based on individual experience and outcomes rather than one based solely on a setting's location, geography, or physical characteristics. The purpose of the HCBS Settings Rule is to maximize the opportunities for individuals receiving Medicaid Home and Community-based Services (HCBS) to receive the benefits of community living, including opportunities to seek employment and work in integrated settings. The requirements set forth in the rule apply to both residential and non-residential programs. The Centers for Medicare and Medicaid (CMS) recently published two documents as guidance to assist states in complying with the non-residential settings requirements.

Highlights from the CMS guidance:

- CMS encourages states to consult both the residential and non-residential guidance documents as many of the questions are relevant to ALL HCBS settings.
- CMS stresses that the nature of the service will impact how the state addresses the settings requirements. The state's determinations about certain settings for services, such as those that are clinical/medical in nature may be different than state decisions/actions for a setting that is less medical/clinical in nature.
- States can "set higher standards" or more restrictive requirements for settings than those found in the regulation.
- The rule does not restrict the opportunity for individuals with representative payees or other types of fiduciaries to participate in HCBS programs.
- People may receive services with other people who have either the same or similar disabilities, but must have the option to be served in a setting that is not exclusive of people with same or similar disabilities.
- CMS does not intend to issue service specific guidance at this time but will continue to respond to questions from stakeholders and offer technical assistance to states.
- CMS does clarify that the regulation does not prohibit facility-based or site-based settings. Such settings, must demonstrate the qualities of HCBS settings, ensure the individual's experience is home and community-based, not institutional in nature, and ensure that it does not isolate the individual from the broader community.
- CMS states that the regulations do not prohibit individuals from receiving pre-vocational services in a facility based setting such as a sheltered workshop, but that ALL HCBS settings must support full access of individuals to the greater community, including facilitating opportunities to seek employment in competitive settings.
- CMS says that a day service that has both HCBS waiver participants and Intermediate Care Facility (ICF) residents and provides HCBS services in an

ICF for individuals with intellectual disabilities is institutional and cannot be covered by HCBS.

- If the day service is provided by a licensed day service operated separately from the ICF/IDD but in the same building, it will be presumed to have institutional characteristics.
- CMS clarifies that states can follow the process to challenge the presumption of institutional characteristics of a setting.
- CMS states that in all settings, the individual must be afforded the rights of privacy, dignity, and respect; and freedom from coercion and restraint.
- CMS states that the person-centered service plan must reflect risk factors and measures in place to minimize them, including back-up plans and strategies.
- CMS states that any restrictions on individual choice must be focused on the health and welfare of the individual. However, risk mitigation strategies must be implemented, documented and evaluated prior to the restriction.

To Learn More:

Questions and Answers Regarding Home and Community-based Settings:
http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/q-and-a-hcb-settings.pdf

Exploratory Questions to Assist States in Assessment of Non-Residential HCBS Settings:
http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/exploratory-questions-non-residential.pdf

These new documents, along with the other CMS toolkit documents, are available on the Medicaid.gov HCBS homepage at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html

CMS Guidance:
The Elements of the Written Person-Centered Plan

On June 6, the United States Department of Health and Hospitals published guidance containing standards on person-centered planning of Home and Community Based Services (HCBS) that should be embedded in all Health and Hospital funded HCBS programs as appropriate.

The written Person-Centered Plan (PCP) must identify the services and supports that are necessary to meet the person's identified needs, preferences, and quality of life goals and must include the following:

1. Reflect that the setting where the person resides is chosen by the individual. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.

2. The plan must be prepared in person-first singular language and be understandable by the person and/or representative.

3. In order to be strengths-based, the positive attributes of the person must be considered and documented at the **beginning** of the plan.

4. The plan must identify risks, while considering the person's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.

5. Goals must be documented in the person's and/or representative's own words, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person. Goals must consider the quality of life concepts important to the person.

6. The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources, including natural supports, to meet the goals in the PCP.

7. The specific person or persons, and/or provider agency or other entity providing services and supports, must be documented.

8. The plan must assure the health and safety of the person.

9. Non-paid supports and items needed to achieve the goals must be documented.

10. The plan must include the signatures of everyone with responsibility for its implementation including the person and/or representative, his or her case manager, the support broker/agent (where applicable), and a timeline for review. The plan should be

discussed with family/friends/caregivers designated by the individual so that they fully understand it and their role(s).

11. Any effort to restrict the right of a person's preferences or goals must be justified by a specific and individualized assessed safety need and documented in the PCP.

The following requirements must be documented in the PCP when a safety need warrants such a restriction:

- The specific and individualized assessed safety need;
- The positive interventions and supports used prior to any modifications or additions to the PCP regarding safety needs;
- Documentation of less intrusive methods of meeting the safety needs that have been tried, but were not successful;
- A clear description of the condition that is directly proportionate to the specific assessed safety need;
- A regular collection and review of data to measure the ongoing effectiveness of the safety modification;
- Established time limits for periodic reviews to determine if the safety modification is still necessary or can be terminated;
- Informed consent of the person to the proposed safety modification; and
- An assurance that the modification itself will not cause harm to the person.

12. The plan must identify the person(s) and/or entity responsible for monitoring its implementation.

13. The plan must identify needed services, and prevent unnecessary or inappropriate services and supports.

14. An emergency back-up plan must be documented that encompasses a range of circumstances (e.g. weather, housing, and staff).

15. The plan must address elements of Self-Directed (SD) services (e.g. fiscal intermediary, support broker/agent, alternative services) whenever a SD service delivery system is chosen.

16. All persons directly involved in the planning process must receive a copy of the plan or a portion of the plan, as determined by the participant or representative.

To Learn More:

You can review the guidance in its entirety at:
www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf

The guidance also included: (1) Required Elements of the Person-Centered Planning Process, (2) Required Elements of Person-Centered Planning Implementation, and (3) Required Elements of Self-Direction. Fact sheets on these elements are also available from Brackin & Associates.

CMS Guidance:
The Elements of the Person-Centered Planning Process

On June 6, 2014, the United States Department of Health and Hospitals published guidance that contains standards on person-centered planning (PCP) of Home and Community Based Services (HCBS) that should be embedded in all Health and Hospital funded HCBS programs as appropriate.

The PCP Process must support the person, make him or her central to the process, and recognize the person as the expert on goals and needs. In order for this to occur there are certain process elements that are required. These include:

1. The person or representative must have control over who is included in the planning process, as well as the authority to request meetings.

2. The process is timely and occurs at convenient times and locations.

3. Necessary information and support is provided to ensure the person and/or representative understands the information. This includes the provision of auxiliary aids and services when needed for effective communication.

4. A strengths-based approach to identifying the positive attributes of the person must be used, including assessment of the person's strengths and needs. The person should be able to choose the specific PCP format or tool used for the PCP.

5. Personal preferences must be used to develop goals and to meet the person's HCBS needs.

6. The person's cultural preferences must be acknowledged in the PCP process, and the PCP process must provide meaningful access to participants and/or their representatives with limited English proficiency (LEP), including low literacy materials and interpreters.

7. People under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, should have the opportunity in the PCP process to address any concerns.

8. There must be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.

9. People must be offered information on the full range of HCBS available to support achievement of personally identified goals.

10. The person must be central in determining what available HCBS are appropriate and will be used.

11. The person must be able to choose between providers and provider entities-including the option of Self Direction services—when choice is available.

12. The PCP must be reviewed at least every twelve months or sooner, when the person's functional needs change, circumstances change, quality of life goals change, or at the person's request. There must be a clear process for individuals to request updates. The accountable entity must respond to such requests in a timely manner that does not jeopardize the person's health and safety.

13. The PCP should not be constrained by any pre-conceived limits on the person's ability to make choices.

14. Employment and housing in integrated settings must be explored, and planning should be consistent with the individual's goals and preferences, including where the individual resides, and who they live with.

To Learn More:

You can review the guidance in its entirety at:
www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf

The guidance also included: (1) Required Elements of the Written Person-Centered Plan, 2) Required Elements of Person-Centered Planning Implementation, and 3) Required Elements of Self-Direction. Fact sheets on these elements are available through Brackin & Associates.

CMS Guidance:
Implementing Person-Centered Planning

On June 6, the United States Department of Health and Hospitals published guidance containing standards on person-centered planning of Home and Community Based Services (HCBS) that should be embedded in all Health and Hospital funded HCBS programs as appropriate.

The Implementation of Person-Centered Planning requires:

1) Monitoring of progress toward achievement of identified goals.
2) A method in place that ensures the plan is reviewed according to established timelines.
3) A method in place that allows the person or representative to report on progress, issues and problems
4) A method in place to ensure that needed changes to the plan can be made and implemented in an expedient manner.
5) Persons be fully involved in the process to update their plans based on their needs and preferences, no less often than annually.
6) Accountable entities (e.g., state or local programs) have policies, mission/vision statements and operations documents that incorporate PCP standards.
7) All staff involved in the PCP process have a consistent understanding of the process and implementation.
8) That leadership, administrative, and other staff be strongly encouraged to participate in competency-based training in person-centered planning.
9) That monitoring of PCP should be implemented at the federal, state, and local levels and be incorporated as an integral component of quality improvement activities across HCBS programs.
10) The person can take an active role in the PCP process by:
    - Providing accurate information for eligibility and service planning;
    - Actively identifying and engaging providers, case managers, family members, friends, direct support workers, support brokers, medical professionals, and others;
    - Approving and signing only a plan that is developed and accepted by everyone involved;
    - Participating fully after the approved plan is implemented (e.g., appearing timely for meetings and appointments, reviewing the plan regularly); and
    - Providing regular feedback on the HCBS provided.

To Learn More:

You can review the guidance in its entirety at:
www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf

The guidance also included: (1) Required Elements of the Person-Centered Planning Process, (2) Required Elements of the Written Person-Centered Plan, and (3) Required Elements of Self-Direction. Fact Sheets on these elements are available from Brackin & Associates.

Policy Issue Fact Sheet
Workforce Innovation and Opportunities Act (WIOA)

Background: The Workforce Innovation and Opportunities Act (WIOA), in general, takes effect on July 1, 2015. This legislation reauthorizes the Workforce Investment Act of 1998 (WIA), including the Rehabilitation Act, through the year 2020. WIOA is designed to help job seekers, including those with disabilities, access employment, education, training, and support services to succeed in the labor market, and to match employers with skilled workers.

The Facts:

- State Vocational Rehabilitation (VR) Programs will have a much larger role in the transition from school to adult life.
- Local VR offices must undertake pre-employment transition coordination activities, including working with schools and the local workforce development system.
- Beginning in 2016, a series of steps are required before an individual under the age of 24 can be placed in a job paying less than minimum wage.
- VR agencies are required to have formal cooperative agreements with the state agency responsible for administering the state Medicaid plan and with state IDD agencies.
- A number of federal disability agencies are moving from the Department of Education to the Department of Health and Human Services.
- The Act defines *competitive integrated employment* as full-time or part-time work at minimum wage or higher, with wages and benefits similar to those without disabilities performing the same work, and fully integrated with co-workers without disabilities.
- *Customized employment* is defined as "competitive integrated employment for an individual with a significant disability, that is based on an individualized determination of the strengths, needs, and interests of the individual with a significant disability, designed to meet the specific abilities of the individual with a significant disability and the business needs of the employer, and carried out through flexible strategies."
- The definition of *supported employment* has been modified. The new definition makes it clear that supported employment is integrated competitive employment, or an individual working on a short-term basis in integrated employment towards integrated competitive employment.
- Standard post-employment support services have been extended from 18 to 24 months.
- Half of the money states receive under supported employment state grants has to be used to support youth with the most significant disabilities.
- Under WIOA, the governor can require public VR agencies to use a maximum of 0.75% of its funds for One-Stop infrastructure, which will gradually increase to a maximum of 1.5% after five years.

- A number of provisions emphasize and/or increase the requirements for the general workforce development system and One-Stop Career Centers to meet the needs of job seekers with disabilities. For example, boards will have to ensure that there are sufficient service providers in the local area with expertise in supporting individuals with disabilities with their career and training needs, annual assessment of physical and programmatic access of One-Stop Career Centers is required, and disability is to be considered in the development of state performance requirements in use of workforce development funds.
- The Act also includes changes in performance measures for core programs, such as VR, youth workforce investment programs, and State Employment Services. These performance measures are a new requirement for state VR programs.

Proposed regulations that provide details on the implementation of WIOA are scheduled to be published for public comment by mid-January 2015.

To Learn More:

You can read the full bill at:
https://beta.congress.gov/bill/113th-congress/house-bill/803/text

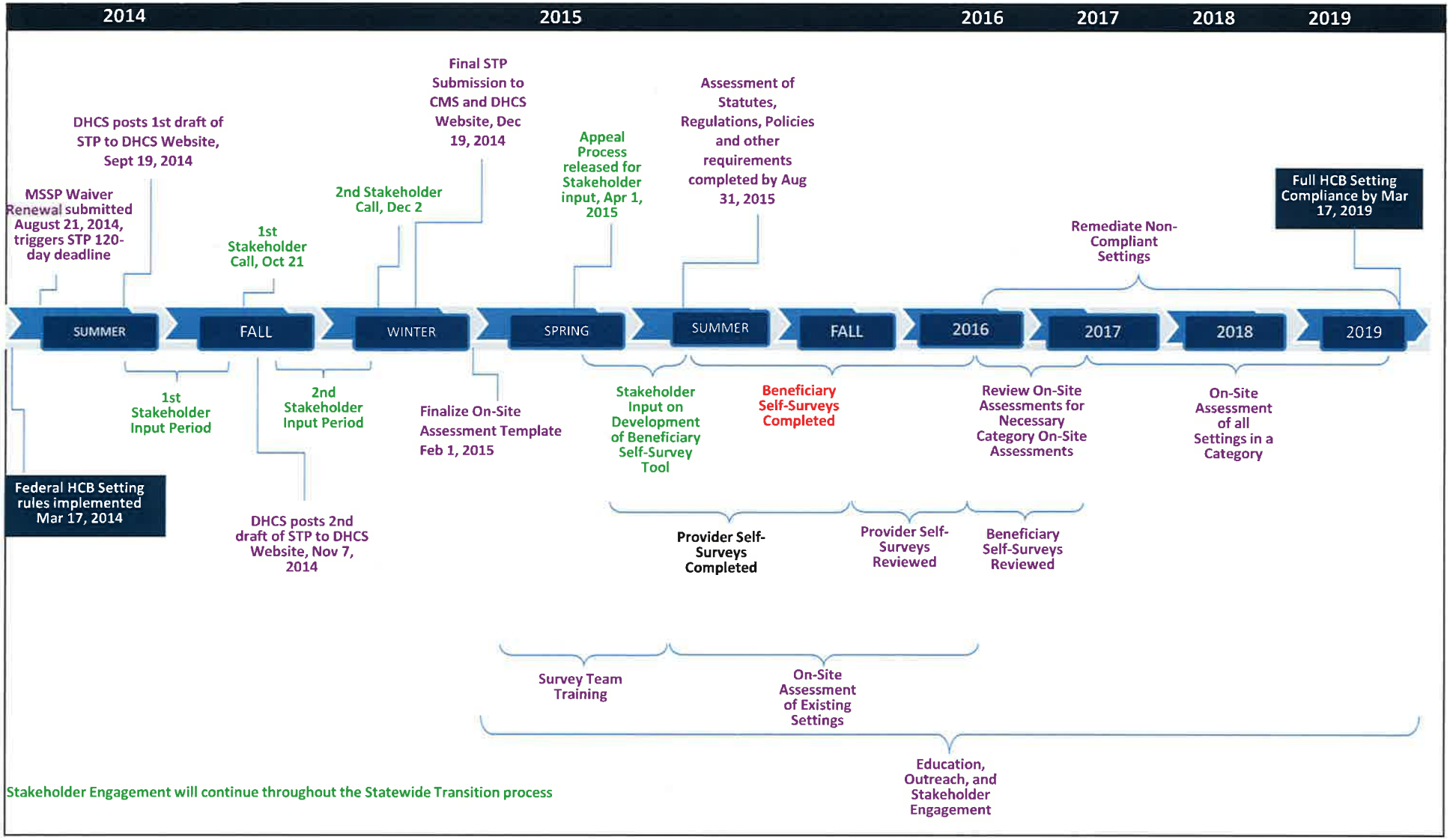
More information on WIOA can be found at:
http://wdr.doleta.gov/directives/corr_doc.cfm?DOCN=3556

Information on the changes to the Rehabilitation Act can be found at:
http://www2.ed.gov/about/offices/list/osers/rsa/publications/wioa-changes-to-rehab-act.pdf

Brief published by National Association of Workforce Boards:
http://www.workforcesnohomish.org/inform/wioa/documents/overview.pdf

WIA is Now WIOA: What the New Bill Means for People with Disabilities:
https://www.communityinclusion.org/article.php?article_id=382

Long-Term Care Division Statewide Transition Plan Process Timeline



Comments / Notes: We are verfifying when individual waiver transition plans are due to CMS in the form of an amendment.

Last update: Dec 19, 2014

Text color legend: Purple: State Red: Beneficiaries Green: Stakeholders Black: Providers

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Disabled & Elderly Health Programs Group

November 16, 2015

Mari Cantwell
Chief Deputy Director, Health Care Programs
State of California, Department of Health Care Services
1501 Capitol Avenue, 6th Floor, MS 0000
Sacramento, CA 95814

Dear Ms. Cantwell,

The Centers for Medicare & Medicaid Services (CMS) has completed its review of California's Statewide Transition Plan (STP) to bring state standards and settings into compliance with new federal home and community-based settings requirements. California submitted its STP to CMS on December 19, 2014 and resubmitted on August 14, 2015. CMS requests additional detail regarding waivers and settings, the systemic assessment, the site-specific assessment, monitoring of settings, remedial actions, heightened scrutiny, relocation of beneficiaries, and public comment. These issues are summarized below.

Waivers and Settings Included in the STP:

- The state has included several services under each waiver, rather than specific settings. The state also included "an initial listing of home and community-based settings that have been assessed through the systemic assessment process" (p. 17). It is unclear whether that listing includes all settings across home and community-based programs within the state. Please provide a list of all settings in which services are provided for each of the 1915(c) waivers, the 1915(i) State Plan, the 1915(k) Community First Choice (CFC) Program and the 1115 demonstration.
- Please clarify how Community Care Facilities (CCFs) relate to other settings under the 1915(c) San Francisco Community Living Support Benefit (SFCLSB) waiver. Is this an umbrella term for Residential Care Facilities for the Elderly or Adult Residential Facilities?
- Please clarify whether the services provided in Public Subsidized Housing, under the 1915(c) California Assisted Living Waiver, are limited to a specific provider, and how those settings comport with the requirements of the home and community-based settings regulation.
- In the STP (p. 4, 12) the state indicates that 1915(k) CFC services are provided in the homes owned by the individual or family member, and apartments where the individual pays rent through a landlord/occupant agreement. However, information received from the state specifying the types of settings individuals receiving CFC services reside, includes settings that could be considered provider-owned and operated. Please identify within the STP all setting types included in under the 1915(k) Community First Choice Program. Additionally, if any settings are confirmed to be provider-owned and operated, the state will ned to perform a

systemic assessment to verify that the settings uphold the federal standards for home and community-based settings.

- The state notes that Community-Based Adult Services (CBAS) centers are the only home and community-based settings under its 1115 demonstration. However, CMS is aware of participants in the 1115 demonstration who receive home and community-based services in settings other than CBAS centers, such as in the In-Home Supportive Services (IHSS) Program. Please identify any other settings in which services are provided outside of CBAS centers under the 1115 demonstration.

Systemic Assessment:

- The state did not provide outcomes for a systemic assessment of settings under the 1915(c) SFCLSB waiver, which includes Adult Residential Facilities, Residential Care Facilities for the Elderly, and Direct Access Housing. Please assess regulations or other governing documents for these settings and provide a crosswalk of the components that address specific characteristics of the settings requirements, indicating whether the state documents comply, do not comply or are silent on the federal regulation.
- CMS reviewed a sample of state policies that were provided in the STP in support of the federal requirements and has the following observations/questions.
    - We have identified many policies that clearly reinforce the regulation. However, there are some state policies that appear to be silent in regard to the federal requirements.
        - For example, in the CBAS transition plan under federal requirement 1—the setting is integrated in and supporting full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid home and community-based services—the state policies T-22 54001, T-22 54207, T-22 78303, STC 98(c), and T-22 54217 do not directly relate to the federal requirement and would be considered silent on this issue. The state has provided other policies that clearly uphold this particular federal requirement. Please clarify which regulation prevails in this instance.
        - CMS has identified two federal requirements, requirement 3-- Ensuring individuals' rights of privacy, dignity and respect, and freedom from coercion and restraint—and requirement 7—Allowing individuals the freedom to have visitors at any time—that CBAS policies do not appear to uphold and CMS would consider the provided regulations to be silent on these federal requirements. Please review your state CBAS regulations for all federal requirements, identify any regulations that are silent on these standards, in addition to those that are out of compliance, and delineate how they will be remediated in order to clearly uphold the federal requirements.

- Under federal requirement 3-- Ensuring individuals' rights of privacy, dignity and respect, and freedom from coercion and restraint—in the CBAS transition plan, state code T-22 78315(a) indicates that, "restraints shall be used only as measures to protect the participant from injury to self, based on the assessment of the participant by the multidisciplinary team." Please clarify whether the multidisciplinary team is the same as the person-centered planning team and how this type of restriction will be applied in accordance with the federal regulation.

Site-Specific Assessments:

- The state included a timeline for activities under the CBAS center assessment process. However, the state did not include a timeline for many of the milestones within the STP. Please provide a timeline for all activities that will be conducted as part of the transition process.
- The state has omitted from the STP several key details about the site-specific assessment process including: when provider self-surveys will be completed, how the state will ensure responses from providers, how beneficiary surveys will be matched to provider assessments, how beneficiary and provider surveys will be used to identify settings that require on-site assessment, an estimate of the number of on-site assessments, how the state will ensure coordination across on-site assessments, and how the on-site assessment tool would be used to categorize compliant and non-compliant settings. Please include these details in the description of this process.
- The state currently has a completion date of July 31, 2018 for on-site assessments and provider survey validation of CBAS centers. This end date may be too late for the state to identify any remaining issues that will allow all settings to fully comply before the March 2019 deadline. Please modify the timeframe for this activity to allow enough time for full validation and remediation for non-compliant sites.
- Please provide a description of how the state intends to assess IHSS settings under the 1115 demonstration that are not CBAS centers.
- It appears that the state included in its standard CBAS provider application and renewal process steps for ensuring that home and community-based characteristics are present. The state incorporated additional steps into existing processes. However, please clarify whether there is an on-site inspection by the state at the time of renewal. If there is not, please describe how the state is assured of a provider's ongoing compliance with settings requirements.
- The state has provided an initial on-site assessment of a sample of Congregate Living Facilities.
    - Please provide additional background information on the on-site assessments including: the total number of facilities under each setting, the number of facilities sampled, and for settings that are non-compliant, the number of beneficiaries who receive services in that setting.

- Additionally, the state indicated instances in which components of these settings conflicted with the federal requirements, and did not provide information about the characteristics of the settings that upheld the federal requirements. Under findings for requirements that appeared to meet federal standards, the state wrote "none." Please clarify what "none" indicates for these settings.

- The state does not provide estimates of how many settings fully comply, do not comply but can with corrections, cannot comply with the settings requirements and will require relocation of beneficiaries, or presumptively have the qualities of an institution. Please provide an estimate of the number of settings that fall under each of these categories as determined from the systemic and site-specific assessments.

Monitoring of Settings:

The state provides a thorough description of the monitoring process that will take place during the CBAS transition process while offering less detail of monitoring activities for other settings included in the STP. Please provide more detail on monitoring activities for other settings. CMS recommends that the state review the CBAS monitoring process and assess its viability for use in other settings.

Remedial Actions:

- For the 1915(k) program, 1915(c) HIV/AIDS, and 1915(c) IHO waivers, the state writes, "the characteristics of home and provider settings are not addressed in State regulations, Waiver language, or applicable Waiver documentation; therefore, a Systemic assessment and remedial strategies are not necessary" (p. 62). Please provide remedial strategies to develop language for settings under this program and these waivers that uphold the federal standards for home and community-based settings.
- The state notes for its remedial strategy under the STP systemic assessment that it "will discuss the impacts of this characteristic during the Waiver renewal process" (Appendix B). Please provide specific remedial language for each conflicting or silent requirement and begin to remediate these policies prior to the waiver renewal process.
- Please provide specific milestones and corresponding timelines when developing remediation strategies for specific settings and sites.
- For the Congregate Living Facilities, the state identified broad remedial actions (e.g., "will need to provide greater accessibility amongst entry ways within the house") but did not include specific milestones and timelines to help implement the required remedial actions. Please add milestones and timeframes for each issue that needs to be remediated.

Heightened Scrutiny:

The state must clearly lay out its process for identifying settings that are presumed to have the qualities of an institution. These are settings for which the state must submit information for the heightened scrutiny process if the state determines, through its assessments, that these settings do have qualities that are home and community-based in nature and do not have the qualities of an institution. If the state determines it will not submit information on the settings that match the

scenarios in the regulation, the presumption will stand and the state must describe the process for informing and transitioning the individuals involved.

Settings that are presumed to be institutional in nature include the following:

- Settings located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;
- Settings in a building on the grounds of, or immediately adjacent to, a public institution;
- Any other setting that has the effect of isolating individuals receiving Medicaid home and community-based services from the broader community of individuals not receiving Medicaid home and community-based services.

Additionally, it is the state's responsibility to ensure that all settings demonstrate the characteristics of a home and community-based setting. If the state is operating with a presumption that an individual's private home or private family home is meeting this requirement, the state needs to confirm that none of these settings were purchased or established in a manner that isolates the individual from the community of individuals not receiving Medicaid funded home and community-based services, including recently piloted communities such as Sweetheart Spectrum and Golden Heart Ranch. Information available in the Toolkit on settings that isolate may be helpful in this regard.

Relocation of Beneficiaries:

The state does not include a plan for the relocation of beneficiaries in either the STP or the CBAS centers' transition plan. Please create a clear process with milestones and timelines to describe how the state will relocate beneficiaries if needed. This process should include: how reasonable notice and due process are provided to these individuals, a timeline for the relocation process, the number of beneficiaries impacted, and a description of the state's process that beneficiaries, through the person-centered planning process, are given the opportunity, the information, and the supports to make an informed choice of an alternate setting that aligns, or will align, with the regulation, with critical services/supports in place in advance of the transition.

Public Comment

- Please provide evidence of public notice for the public input periods to the STP. These were provided for the CBAS transition plan but were omitted in the STP.
- CMS notes that the state included an overview of public comments (Appendix A). In addition, please provide a summary of responses to themes identified in public comments received and clarify what changes were made to the STP based on public comment.

Other Concerns

- Currently the state includes some milestones in the CBAS transition plan. Additionally, some milestones have start dates but no identified completion date. Please add clearer milestones and timelines with reasonable timeframes.

- Previously, the state gave the assurance that it would not use settings with delayed egress and secured perimeters inside the waiver program. Please clarify how the state defines delayed egress, how the state defines secured perimeters, whether these settings are being used and if so, how the state is ensuring that they comport with the requirements of the regulation.
- Comments identified in the CBAS plan indicated that there may be characteristics of settings that are institutional in nature. For example, a comment that appears in the CBAS *HCB Settings Stakeholder Input Log* indicates that participants in certain settings have "name badges [to] identify their diet" and sit one-on-one with staff (p. 1 of comments, row 12). Practices that label the individual and publically identify what they can and cannot eat do not enforce rights to privacy and dignity. Please describe how the state is assessing those settings against the federal requirements to ensure compliance.

CMS would like to have a call with the state to go over these issues and to answer any questions the state may have. The state should resubmit its revised STP, in accordance with the questions and concerns above, within 75 days of the follow up phone call to this letter. A representative from CMS' contractor, NORC, will be in touch shortly to schedule the call. Please contact Amanda Hill in the CMS Central Office at 410-786-2457 or Amanda.hill@cms.hhs.gov with any questions related to this letter.

Sincerely,

Ralph F. Lollar, Director
Division of Long Term Services and Supports

cc: Henrietta Sam-Louie ARA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

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

Statewide Transition Plan Toolkit for Alignment with the Home and Community-Based Services (HCBS) Final Regulation's Setting Requirements

September 5, 2014

The following information is intended to suggest alternative approaches and considerations for states as they prepare and submit Statewide Transition Plans as required by the HCBS final regulation published January 16, 2014 (available at http://www.gpo.gov/fdsys/pkg/FR-2014-0116/pdf/2014-00487.pdf). This toolkit relates specifically to the Federal requirements for residential and non-residential home and community-based settings. These regulatory requirements can be found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2).

What is a Statewide Transition Plan?

The Statewide Transition Plan is the vehicle through which states determine their compliance with the regulation requirements for home and community-based settings at 42 CFR 441.301(c)(4)(5) and 441.710(a)(1)(2), and describe to CMS how they will comply with the new requirements. A Statewide Transition Plan includes the state's assessment of the extent to which its regulations, standards, policies, licensing requirements, and other provider requirements ensure settings that comport with the requirements outlined at 42 CFR 441.301(c)(4)(5) and 42 CFR 441.710(a)(1)(2). The Statewide Transition Plan also describes actions the state proposes to assure full and on-going compliance with the HCBS settings requirements, with specific timeframes for identified actions and deliverables.
The Statewide Transition Plan is subject to public input, as required at 42 CFR 441.301(6)(B)(iii) and 42 CFR 441.710(3)(iii).

Who Submits?

Each state operating a section 1915(c) waiver or a section 1915(i) state plan benefit that was in effect on or before March 17, 2014 is required to file a Statewide Transition Plan.

When to Submit?

The trigger for filing a Statewide Transition Plan is the state's first 1915(c) waiver or 1915(i) SPA renewed or amended between March 17, 2014 and March 16, 2015. A Statewide Transition Plan must be submitted within 120 days after the submission date of the first renewal or amendment. If a state does not submit an amendment or renewal between March 17, 2014 and March 16, 2015, the state must submit a Statewide Transition Plan no later than March 17, 2015. States must be in full compliance with the Federal requirements by the time frame approved in their Statewide Transition Plan, not to exceed March 17, 2019.

How can states determine alignment with the new Federal requirements on HCBS settings?

The purpose of the Statewide Transition Plan is to describe how the state will bring all preexisting 1915(c) and 1915(i) programs into compliance with the home and community-based settings requirements at 42 CFR 441.301(c)(4)(5) and Section 441.710(a)(1)(2). To determine whether state transition actions are needed for compliance, CMS expects that states must first determine their current level of compliance with the settings requirements and provide a written description to CMS. Included in the written description should be the state's assessment of the extent to which its standards, rules, regulations, or other requirements comply with the Federal HCBS settings requirements and the description of the state's oversight process to ensure continuous compliance. The state may also assess individual settings/types of settings to further document their compliance.

Possible scenarios might include:

1) Upon conducting its compliance assessment, a state may determine that existing state standards meet the Federal settings requirement, the state's oversight process is adequate to ensure compliance, and, therefore, any settings currently approved under the state's standards meet the Federal settings requirement. In this scenario, the state describes its process for conducting the compliance review and the outcomes of that review; or

2) The state conducts its compliance review and determines that its standards may not meet the Federal settings requirements. In this scenario, the state includes in the Statewide Transition Plan the specific actions to be taken to come into compliance. These actions might include proposing new state regulations or revising existing ones; revising provider requirements; and conducting statewide provider training on the new state standards. The Statewide Transition Plan should also include the time frames for completing these actions, an estimate of the number of settings that likely do not meet the Federal settings requirement and the time frame necessary to bring individual settings into compliance.

In situations where the state standards do not coincide with the Federal standards, it is possible that specific settings are still in compliance with the Federal requirements. In this case, a state may choose to assess individual sites to determine which are/are not in compliance with the Federal standard. Such an assessment may impact the time frames proposed to bring settings into compliance; if so, the Statewide Transition Plan should include these additional actions and timeframes.

States may conduct specific site evaluations through a variety of standard processes including, but not limited to licensing reviews, provider qualification reviews, and support coordination visit reports. States may also engage individuals receiving services as well as

representatives of consumer advocacy entities (such as long-term care ombudsman programs and protection and advocacy systems) in the assessment process.

States may conduct – or develop a tool for qualified entities to conduct – site specific evaluations of settings using the Federal requirements as a basis for the evaluation. Such evaluations may be conducted by entities including, but not limited to state personnel, case managers that are not associated with the agency operating the setting in which services are provided, licensing entities, Managed Care Organizations, individuals receiving home and community-based services, representatives of consumer advocacy entities such as longterm care ombudsman programs and/or protection and advocacy systems. States may also perform on-site assessments of a statistically significant sample of settings. When states do not have full knowledge of the settings in their system, CMS strongly encourages, at a minimum, a sampling approach to on-site reviews.

States may also administer surveys to providers to determine whether the settings in which those providers operate meet the home and community-based settings requirements. In this instance, providers could "self-assess" their compliance with the Federal requirements or provide information required by the state to make a determination of compliance. In either situation, states could perform assessments of individual settings to verify compliance. If providers indicate they do not meet the new requirements, states should include remediation strategies in the Statewide Transition Plan, including actions and associated time frames for bringing the programs/settings into compliance.

It should be noted that assessment of individual settings is not a substitute for ensuring that state standards, regulations, policies, and other requirements are consistent with Federal requirements and that the state has an oversight system in place to assure ongoing compliance with the requirements. In addition, where the state is submitting evidence that a setting presumed not to be home and community-based is in fact home and community-based and does not have the qualities of an institution, evidence of a site visit will facilitate the heightened scrutiny process.

The state's determination of compliance is the first step in Statewide Transition Plan development. The next step is developing and describing to CMS the state's actions to come into full compliance, including timelines and milestones.

What does CMS expect to see in a Statewide Transition Plan?

Presence of the following items will facilitate CMS review of the states' submitted plans:

- A detailed description of the state's assessment of compliance with the home and community-based settings requirements and a statement of the outcome of that assessment.
    - If the state determines on the basis of the review of current state regulations, standards, and policy that settings within the state are consistent

with Federal settings requirements, the state should describe the process of the compliance assessment, the basis for the conclusion and the oversight (monitoring) process that ensures this. If the process of assessment is not yet complete and has required, or will require, greater than six (6) months for review, the state must submit justification for the additional time frame.

- If the assessment is based on state standards, the state needs to provide their best estimate of the number of settings that: 1) fully align with the Federal requirements; 2) do not comply with the Federal requirements and will require modifications; 3) cannot meet the Federal requirements and require removal from the program and/or the relocation of individuals; 4) are presumptively non-home and community-based but for which the state will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings (to be evaluated by CMS through the heightened scrutiny process). In instances where a system review identifies settings which are presumed not to be home and community-based (home and community-based) and the state intends to submit evidence that the setting is home and community-based and does not have institutional characteristics, CMS would expect an onsite assessment that supports the state's assertion.

- If the state conducts site specific evaluations, the state needs to provide the best estimate of the number of settings that 1) fully comply with the Federal requirements; 2) do not meet the Federal requirements and will require modifications; 3) cannot meet the Federal requirements and require removal from the program and/or the relocation of individuals; 4) are presumptively non-home and community-based but for which the state will provide justification/evidence to show that those settings do not have the characteristics of an institution and do have the qualities of home and community-based settings (to be evaluated by CMS through the heightened scrutiny process).

- A detailed description of the remedial actions the state will use to assure full compliance with the home and community-based settings requirements, including timelines, milestones and monitoring process. Remedial actions might include:
  - At the state level, remedial actions might include, but are not limited to, new requirements promulgated in statute, licensing standards or provider qualifications, revised service definitions and standards, revised training requirements or programs, plans to relocate individuals to settings that are compliant with the regulations, and a description of the state's oversight and monitoring processes.

- At the provider level, remedial actions might include, but are not limited to, changes to the facility or program operation to assure that the Medicaid beneficiary has greater control over critical activities like access to meals, engagement with friends and family, choice of roommate, and access to activities of his/her choosing in the larger community, including the opportunity to seek and maintain competitive employment.

- If the state decides to submit evidence to CMS for the application of the heightened scrutiny process for settings that are presumed not to be home and communitybased, the Statewide Transition Plan should include evidence sufficient to demonstrate the setting does not have the characteristics of an institution and does meet the home and community-based setting requirements. Evidence of a site visit by the state, or an entity engaged by the state, will facilitate the heightened scrutiny process. CMS will consider input from the state, information collected during the public input process, and information provided by other stakeholders as part of the heightened scrutiny process. CMS may also conduct individual site visits as well.

- When relocation of beneficiaries is part of the state's remedial strategy, the Statewide Transition Plan should include: o An assurance that the state will provide reasonable notice to beneficiaries and due process to these individuals;
  - A description of the timeline for the relocation process;
  - The number of beneficiaries impacted; and
  - A description of the state's process to assure that beneficiaries, through the person-centered planning process, are given the opportunity, the information, and the supports to make an informed choice of an alternate setting that aligns, or will align, with the regulation, and that critical services/supports are in place in advance of the individual's transition.

- The time frame and milestones for state actions, including assessment and remedial actions. If state standards must be modified in order to effect changes in the state system, the state should propose a reasonable time frame for making the modifications. If the state intends to conduct an assessment after adopting new standards, the state should provide information on how, in the interim, the state will communicate the need for change, educate providers, inform individuals and families, and establish a time frame for the activities. The state must also include a complete timetable for coming into full compliance.

- A description of the public input process, with a summary of public comments, including the full array of comments whether in agreement or not with the state's determination of the system-wide compliance and/or compliance of specific settings/types of settings; a summary of modifications to the Statewide Transition

Plan made in response to public comment; and in cases where the state's determination differs from public comment, the additional evidence and rationale the state used to confirm the determination (e.g. site visits to specific settings).

- The URL where the Statewide Transition Plan is posted.

When is Public Input Required?

Prior to filing with CMS, a state must seek input from the public on the state's proposed Statewide Transition Plan, providing no less than a 30-day period for that input. CMS encourages states to seek input from a wide range of stakeholders representing consumers, providers, advocates, families, and other related stakeholders. The process for individuals to submit public comment should be convenient and accessible for all stakeholders, particularly individuals receiving services. CMS requires states to post the Statewide Transition Plans on their website in an easily accessible manner and include a website address for comments. At least one additional option for public input, such as public forums, is required.

The Statewide Transition Plan requirements set forth that states must provide evidence of two statements of public notice and requests for public input, the timeframe for public input (which verifies that a minimum of 30-days was afforded for public review and comment), and a description of the public input process. To accomplish this, the state could include in the Statewide Transition Plan the actual date of the public notice, the processes used for providing the public notice (e.g., publication in newspapers, announcement via websites) and how public input was received (e.g., testimony, web response).

When filing the Statewide Transition Plan with CMS, the state must provide a summary of public comments, including comments that agree/disagree with the state's determinations about whether types of settings meet the home and community-based settings requirements; a summary of modifications to the Transition Plan made in response to public comment; and in the case where the state's determination differs from public comment, the additional evidence and the rationale the state used to confirm the determination (e.g. site visits to specific settings). At the time the state files the Statewide Transition Plan with CMS, the state must simultaneously post the submitted plan on the state's website. The URL for that posting should be included in the Statewide Transition Plan submission to CMS.

The state must also provide an assurance that the Statewide Transition Plan, with any modifications made as a result of public input, is posted for public information no later than the date of submission to CMS, and that all public comments on the Statewide Transition Plan are retained and available for CMS review for the duration of the transition period or approved waiver, whichever is longer.[1]

[1] States filing waiver renewals or amendments to existing 1915(c) waivers require a public input process in addition to the public input process for the embedded waiver specific Transition Plan. A state could use one public input process to meet both requirements.

CMS wishes to ensure that states recognize the changes in the public notice and public input process required by this regulation. States must ensure the document is posted and, in the case of public forums, available or distributed for comment. States can use summary documents or offer explanations of contents of the Statewide Transition Plan, in addition to the document itself. However, the state must ensure the full Statewide Transition Plan is available to the public for comment, including individuals receiving services, individuals who could be served, and the full stakeholder community. While a state may find meetings held with selected representatives of types of stakeholder useful, such meetings will not be sufficient to demonstrate adequate notification or input.

Finally, consistent with the Toolkit document "STEPS TO COMPLIANCE FOR HCBS SETTINGS REQUIREMENTS IN A 1915(c) WAIVER and 1915(i) SPA" substantive changes in a Statewide Transition Plan will require public comment. For example, when a state submits an amendment or modification to a Statewide Transition Plan where additional assessment has resulted in a change in the findings or where the state adds more specific remedial action and milestones, the state must incorporate the public notice and input process into that submission. CMS believes it would be very helpful for the states to use public input in the assessment of the state's progress on the milestones approved in the Statewide Transition Plan. Therefore, states are strongly encouraged to describe their process for ensuring ongoing transparency and input from the stakeholders in the Plan.