TRI-COUNTIES REGIONAL CENTER
EXECUTIVE DIRECTOR REPORT
November 7, 2014

I. BUDGET UPDATE

- **Attachment #1: DDS/Lanterman Act Letter to Governor Brown from Senators and Assembly Members Urging the Governor to Take Action on Regional Center Budget for FY 2015-2016**

- **Attachment #2: The Annual Budget Process**

The California Senate Human Services Committee, chaired by Senator Jim Beall (D), held a hearing on the Developmental Services System on October 9, 2014 in Los Angeles. The hearing took place from 1:30-3:30 pm in Session Room 350 at the L.A. City Hall (Board of Public Works) located at 200 North Spring Street, Los Angeles. The hearing focused on the impact of the budget reductions on regional center Purchase of Services (POS) and Operations (OPS) budgets. Three panels addressed the challenges of the budget reductions and their impact on the Developmental Services system. Association of Regional Center Agencies (ARCA) testified at the hearing addressing the impact of the budget reductions on families and persons served, service providers , regional center operations, and federal funding. The hearing was well attended by several hundred participants many of whom provided public testimony. In part, as a result of the hearing, eight Senators and Assembly Members sent a letter to the Governor requesting the Governor to (1) Apply fair budget policies that treat the regional centers and service providers equal to other state agencies that build regular Cost of Living Adjustments (COLA) (2) End the shifting of the state's financial responsibility for federal and state mandates onto an already fragile regional center employees and service providers (3) Include these costs as well as a COLA for regional center employees and service providers in the upcoming Governor's Budget Proposal for FY 2015-2016 **(Attachment #1)**. The Governor's release of his budget proposal for FY 2015-2016 due out in the first half of January, 2015 will officially start the budget process for the new FY 2015-2016 that begins July 1, 2015**(Attachment #2)**.

II. NEW CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) RULES FOR HOME AND COMMUNITY BASED SERVICES (HCBS) Waiver

- **Attachment #3: Autistic Self Advocacy Network (ASAN): A Guide for Advocates and Families on the New Rules for Home and Community-Based Settings and the Person-Centered Planning Process**

- **Attachment #4: CMS Informational Bulletin**
- **Attachment #5: CMS Fact Sheet: Home and Community Based Services**
- **Attachment #6: CMS Fact Sheet: Summary of Key Provisions of the Home and Community Based Services (HCBS) Settings Final Rule**
- **Attachment #7: Summary of Key Provisions of the 1915(c) Home and Community Based Services (HCBS) Waiver Final Rule**
- **Attachment #8: Summary of Key Provisions of the 1915(i) Home and Community Based Services (HCBS) State Plan Option**
- **Attachment #9: Draft HCBS Statewide Transition Plan**
- **Attachment #10: CMS Statewide Transition Plan Tool Kit for Alignment With the HCBS Final Regulation's Setting Requirements**
- **Attachment #11: CDCAN Report: Stakeholder Call October 21 10-12 Noon on Initial Draft Statewide Transition Plan by Department of Health Care Services to Implement Major New Federal MediCaid HCBS Regulations**
- **Attachment #12: ARCA Response to Draft Statewide Transition Plan for Home and Community Based Services Waiver (HCBS)**
- **Attachment #13: Joint Response to Draft Statewide Transition Plan for HCBS Waiver From ARC, CFILC, DRC, DREDF, NHLP, NSCLC**
- **Attachment #14: TCRC Task Force on CMS Final Rule for HCBS Waiver**

On March 17, 2014 the Centers for Medicaid and Medicare Services (CMS) final rule pertaining to Home and Community Based Services that applies to 1915(c) Waiver services as well as 1915(i) SPA services went into effect. These changes could have significant impact on the future of the Developmental Services landscape. While states have some time to

modify their services depending on when their next Waiver or SPA applications are due, the final rule clarifies:

- Home and community-based settings requirements to apply to all services delivery, not just to residential settings. This includes day and work settings.
- Participants in HCBS services should be integrated into the community to the same degree that non-participants in HCBS services are. More guidance on isolating settings can be found here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Settings-that-isolate.pdf
- New standards for home and community-based settings defined "by the nature and quality of individuals' experience" rather than by "what they are not"
- The requirement for choice of provider in provider owned or controlled settings
- The responsibility of the state rather than the provider for ensuring private room and roommate choice
- Service planning must be done through a person-centered planning process (additional CMS guidance on this will follow)

Full text of the rule is available for download here: https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider.

Autistic Self Advocacy Network (ASAN) has developed an informational guide on the new CMS Rules for families and advocates that provides a good overview of the changes and their potential impact **(Attachment #3)**. Informational Bulletin **(Attachment #4)** and several fact sheets addressing Overview of Regulation **(Attachment #5),** 1915(c): Changes to HCBS Waiver Program **(Attachment #6),** 1915 (i): Key Provisions for HCBS State Plan Option **(Attachment #7)** and Summary of Key Provisions of the HCBS Settings Final Rule **(Attachment #8)** provide additional detailed information regarding the changes.

CMS offered a webinar on this information. The PowerPoint presentation from that training can be downloaded here: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Final-Rule-Slides-01292014.pdf

Additionally, the US Department of Labor in conjunction with CMS conducted a webinar regarding the implications of the new rule on day and employment services. Slides from that webinar as well as a video archive can be accessed here: http://www.leadcenter.org/webinars/implications-hcbs-final-rule-non-residential-settings-impact-new-hcbs-guidance-employment-day-services

The California Department of Health Care Services (DHCS), the agency that oversees the State's MediCaid Program called "Medi-Cal" took an official step toward implementation of the new CMS rules by releasing for public comment a draft Statewide Transition Plan (STP) that includes outlining the overall statewide process, what state departments are involved

and what specific waivers and services are impacted. The DHCS has been collaborating with partner departments including the Department of Developmental Services (DDS), the California Department of Aging (CDA), the California Department of Health (CDH) and others to draft the initial draft STP for public stakeholder input **(Attachments #9-#11)**. In addition to the specific stakeholder process for the statewide draft STP, individual state departments including DDS will also release in the near future individual HCBS waiver STPs for public stakeholder input. ARCA and several other statewide service provider and advocacy organizations have submitted their written comments to DHCS for consideration **(Attachments #12-#13)**. DHCS plans on releasing a second revised draft STP that will reflect changes and revisions including those from public comments received. There will be a public stakeholder conference call tentatively scheduled on December 2, 2014 from 10:00 AM – 12:00 noon for DCHS to provide an update on the STP, answer questions and receive additional comments.

Tri-Counties Regional Center (TCRC) has formed a joint CMS Final Rule Task Force with TCRC service providers to attempt to stay abreast of all the changes taking place in this area and to work together with the TCRC service providers to prepare for the eventual implementation of the myriad new changes required by CMS. The second meeting of the newly formed task force is scheduled to take place on November 6, 2014 from 9-10 am in Santa Barbara. All TCRC service providers are welcome to participate **(Attachment #14)**.

Tri-Counties Regional Center and Association of Regional Center Agencies (ARCA) will continue to monitor these changes as they unfold, particularly as CMS releases additional guidance on service planning, as well as specific details regarding what this rule means for non-residential settings.

III. MEDI-CAL SERVICES FOR CHILDREN WITH AUTISM SPECTRUM DISORDER

- **Attachment #15: CMS Informational Bulletin on Medicaid Coverage of Services to Children with Autism Spectrum Disorder**
- **Attachment #16: State Plan Amendment to CMS to Add ABA as a Medi-Cal Benefit**
- **Attachment #17: DCHS Letter to Medi-Cal Managed Care Plans on Implementation of ABA as a Medi-Cal Benefit**
- **Attachment #18: ARCA Comments on the Draft State Plan Amendment for Medi-Cal Behavioral Health Treatment**

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) issued guidance that requires states to cover Behavioral Health Services (BHS) including Applied Behavioral Analysis (ABA) for individuals under age 21 with Autism Spectrum Disorder (ASD) through their Medicaid plans **(Attachment #15)**. The California Department of Health Care Services (DHCS) will be holding a series of stakeholder meetings to discuss the implementation of new Medi-Cal benefits for individuals under age 21 with ASD on 9/4/14, 10/21/14, 11/18/14, 12/19/14, and 1/13/15. For more information about these meetings go to: http://www.dhcs.ca.gov .

DHCS has issued two draft documents that they are seeking comment on from stakeholders. The first is the State Plan Amendment (SPA), which when finalized will be submitted to CMS to add ABA as a Medi-Cal benefit **(Attachment #16)**. The second is a draft letter to managed care Medi-Cal plans that outlines how they should implement new services for individuals with ASD **(Attachment #17)**. Included in this document is a provision that allows individuals already receiving services through regional centers to continue receiving those services until there is a transition plan developed by DHCS and Department of Developmental Services (DDS). ARCA has submitted written comments to DHCS on the draft SPA **(Attachment #18)**.

While Medi-Cal funded BHT is a positive development, many questions and concerns remain about how this new benefit will affect children who are part of California's Regional Center System. Issues related to transition from Regional Center funded services to Medi-Cal funded services, choice of service providers through Medi-Cal, adequate Medi-Cal rates for service providers, and timeliness of services are some of the issues that need further clarification. In the interim, TCRC has begun to confer with the local Medi-Cal health plans in the Tri-Counties area that consist of CenCal Health in Santa Barbara and San Luis Obispo Counties and Gold Coast Health that serves Ventura County. TCRC will continue to confer with and provide guidance to TCRC ABA providers on the transition plan as new information becomes available. TCRC will continue to serve individuals eligible for regional center services and needing BHT services until the local health plans are adequately ready and able to assume responsibility for providing BHT services.

IV. QUESTIONS & ANSWERS

Attachment #1

CALIFORNIA LEGISLATURE

STATE CAPITOL
SACRAMENTO, CALIFORNIA
95814

October 27, 2014

Governor Jerry Brown
Office of the Governor
State Capitol, Suite 1173
Sacramento, CA 95814

Dear Governor Brown:

Since the ratification of the Lanterman Act in 1977, California has recognized the right of people with developmental disabilities to live an independent and normal life. To facilitate the promise of the Lanterman Act, California created 21 regional centers to triage and direct more than 260,000 people with developmental disabilities to some 65,000 providers who furnish the appropriate support and services they need.

But the state's ability to meet our basic obligations to Californians with developmental disabilities is being severely hindered by a lack of employee cost of living increases for regional center employees and inadequate service provider rates.

Cost of living increases for employees and providers lag far behind inflation. The result has not only imperiled service providers who are struggling to remain open but has seriously undermined the ability of our regional centers to recruit and retain a qualified staff.

While state agencies generally build in cost increases such as health benefits, transportation cost increases and negotiated salary COLAs, regional centers and vendors within the California Department of Developmental Services (DDS) system do not have these accepted adjustments.

The California Department of Developmental Services (DDS) has seen some adjustments to their budget for policies such as federally mandated overtime changes and the state minimum wage adjustment. However, these increases went through an arduous legislative budget process instead of being built into the January base budget. Moreover, many other new federal and state mandates have not been included and these costs are absorbed by regional centers and providers. These include adjustments for transportation increases, health benefits, minimum wage mandates by local municipalities and other costs.

In the current budget year, funding for DDS is $5.2 billion. Since 2009, the state has reduced costs to developmental services programs by more than $1 billion (GF) instituting restrictions on payments for specific services, across-the-board reductions, mandated furlough days, suspension of services and other cuts. Prior to that, the state had frozen rates to providers in order to contain costs. These freezes and caps have fractured the infrastructure of the community services and support systems. Without building in adjustments for cost of living increases, it will not be sustainable. In 1999, even before the substantial reductions and freezes prompted by the Great Recession, the Bureau of State Audits released a report concluding that community services were "undermined by insufficient state funding and budget cuts."

Meanwhile, pending mandates from the Federal government will require California to restructure day programs, work programs and residential settings to reduce the number of consumers and require more community inclusion. State mandates that will be implemented include the Employment First model, self-determination pilot program, and others that require more intensive case management and development of new programs.

At a Senate Human Services hearing this month, many providers testified that they are unable to sustain innovative and inclusive programs, much less expand them or create new ones because of historic freezes and caps. I realize that the cost of total restoration is outside our reach today. However, we must take steps to address the gap -- 260,000 Californians who rely on the Lanterman Act need our help.

We urge you to apply fair budget policies that treat the regional centers and providers equal to other state agencies that build COLAs and fund new federal and state mandates in their base budget.

And, we respectfully request an end to the shifting of our financial responsibility for federal and state mandates onto our already fragile regional centers and providers. We strongly urge these costs -- as well as a COLA for regional center employees and providers -- be included in the January budget.

Thank you in advance for your consideration.

Sincerely,

Jim Beall
State Senate, District 15

Carol Liu
State Senate, District 25

Marty Block
State Senate, District 39

Fran Pavley
State Senate, District 27

Joan Buchanan
State Assembly, District 16

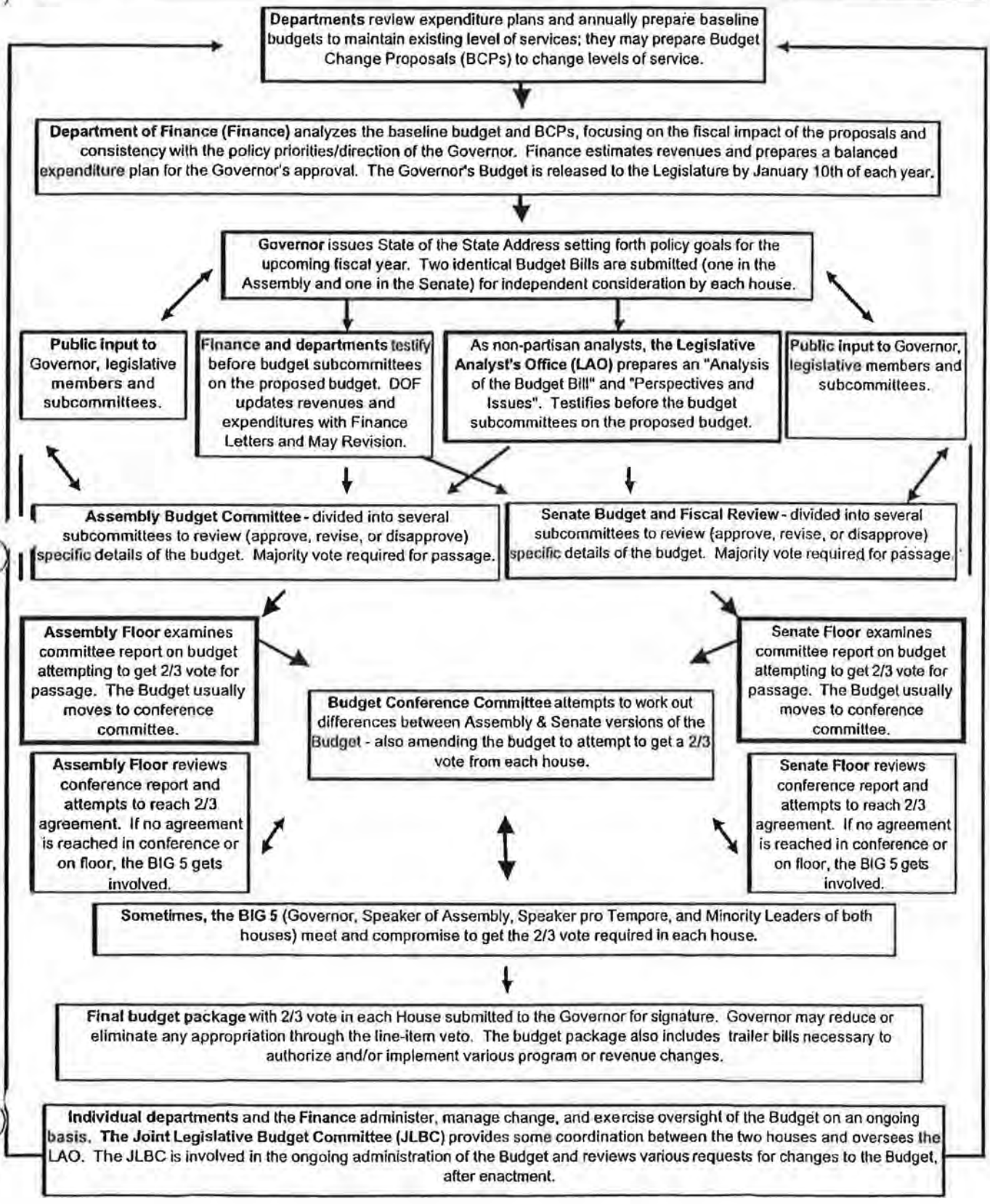
Rich Gordon
State Assembly, District 24

Brian Jones
State Assembly, District 71

Mariko Yamada
State Assembly, District 4

Cc: Diana S. Dooley, Secretary, California Health and Human Services Agency
Santi Rogers, Director, Department of Developmental Services
California Senate Budget Committee Members
California Assembly Budget Committee Members

THE ANNUAL BUDGET PROCESS



Attachment #3

New Rules for Home and Community-Based Settings and the Person-Centered Planning Process A Guide For Advocates and Families

Introduction

In January 2014, the federal government announced a new rule explaining which kinds of services can be covered through Medicaid-funded home and community-based services (HCBS) programs.[1] The new rule will help make sure that people who use HCBS are truly integrated into their communities. States will not be allowed to use federal Medicaid dollars to pay for HCBS in settings that isolate people from the community or that do not show respect for people's right to privacy, dignity, and self-determination.

Because states may need some time to make sure that the services that they are providing are actually integrated, the government has told the states to create five-year transition plans explaining how they will follow the new rule. The states must give people with disabilities, their friends and families, and other advocates the opportunity to comment on the transition plans.

This guide is here to help you understand what the new rule means and what they can do to help keep their states on track. States need to hear from you in order to know which kinds of services and supports help people make the most of life in the community.

What is HCBS?

Home and community-based services, or HCBS, are a type of service covered by Medicaid. Many people with disabilities rely on HCBS in order to help them live in their own homes. These services, which are available to many people with disabilities who are covered by Medicaid, can include services like:

- Personal care attendants to help with activities like bathing, dressing, eating, and moving around in the community;
- Help with home-based health care like ventilators, feeding tubes, and diabetes care;
- Help with housekeeping and cooking;
- Help with case management and coordinating of services;
- Transportation services around the community;
- Habilitation, including day habilitation;
- Respite care;
- Supported employment services to help people find an keep a job; and
- "Pre-employment" services to help people develop the skills they need to get a job.

Not everyone on Medicaid gets home and community-based services. They are only available to people with disabilities who need help in order to live safe and healthy lives in the community. In some states, only people with certain kinds of disabilities can get HCBS, and there are often long waiting lists. Home and Community-Based Services programs may

1 The official citation for the new rule is 79 Fed. Reg. 2947 (Jan. 16, 2014). You can read it online at https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider. You can also read important parts of the new rule at page of this Guide.

be limited to only certain areas or may have limits on the number of people who receive services.

Every state's HCBS program is different. In some states, HCBS is provided through what's called a "waiver." Waivers allow states to give services that aren't usually covered for most people who are on Medicaid to people in certain groups (like people with disabilities). There may be different waivers for different groups – for example, one for people with intellectual and developmental disabilities and one for people who have physical disabilities. Other states may provide HCBS through what's called a "Money Follows the Person demonstration," "state plan option," or "community first choice state plan option." The new rule applies to all of these programs.

What Does the New Rule Say?

The purpose of the new rule was to make sure that states didn't use HCBS funding for programs that are not really integrated into the community, such as group living settings that isolate people from the community. It makes it clear that, in order for a service to be HCBS, it needs to be in a setting that gives people real opportunities to work, live, and socialize in the community.

In General

The new rule includes five standards that all home and community-based services need to meet.

1. Integration into the Community

> "Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:
>
> (i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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 HCBS."
>
> —42 C.F.R. § 441.301(c)(4), (c)(4)(i) (about HCBS waivers); § 441.530(a)(1), (a)(1)(i) (about Community First Choice programs); § 441.710(a)(1), (a)(1)(i) (about State Plan programs).

The rule requires that home and community-based services be provided in a setting that offers full opportunities for integration into the community. This includes making sure that people receiving HCBS are able to:

- Work alongside people without disabilities, and be paid the same amount as people without disabilities;[2]
- "Engage in community life," which can include going to church, volunteering, and/or making and keeping friends outside the service setting;
- Control their own money, possessions, and other resources; and
- Receive services "in the community" and not in isolated settings.

All people who use HCBS need to have these opportunities – not just people who are labeled as "high-functioning" or have fewer support needs. Service providers can't simply assume that a person is too disabled to work or control their own money. Instead, they need to make sure that everyone has the support they need to do these things.

For example, some people may need a lot of help, such as transportation and accompaniment by a support person, to travel around in the community. Without that support, the person won't have full access to the community even if the service provider says that they're "free to go into the community" whenever they want to. People may also need a financial coach or job coach in order to have real access to employment and real opportunities to control their own money.

2 This does not mean that people who receive HCBS have to get a job, it does mean that they have to have the opportunity and support they need to do so. See Eric Carlson, National Senior Citizens Law Center, Just Like Home: An Advocate's Guide for State Transitions under the New Medicaid HCBS Rules page, 15 (2014). You can find this guide online at http://www.nsclc.org/wp-content/uploads/2014/06/Just-Like-Home_-An-Advocates-Guide-for-State-Transitions-Under-the-New-Medicaid-HCBS-Rules.pdf.

The rule requires that people receiving HCBS have access to the greater community "to the same degree" as other people. This means that, for example, an HCBS service provider cannot be "community-based" if it only lets people go on occasional or scheduled trips into the community. Like people without disabilities, people receiving HCBS should be able to choose where they go and when. At the same time, services can still be community-based if they're located in a rural area, as long as people receiving HCBS can travel around and participate in community life in the same way that other people living in that area can.

2. Individual Choice

> "The setting 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. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board."
>
> —42 C.F.R. § 441.301(c)(4)(ii) (about HCBS waivers); § 441.530(a)(1)(ii) (about Community First Choice programs); § 441.710(a)(1)(ii) (about State Plan programs).

The new rule also requires that people receiving HCBS have choices about where they get services. They must have the option to get services in places that aren't "disability-specific" – for example, they must have the option of getting in-home services while living in their own apartment instead of having to live in a group home just for people with disabilities. People receiving HCBS also must have the option of choosing a private room instead of having to live with a roommate. The choices have to be based on the person's own needs, preferences, and situation – for example, it is not enough to offer someone a chance to live in their own apartment if the apartment isn't accessible or affordable.

Even if a person has a choice of settings, the setting they do choose needs to meet all the other requirements of the new rule. A setting that is isolated or that does not offer full access to the community cannot be considered "home and community-based" simply because the individual had the option of living in a non-disability specific setting.

3. Individual Rights

> "Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint."
>
> —42 C.F.R. § 441.301(c)(4)(iii) (about HCBS waivers); § 441.530(a)(1)(iii) (about Community First Choice programs); § 441.710(a)(1)(iii) (about State Plan programs).

People who receive HCBS must have a right to "privacy, dignity and respect, and freedom from coercion and restraint."[3] This can include the right to lock one's own bedroom or bathroom door and the right to choose a private room or choose a roommate.[4] It can also include the right to talk privately with friends and family, whether over the phone or the internet. Many self-advocates have said that privacy and dignity are a big part of the difference between an institution and a community-based setting.[5]

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3 42 C.F.R. §§ 441.301(c)(4)(iii), 441.530(a)(1)(iii), 441.710(a)(1)(iii).

4 Id.; 42 C.F.R. §§ 441.301(c)(4)(ii), 441.530(a)(1)(ii), 441.710(a)(1)(ii). See also 42 C.F.R. §§ 441.301(c)(4)(vi), 441.530(a)(1)(vi), 441.710(a)(1)(vi) (referring to provider-owned or controlled residential settings).

5 See Autistic Self Advocacy Network, Keeping the Promise: Self Advocates Defining the Meaning of Community Living pp. 6-7 (2012). You can find this report available at http://autisticadvocacy.org/wp-content/uploads/2012/02/KeepingthePromise-SelfAdvocatesDefiningtheMeaningof-Community.pdf.

4. Autonomy

"Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact."

—42 C.F.R. § 441.301(c)(4)(iv) (about HCBS waivers); § 441.530(a)(1)(iv) (about Community First Choice programs); § 441.710(a)(1)(iv) (about State Plan programs).

People who receive HCBS must be able to make day-to-day choices for themselves, including choices about what they do every day, who they talk to, what kinds of relationships to be part of, and where they spend their time. The HCBS provider can't "regiment" these choices, such as by offering only a few options or by requiring people to keep to a rigid schedule.

People need the same kinds of choices and freedoms that non-disabled people usually have. This doesn't necessarily mean that people who receive HCBS should never have to do certain things at certain times: for example, a person receiving HCBS who works at a restaurant will still have to show up at the restaurant at their scheduled times, just as anyone else who works at that restaurant. But people who get HCBS should have the ability and the support they need to make last-minute plans or decisions about how to spend their free time, just like everyone else.

This same idea applies to the rules that people receiving HCBS have to follow. For example, if a person receives in-home HCBS while living in an apartment, they may have to follow normal rules of apartment living like paying rent on time and avoiding loud activities late at night. But they should not have to follow rules that other people living in apartments don't have to follow, like a night-time curfew or rules against having guests, choosing furniture or putting pictures on walls.

Sometimes people might need support to make these choices. For example, they might need help remembering appointments, choosing meals, and deciding what to do during the day. People might need communication technology or other forms of support in order to communicate and have relationships with other people. Someone's need for support cannot be used as a reason to take away options, or to only provide supports when the person makes the choices that the provider wants them to make.

5. Choice Regarding Services and Providers

"Facilitates individual choice regarding services and supports, and who provides them."

—42 C.F.R. § 441.301(c)(4)(v) (about HCBS waivers); § 441.530(a)(1)(v) (about Community First Choice programs); § 441.710(a)(1)(v) (about State Plan programs).

People need to have the ability to choose what services they get and who provides those services. Whenever possible, people should be encouraged to "self-direct" their own services by choosing their own support workers and deciding which days and times of day they need their support workers. Nobody should have to accept services that they don't want. People also need a meaningful choice of services and providers. If a person is offered a choice of many providers, and only one of them actually offers the services that the person needs or is actually available, that would not be considered a meaningful choice.

The new rule requires that services be chosen through a "person-centered service planning process." This process, which has to happen at least once a year, is supposed to help make sure that people are getting the services that they want from the providers they want. People need to be given meaningful choices during this process, including the ability to get services in non-disability-specific settings. There must be safeguards in place to make sure that the process isn't driven by the same service providers who are going to be providing HCBS to the person, unless there is nobody else who can help with the process. This helps prevent service providers from letting their own interests influence the planning process.

The plan must "be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter."

—42 C.F.R. § 441.301(c)(2)(vii) (about HCBS waivers); § 441.725(b)(7) (about State Plan programs).

How Can I Make Sure States Follow the New Rule?

The new rule includes lots of opportunities for self-advocates, their friends, and families to help make sure states follow the new rule. The new rule requires states to create a *transition plan* describing the changes they will make to their programs in order to follow the new rule. People with disabilities and their families have to have the chance to read the transition plan and comment on it.

By sending in your comments on your state's transition plan, you can tell states which types of services are really integrated into the community and which aren't. You can also tell them what kinds of policies they need to put in place in order to make sure that service providers follow the rule.

Find Out What Is Going on in Your State

The first step is to find out when your state needs to send in a transition plan, what it says in its transition plan, and what advocacy groups in your state are saying.

You can find this information by going to HCBSAdvocacy.org. This is a web site created by a group of advocacy organizations: the Association of University Centers on Disabilities (AUCD), National Association of Councils on Developmental Disabilities (NACDD), and the National Disability Rights Network (NDRN).

Once you go to HCBSAdvocacy.org, you can find the page for your state either by clicking on the map in the middle of the screen, or by scrolling down and finding the name of your state on the list:

Clicking on your state will bring you to a page that contains the following information:

- "Dates and Deadlines." These are the deadlines by which the state must submit a transition plan.
- "State Documents." These are announcements and transition plans that the state has already published. If your state has not yet created a transition plan, this section might be blank.
- "Resources." These include letters or other things that advocates have written about the state's need to follow the new rule on home and community-based services.
- "News." These include any other bits of news about the state's compliance with the new rule.
- "State Partners." These include any organizations that may help make sure the state is following the new rule.

Dates and Deadlines

When you look at your state's page on HCBSAdvocacy.org, the first thing you should do is look at the "Dates and Deadlines" section. This gives you information on when your state is going to publish its transition plan.

States have to publish a transition plan either (1) whenever it has to ask the government to renew or change one of its HCBS programs, or (2) by March 17, 2015, *whichever is earlier*. HCBSAdvocacy.org will tell you whether the state has to ask the government to renew or change one of its HCBS programs before March 17, 2015. For example, if you look at the Virginia page, you will see this:

> 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.
>
> Virginia has one waiver expiring before March 17, 2015. The Intellectual Disability 1915(c) waiver provides personal assistance, prevocational services, residential support, respite, supported employment, and other services for individuals with intellectual disabilities of any age. It expires June 30, 2014.
>
> For more information visit Medicaid.gov.

This means that Virginia had to submit a transition plan by June 30, 2014.

If your state has already submitted a transition plan, go to the "State Documents" section on the same page, and check out what your state has already said in its transition plan. Check to see if there is a deadline for comments on the plan. If the deadline has already passed, don't worry! Most transition plans will have to be updated before they are accepted, so there may be another opportunity for comments later.[11] You can also send in comments at any time, or send comments to your "state partners." This guide will talk about this in more detail later.

If your state has not yet submitted a transition plan, you can still write to your state Medicaid agency or to your state partners to tell them what you think. Or you can make a note of the deadline for the transition plan, and check HCBSAdvocacy.org again on that date. If the transition plan isn't yet published, you might need to wait a few days and check again.

State Documents

If your state has already posted a transition plan, it should show up under "State Documents." For example, if you go to Virginia's page on HCBSAdvocacy.org, you will see this:

> Draft Transition Plan for ID Waiver open for public comment until September 5, 2014.
>
> Integrated Day Activity Plan open for public comment until August 21, 2014.
>
> - Accompanying Service Definition
> - Responses
>
> For more information visit Medicaid.gov.

Here you can see that there are deadlines for public comments: September 5, 2014, for the ID Waiver transition plan and August 21, 2014, for the Integrated Day Activity Plan.

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11 See National Senior Citizens Law Center, State Transition Plans for New Medicaid HCBS Regulations: Four Tips for Consumer Advocates (2014), available at http://www.nsclc.org/wp-content/uploads/2014/07/State-Transition-Plans-for-New-Medicaid-HCBS-Regulations_Four-Tips-for-Consumer-Advocates.pdf.

Many "transition plans" that have already been published will have to be updated later. This means that if the public comment period for your state has already passed, you will still have a chance to comment when the transition plan is updated. Sometimes, if you read the transition plan carefully, you will also see that there are other periods for public comment built into the transition plan. And even outside of special "public comment" periods, you can still send in your comments to the state or to your State Partners.

Resources and News

Sometimes, but not always, a state page on HCBSAdvocacy.org will have other resources for advocates, and news articles. Reading these resources on HCBSAdvocacy.org might help give you some more information about what other advocacy groups think. For example, on Wisconsin's page under "Resources," you will find a link to a letter from disability organizations explaining how Wisconsin should follow the new rule, and another link to a web site for advocates. And on Wisconsin's page under "News," you will see many news articles on how advocates in Wisconsin are responding to Wisconsin's transition plan.

State Partners

The "State Partners" section includes a list of groups in your state that are helping advocate for people with disabilities who use HCBS. These may include your state's Protection and Advocacy (P&A) organization, its council on developmental disabilities, and any other disability-related advocacy organizations. You may want to send comments to these organizations explaining your thoughts and asking if they know of any other opportunities for advocacy.

Think About What You Need to Say.

Once you've seen your state's transition plan, it is time to decide what you want to say in your comments. Your comments don't just have to be about what's *in* the transition plan. They can also be about your own experiences with HCBS so far, or about things that aren't in the transition plan or aren't clearly explained. It is okay if you don't feel that you understand everything about the transition plan before writing your comments.

If you already use HCBS, you should say so in your comments. Explain, in one or two sentences, what kinds of home and community-based services you use, who provides them, and where you receive them. Then, talk for one or two paragraphs about whether you think these services are meeting the standards of the new rule: do you have the chance to find a job in the community, talk with friends, and set your own schedule? Do you feel included in your community? What would you like to see changed?

Whether or not you use HCBS, you can also talk about the transition plan. Here are some questions to think about:

- Is it understandable or is it confusing?
- Do you think it will actually help people get services in the community, or will it still allow some providers to segregate or isolate people?
- Does it have enough detail already, or does it say that it will come up with a more detailed plan later? What details do you think it needs to include?
- Does it include a plan to make sure that people have real, meaningful access to services in non-disability-specific settings like their own apartment, or does it continue to assume that most people will be in group homes and center-based day programs?
- Does it include a plan to make sure that people get day services in integrated settings, or does it only talk about residential services? Does it assume that day services are "integrated" simply because people can take part in organized community activities, like group trips to the movies?
- Many transition plans say that they will follow a process to decide which providers already follow the rule. Does the process include asking people who use the provider about their experiences, or will it take the provider's word on whether it follows the rule?
- Does the plan talk about how it will make sure providers continue to follow the rule even after they've been approved? Does it explain what people can do if they have a complaint?
- Does it acknowledge that people have the right to the supports they need in order to participate in the community, like transportation, supported employment, and personal assistants?
- Does it explain how it will manage "conflicts of interest" when the same service provider plays a part in someone's person-centered planning process and provides services to the person?
- Does it make lots of "exceptions" to the rule that it shouldn't be making, like allowing people to live in gated communities or allowing group homes to limit people's activities and privacy?

It can help to take a few notes about what you want to say, or to talk through the comments you want to send with someone you trust.

Find Out Where to Send Comments.

State Agencies

Check your state's transition plan on HCBSAdvocacy.org to see where to send your comments. This information will usually be on the first or last page of the transition plan. In some states this information is in one of the other documents under "State Resources" on HCBSAdvocacy.org, often named something like "Public Notice Regarding Transition Plan," or "Fact Sheet for Transition Plan."

If you still can't figure out where to send your comments, check out the contact information for your state Medicaid director at http://medicaiddirectors.org/about/state-directors, and your state ID/DD Services director at http://www.nasddds.org/state-agencies/. Some states want commenters to send their comments to the Medicaid director, and others want commenters to send comments to the ID/DD Services director. This means that, if you can't tell where to send in your comments, it's a good idea to send them to both.

Local Partners

You may also want to send comments to one of the "local partner" organizations listed on HCBSAdvocacy.org. These organizations will probably be sending in comments to the state agencies, and it can help to let them know what people with disabilities in your state are experiencing and how they feel about the HCBS they are receiving. You can also ask them if they know of other opportunities to get involved.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is the part of the United States government that sets rules for states on how to run their Medicaid programs. It's CMS that wrote the new rules for home and community-based services. If you write comments to your state Medicaid director, you can also send those comments to CMS by emailing them to Hcbs@cms.hhs.gov. That way they will know what people in your state think about your state's transition plan. If you have things you want to say about the rule in general, you can e-mail your thoughts to Hcbs@cms.hhs.gov too.

Write Your Comments.

Once you've decided where to send your comments, it's time to write them down!

There's no single format that you need to follow when writing down your comments. That said, it is usually a good idea to type them up in the form of a letter. The letter should probably be 2-3 pages, and no more than five. If your letter is much longer than that, pick the parts that are *most* important to you, and cut out less important parts. Keep the focus on specific things that you'd like to change – you don't need to spend a lot of space explaining the purpose of the rule or what it says, or explaining why it's important that people live in the community. That's something you can assume the person reading the comments already knows.

On the next page is an example of a letter that you could send. Most likely, you will want to change some details and add other details so that it matches your experiences and describes the actual transition plan for your state. This guide will also include a fill-in-the-blank document that you can type into in order to write your own letter.

Most state transition plans are not very detailed right now. If that is the case for your state, include a paragraph like this first.

The new regulations require that states let people who use HCBS comment on the transition plans. I have read the transition plan, but it is not detailed enough for me to tell which kinds of services people will be getting. It only says that you will be forming a detailed plan based on our comments and then you will submit the plan to CMS for approval. It is important that you also let us comment on the full plan before you send it to CMS. In the meantime, here are some thoughts on what needs to be in the full plan.

Using headings can help you organize your letter.

Enforcement

This is just an example of one of the issues you might want to comment on.

The full plan needs to explain how you will make sure that providers are really following the rule. It is not enough to simply make sure that providers have written policies saying that they will do things like respecting people's privacy, helping people find competitive employment, and so on. People I know who live in group homes especially have told me that what is in the written policy is very often very different from how staff actually act. For example, some group homes will say that residents can leave at any time, but they won't have enough staff to accompany people when they want to leave. This means that people often have to wait a long time until someone can help them go somewhere, or are even forced to just stay at home instead.

There needs to be a way for HCBS users and their advocates to complain about providers that aren't actually following the rules. Because some people might not know how to send in a complaint, the state should also interview service users on a regular basis to make sure that providers are following the rule.

Here is another example. It may help to include specific information about what day services in your state are like right now, if you know.

Day Services

The plan needs to make sure that people are included in the community not just in terms of where they live, but also how they spend their day. Right now many people are getting group-based day services that are not really integrated. People will spend most of the day at a center that only serves people with disabilities. When they go out on trips "into the community," they are in big groups and don't get to interact with people outside of the group.

Instead of funding center-based day services, we should be giving people individual day services that let them participate in the community on their own terms. For example, a person might need transportation support and a personal attendant to help them find their way around the community. People should be able to choose activities that they want to do, not just options on a list. We should have the support that we need to visit our friends and relatives, join clubs, volunteer, or find a job.

Sheltered workshops and "work crews" are also an example of day services that aren't integrated. In sheltered workshops, people with disabilities all work together – the only people without disabilities are supervisors and service workers. In work crew arrangements, people might be working in the same building as nondisabled people but they are still isolated because everyone on the work crew has a disability. Sheltered workshops and work crews also usually pay less than the minimum wage. Instead of funding these kinds of job placements, we should be funding supported employment services that help people find and keep real jobs that pay real wages. People should be working either independently or alongside coworkers who don't have disabilities. Many states, like Rhode Island, are already moving people out of sheltered workshops and into integrated employment.

Here's another topic that you might want to raise. Again, if you've gotten HCBS services before – either in a group home or while living in your own home, or both at different times – it can help to add that in.	***Supported Housing*** The plan should make sure that everyone, even people who need a lot of support, has the chance to live in their own home instead of a group home. Even if a group home has policies saying that they will respect people's freedom, privacy, and unique needs, in practice they are very restrictive. Whenever service providers group people with disabilities together in the same place, they are isolating us from the rest of the community. Grouping people together also makes it much harder for people to decide exactly which services they need, because people are limited by the needs of the staff. For example, staff might not be able to leave the group home to help one resident go to the store, because they need to stay and provide services to someone else in the group home. Instead, people with disabilities should be able to live in their own apartment or with family and friends. Instead of paying staff at a group home, the HCBS program would pay someone to come to people's homes and provide the services that they need. People would be able to choose who provides their services and when. They would also be able to decide which services they needed at which times. By choosing their own staff, people with disabilities would be able to make sure that the person who helps them on a daily basis is someone works well with them and understands their needs. As someone who has a personal care attendant who comes to my house, I know that this system works very well.
Include references to other resources.	I also encourage you to review the Autistic Self Advocacy Network's toolkit for administrators, which is available at http://autisticadvocacy.org/hcbs/. This toolkit explains in more detail the types of services that do and do not comply with the new rule.
Include a "thank you" at the end and an explanation of how best to contact you (for example, by phone or by email).	Thank you for taking the time to read my comments. Please feel free to contact me with any questions you may have. I do not use the phone, but I can be reached via email at janedoe@email.com.
Type your name at the bottom. If you plan on printing the letter and mailing it, you should leave a space for your signature, and sign it before mailing.	Sincerely, Jane Doe

You may also want to write a letter to your state partners. Here is an example of a quick letter or email that you can send.

Your Address Goes Here	Jane Doe 1457 Imaginary Dr. Springfield, State, 00000
The date that you sent the letter	September 2, 2014

The address of the state partner

John Roe

Health Policy Director

State Disability Rights Project

8203 Imaginary Lane

Springfield, State, 00001

Introduce yourself and explain your personal experience (if any) with HCBS.

Dear Mr. Roe,

I am a 25-year-old autistic person living in Springfield. I am writing because I am interested in helping to speak out about the new home and community-based services regulation and the state transition plan.

I am a 25-year-old autistic person living in Springfield. I use home and community-based services, including a personal care attendant to help me stay in my home. My personal care attendant comes to my apartment for two hours a day to help me dress myself, cook, and keep the apartment clean. I have many friends who also use HCBS. Some of them live in group homes.

It is very important to make sure that the state transition plan gives everyone the chance to live and spend their days in integrated settings. As someone who uses HCBS, I want to make sure that my voice is heard.

Mention if you are interested in joining any advocacy efforts.

Please let me know if you know of any volunteer opportunities or upcoming events where I can share my thoughts. I also plan on sending in comments on the transition plan. I'm attaching a copy of my comments to this letter.

If you've written comments on the transition plan, print them out and include them in the letter.

Let your state partner know about other resources they might find helpful.

I'd also like to make sure that you know about a resource that the Autistic Self Advocacy Network has written for administrators and advocates on how to make sure that HCBS services are fully integrated into the community. You can find it at http://autisticadvocacy.org/hcbs/.

Include a "thank you" at the end and an explanation of how best to contact you (for example, by phone or by email).

Thank you for your time. Please feel free to contact me with any questions you may have. I do not use the phone, but I can be reached via email at janedoe@email.com.

Type your name at the bottom. If you plan on printing the letter and mailing it, you should leave a space for your signature, and sign it before mailing.

Sincerely,

Jane Doe

Other Resources

You might find these other resources helpful in understanding the new rule.

State Transition Plans for New Medicaid HCBS Regulations: For Tips for Consumer Advocates, by the National Senior Citizens Law Center and National Disability Rights Network, available at http://www.nsclc.org/wp-content/uploads/2014/07/State-Transition-Plans-for-New-Medicaid-HCBS-Regulations_Four-Tips-for-Consumer-Advocates.pdf

HCBS Advocates Worksheet for Assessing Services and Settings, by the National Association of Councils on Developmental Disabilities, Association of University Centers on Disabilities, and National Disability Rights Network, can help you decide whether specific services you've seen are following the new rule. It is available at http://hcbsadvocacy.files.wordpress.com/2014/04/hcbs-advocates-worksheet.pdf

Just Like Home: An Advocate's Guide for State Transitions Under the New Medicaid HCBS Rules, by the National Senior Citizens Law Center, available at http://www.nsclc.org/wp-content/uploads/2014/06/Just-Like-Home_-An-Advocates-Guide-for-State-Transitions-Under-the-New-Medicaid-HCBS-Rules.pdf

Keeping the Promise: Self Advocates Defining the Meaning of Community Living, by the Autistic Self Advocacy Network, available at http://autisticadvocacy.org/wp-content/uploads/2012/02/KeepingthePromise-SelfAdvocatesDefiningtheMeaningofCommunity.pdf

Separate and Unequal: States Fail to Fulfill the Community Living Promise of the Americans with Disabilities Act, by the United States Senate Health, Education, Labor, and Pensions Committee, available at http://www.harkin.senate.gov/documents/pdf/OlmsteadReport.pdf

If you have any questions about this toolkit, please let us know by contacting Samantha Crane, Director of Public Policy, at scrane@autisticadvocacy.org.

Appendix: Quick Reference: New Rules for Home and Community-Based Settings and the Person-Centered Planning Process

The new rule can be found online at https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider. This web site, however, can be confusing to read. It includes a long discussion of how they decided on the rule and responses to comments that people sent in about the new rule. Here is a copy of the rule itself.

You can use this to talk about specific parts of the new rule. If you want to talk about a specific part of the rule, there's a specific way to write out the place in the rule you're talking about. First you write out the title and section, then you write the subsections.

The title and section are the letters and numbers at the top of each part of the rule typed out here. For example, the title and section of the part about HCBS programs is "42 C.F.R. § 441.301." "42" is the title, and "441.301" is the section. "C.F.R." means "Code of Federal Regulations," which is a set of books where this rule will eventually be published. The "§" is called a "section symbol." The subsections are the letters and numbers in parentheses (like "(a)" and "(1)").

So, for example, if you want to talk about the part of the rule where it says the person-centered planning process has to include people "chosen by the individual," you would write "42 C.F.R. § 441.301(c)(1)(i).

How to write in the subsections can be confusing. If you're having trouble, the Guide for Advocates has taken a lot of the most important parts of the rule and written out the citation right below, like this:

"The setting is physically accessible to the individual."

—42 C.F.R. § 441.301(c)(4)(vi)(E) (about HCBS waivers); § 441.530(a)(1)(vi)(E) (about Community First Choice programs); § 441.710(a)(1)(vi)(E) (about combined programs for the elderly and people with disabilities).

Regulations for HCBS waiver programs.

42 C.F.R. § 441.301. Contents of request for a waiver.

Note: Section § 441.301 itself is not new. The old § 441.301 only had a subsection (a) and a subsection (b). The new rule added a new subsection, (c). Subsection (a) and (b) include other rules about HCBS waivers that aren't very important to this Guide.

(c) A waiver request under this subpart must include the following—

(1) Person-Centered Planning Process. The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

(i) Includes people chosen by the individual.

(ii) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(iii) Is timely and occurs at times and locations of convenience to the individual.

(iv) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.

(v) Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

(vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

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

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

(ix) Records the alternative home and community-based settings that were considered by the individual.

(2) The Person-Centered Service Plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

(i) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS 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 HCBS.

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

(iii) Reflect clinical and support needs as identified through an assessment of functional need.

(iv) Include individually identified goals and desired outcomes.

(v) 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, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

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

(vii) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.

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

(ix) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

(x) Be distributed to the individual and other people involved in the plan.

(xi) Include those services, the purpose or control of which the individual elects to self-direct.

(xii) Prevent the provision of unnecessary or inappropriate services and supports.

(xiii) Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(A) Identify a specific and individualized assessed need.

(B) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(C) Document less intrusive methods of meeting the need that have been tried but did not work.

(D) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(E) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

(F) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(G) Include informed consent of the individual.

(H) Include an assurance that interventions and supports will cause no harm to the individual.

(3) Review of the Person-Centered Service Plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

(4) Home and Community-Based Settings. Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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 HCBS.

(ii) The setting 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. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the qualities at § 441.301(c)(4)(i) through (v), the following additional conditions must be met:

(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

(B) Each individual has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

(2) Individuals sharing units have a choice of roommates in that setting.

(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

(D) Individuals are able to have visitors of their choosing at any time.

(E) The setting is physically accessible to the individual.

(F) Any modification of the additional conditions, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

(5) Settings that are not Home and Community-Based. Home and community-based settings do not include the following:

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;

(iv) A hospital; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

(6) Home and Community-Based Settings: Compliance and Transition:

(i) States submitting new and initial waiver requests must provide assurances of compliance with the requirements of this section for home and community-based settings as of the effective date of the waiver.

(ii) CMS will require transition plans for existing section 1915(c) waivers and approved state plans providing home and community-based services under section 1915(i) to achieve compliance with this section, as follows:

(A) For each approved section 1915(c) HCBS waiver subject to renewal or submitted for amendment within one year after the effective date of this regulation, the State must submit a transition plan at the time of the waiver renewal or amendment request that sets forth the actions the State will take to bring the specific waiver into compliance with this section. The waiver approval will be contingent on the inclusion of the transition plan approved by CMS. The transition plan must include all elements required by the Secretary; and within one hundred and twenty days of the submission of the first waiver renewal or amendment request the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

(B) For States that do not have a section 1915(c) HCBS waiver or a section 1915(i) State plan benefit due for renewal or proposed for amendments within one year of the effective date of this regulation, the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. This plan must be submitted no later than one year after the effective date of this regulation. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

(iii) A State must provide at least a 30-day public notice and comment period regarding the transition plan(s) that the State intends to submit to CMS for review and consideration, as follows:

(A) The State must at a minimum provide two (2) statements of public notice and public input procedures.

(B) The State must ensure the full transition plan(s) is available to the public for public comment.

(C) The State must consider and modify the transition plan, as the State deems appropriate, to account for public comment.

(iv) A State must submit to CMS, with the proposed transition plan:

(A) Evidence of the public notice required.

(B) A summary of the comments received during the public notice period, reasons why comments were not adopted, and any modifications to the transition plan based upon those comments.

(v) Upon approval by CMS, the State will begin implementation of the transition plans. The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation.

The regulations for HCBS Community First Choice services are available at 42 C.F.R. § 441.530.

§ 441.530 Home and Community-Based Setting.

(a) States must make available attendant services and supports in a home and community-based setting consistent with both paragraphs (a)(1) and (a)(2) of this section.

(1) Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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 HCBS.

(ii) The setting 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. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(1)(i) through (v) of this section, the following additional conditions must be met:

(A) The unit or dwelling is a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

(B) Each individual has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed.

(2) Individuals sharing units have a choice of roommates in that setting.

(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

(D) Individuals are able to have visitors of their choosing at any time.

(E) The setting is physically accessible to the individual.

(F) Any modification of the additional conditions, under paragraphs (a)(1)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regulation collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

(2) Home and community-based settings do not include the following:

(i) A nursing facility;

(ii) An institution for mental diseases;

(iii) An intermediate care facility for individuals with intellectual disabilities;

(iv) A hospital providing long-term care services; or

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

(b) [Reserved]

The regulations for HCBS State Plan services at 42 C.F.R. § 441.710 and § 441.725.

§ 441.710 State plan home and community-based services under section 1915(i)(1) of the Act.

(a) Home and Community-Based Setting. States must make State plan HCBS available in a home and community-based setting consistent with both paragraphs (a)(1) and (a)(2) of this section.

(1) Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

(i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS 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 HCBS.

(ii) The setting 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. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(iv) Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(v) Facilitates individual choice regarding services and supports, and who provides them.

(vi) In a provider-owned or controlled residential setting, in addition to the above qualities at paragraphs (a)(1)(i) through (v) of this section, the following additional conditions must be met:

(A) The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the State must ensure thata lease, residency agreement or other form of written agreement will be in place for each HCBS participant and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law;

(B) Each individual has privacy in their sleeping or living unit:

(1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors;

(2) Individuals sharing units have a choice of roommates in that setting; and

(3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

(C) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;

(D) Individuals are able to have visitors of their choosing at any time;

(E) The setting is physically accessible to the individual; and

(F) Any modification of the additional conditions, under paragraphs (a)(1)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(1) Identify a specific and individualized assessed need.

(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(3) Document less intrusive methods of meeting the need that have been tried but did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

(2) Home and community-based settings do not include the following:

(i) A nursing facility.

(ii) An institution for mental diseases.

(iii) An intermediate care facility for individuals with intellectual disabilities.

(iv) A hospital.

(v) Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.

(3) Compliance and transition:

(i) States submitting state plan amendments for new section 1915(i) of the Act benefits must provide assurances of compliance with the requirements of this section for home and community-based settings as of the effective date of the state plan amendment;

(ii) CMS will require transition plans for existing section 1915(c) waivers and approved state plans providing home and community-based services under section 1915(i) to achieve compliance with this section, as follows:

(A) For each approved section 1915(i) of the Act benefit subject to renewal or submitted for amendment within one year after the effective date of this regulation, the State must submit a transition plan at the time of the renewal or amendment request that sets forth the actions the State will take to bring the specific 1915(i) State plan benefit into compliance with this section. The approval will be contingent on the inclusion of the transition plan approved by CMS. The transition plan must include all elements required by the Secretary; and within one hundred and twenty days of the submission of the first renewal or amendment request the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

(B) For States that do not have a section 1915(c) waiver or a section 1915(i) State plan benefit due for renewal or proposed for amendments within one year of the effective date of this regulation, the State must submit a transition plan detailing how the State will operate all section 1915(c) waivers and any section 1915(i) State plan benefit in accordance with this section. This plan must be submitted no later than one year after the effective date of this regulation. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

(iii) A State must provide at least a 30-day public notice and comment period regarding the transition plan(s) that the State intends to submit to CMS for review and consideration, as follows:

(A) The State must at a minimum provide two (2) statements of public notice and public input procedures.

(B) The State must ensure the full transition plan(s) is available to the public for public comment.

(C) The State must consider and modify the transition plan, as the State deems appropriate, to account for public comment.

(iv) A State must submit to CMS, with the proposed transition plan:

(A) Evidence of the public notice required.

(B) A summary of the comments received during the public notice period, reasons why comments were not adopted, and any modifications to the transition plan based upon those comments.

(v) Upon approval by CMS, the State will begin implementation of the transition plans. The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation.

(b) Needs-Based Eligibility Requirement. Meet needs-based criteria for eligibility for the State plan HCBS benefit, as required in § 441.715(a).

(c) Minimum State plan HCBS Requirement. Be assessed to require at least one section 1915(i) home and community-based service at a frequency determined by the State, as required in § 441.720(a)(5).

(d) Target Population. Meet any applicable targeting criteria defined by the State under the authority of paragraph (e)(2) of this section.

(e) Nonapplication. The State may elect in the State plan amendment approved under this subpart not to apply the following requirements when determining eligibility:

(1) Section 1902(a)(10)(C)(i)(III) of the Act, pertaining to income and resource eligibility rules for the medically needy living in the community, but only for the purposes of providing State plan HCBS.

(2) Section 1902(a)(10)(B) of the Act, pertaining to comparability of Medicaid services, but only for the purposes of providing section 1915(i) State plan HCBS. In the event that a State elects not to apply comparability requirements:

(i) The State must describe the group(s) receiving State plan HCBS, subject to the Secretary's approval. Targeting criteria cannot have the impact of limiting the pool of qualified providers from which an individual would receive services, or have the impact of requiring an individual to receive services from the same entity from which they purchase their housing. These groups must be defined on the basis of any combination of the following:

(A) Age.

(B) Diagnosis.

(C) Disability.

(D) Medicaid Eligibility Group.

(ii) The State may elect in the State plan amendment to limit the availability of specific services defined under the authority of § 440.182(c) of this chapter or to vary the amount, duration, or scope of those services, to one or more of the group(s) described in this paragraph.

§ 441.725 Person-centered service plan

(a) Person-centered planning process. Based on the independent assessment required in § 441.720, the State must develop (or approve, if the plan is developed by others) a written service plan jointly with the individual (including, for purposes of this paragraph, the individual and the individual's authorized representative if applicable). The person-centered planning process is driven by the individual. The process:

(1) Includes people chosen by the individual.

(2) Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

(3) Is timely and occurs at times and locations of convenience to the individual.

(4) Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.

(5) Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.

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

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

(8) Records the alternative home and community-based settings that were considered by the individual.

(b) The person-centered service plan. The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must:

(1) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS 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 HCBS.

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

(3) Reflect clinical and support needs as identified through an assessment of functional need.

(4) Include individually identified goals and desired outcomes.

(5) 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, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS.

(6) Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.

(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.

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

(9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

(10) Be distributed to the individual and other people involved in the plan.

(11) Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of § 441.740.

(12) Prevent the provision of unnecessary or inappropriate services and supports.

(13) Document that any modification of the additional conditions, under § 441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(i) Identify a specific and individualized assessed need.

(ii) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

(iii) Document less intrusive methods of meeting the need that have been tried but did not work.

(iv) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.

(vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(vii) Include informed consent of the individual; and

(viii) Include an assurance that the interventions and supports will cause no harm to the individual.

(c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in § 441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

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CMS
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CMCS Informational Bulletin

DATE: January 10, 2014

FROM: Cindy Mann
Director

SUBJECT: **Final Rule - CMS 2249-F – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and CMS 2296-F 1915(c) Home and Community-Based Services Waivers**

Today the Centers for Medicare & Medicaid Services (CMS) is pleased to announce the publication of an important final rule about home and community-based services (HCBS) provided through Medicaid's 1915(c) HCBS Waiver program, 1915(i) HCBS State Plan Option, and 1915(k) Community First Choice. The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living. The rule is available at http://www.medicaid.gov/HCBS.

The final rule is a result of multiple rulemaking efforts over the last five years and consideration by CMS of input from thousands of stakeholders. This robust process helped CMS ensure that the regulation takes into account a wide range of stakeholder perspectives and the varying experiences across the states. There will be continued opportunities for stakeholder input as CMS works with states to implement this final rule.

CMS will offer opportunities for additional information, issuing additional guidance, and providing assistance as states begin implementing this final rule. We recognize that implementing this final rule may require states to evaluate and make adjustments in their current systems and that this process will take time. The final rule provides for a process that will allow states to implement this rule in a manner that will support continuity of services for Medicaid participants and minimize disruptions in service systems during implementation. This Informational Bulletin contains a brief overview of this transition process and the assistance available from CMS to assist states with the process.

Additional Information and Forthcoming Guidance

CMS is committed to ensuring that stakeholders have immediate access to information to help them understand the final rule. CMS has developed a website dedicated to providing information about the rule, available at http://www.medicaid.gov/HCBS. On this website, stakeholders can find links to fact sheets, questions and answers and other related resources. In addition, CMS will be holding a series of informational webinars over the next several weeks. The dates for these webinars can be

found on the website. CMS has also established a mailbox at HCBS@cms.hhs.gov and encourages you to submit questions to the mailbox.

As states begin implementation, CMS will provide additional information on a number of topics over the next several weeks and months. The information will be provided through additional Informational Bulletins and through revisions to the 1915(c) Waiver Technical Guide for regulatory changes for the 1915(c) HCBS Waivers, CMS will also be creating additional fact sheets and frequently asked questions (FAQs) to address questions from the public after they have had a chance to review the final rule.

Transition for Implementing Home and Community-Based Settings Requirements

CMS recognizes that states and providers may need time to implement the clarifying requirements about the characteristics of home and community-based settings. The final regulation provides for a transition process that will allow states to implement this rule in a manner that supports continuity of services for Medicaid participants and minimizes disruptions in service systems during implementation. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress towards compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing sub-regulatory guidance to provide the details regarding requirements for transition plans.

Assistance from CMS

CMS is committed to assisting states in implementing these rules and is available to work closely with individual states at the beginning and throughout the development of their transition plans. In addition, CMS is working to provide additional technical assistance resources to states and will provide information about these resources as soon as possible.

Many states have made significant progress in recent years to increase the availability and quality of home and community-based services. We believe the implementation of these rules will contribute

significantly to the quality and experience of participants in Medicaid HCBS programs and will further expand their opportunities for meaningful community integration in support of the goals of the Americans with Disabilities Act and the Supreme Court's decision in *Olmstead v. L.C.*

We thank the many individuals and organizations who contributed input to these rules and look forward to the continuing dialogue with stakeholders as we work together to make them a reality.

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF COMMUNICATIONS

FACT SHEET

FOR IMMEDIATE RELEASE
January 10, 2014

Contact: CMS Media Relations
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Home and Community Based Services

Overview

The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for home and community-based services (HCBS). The rule supports enhanced quality in HCBS programs, adds protections for individuals receiving services. In addition, this rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. Highlights of this final rule include:

- Provides implementing regulations for section 1915(i) State Plan HCBS, including new flexibilities enacted under the Affordable Care Act to offer expanded HCBS and to target services to specific populations;
- Defines and describes the requirements for home and community-based settings appropriate for the provision of HCBS under section 1915(c) HCBS waivers, section 1915(i) State Plan HCBS and section 1915(k) (Community First Choice) authorities;
- Defines person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities;
- Provides states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses on functional needs.
- Allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).
- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs.

Key Provisions of the Final Rule

1915(c) Home and Community-Based Waivers

The final rule amends the regulations for the 1915(c) HCBS waiver program, authorized under section 1915(c) of the Social Security Act (the Act), in several important ways designed to improve the quality of services for individuals receiving HCBS. Specifically, it establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act, defines person-centered planning requirements, provides states with the option to combine multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and provides CMS with additional compliance options for HCBS programs. For more detail, please refer to the 1915(c) fact sheet at http://www.medicaid.gov/HCBS.

Section 1915(i) Home and Community-Based State Plan Option

The final rule implements the section 1915(i) HCBS state plan option, including new flexibilities enacted under the Affordable Care Act that offer states the option to provide expanded home and community-based services and to target services to specific populations. In addition, the final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. For more detail, please refer to the 1915(i) fact sheet at http://www.medicaid.gov/HCBS.

Section 2601 of the Affordable Care Act: Five Year Period for Certain Demonstration Projects and Waivers

To simplify administration of the program for states, this final rule provides a five-year approval or renewal period for demonstration and waiver programs in which a state serves individuals who are dually eligible for Medicare and Medicaid benefits. This provision allows states to use a five year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).

Home and Community-Based Settings Requirements

The final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. The rule creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The regulatory changes will maximize the opportunities for HCBS program participants to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid home and community-based services to provide alternatives to services provided in institutions. For more detail, please refer to the HCBS Settings fact sheet at http://www.medicaid.gov/HCBS.

The final rule includes a provision requiring states offering HCBS under existing state plans or waivers to develop transition plans to ensure that HCBS settings will meet final rule's requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress toward compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan that provides for the delivery of HCBS services within settings meeting the final rule's requirements, and CMS may approve transition plans for a period of up to five years, as supported by an individual state's circumstances.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year after the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will be issuing future guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

Attachment #6

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CMS
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January 10, 2014

Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule
(CMS 2249-F/2296-F)

This final rule establishes requirements for the qualities of settings that are eligible for reimbursement for the Medicaid home and community-based services (HCBS) provided under sections 1915(c), 1915(i) and 1915(k) of the Medicaid statute. Over the past five years, CMS has engaged in ongoing discussions with stakeholders, states and federal partners about the qualities of community-based settings that distinguish them from institutional settings. As part of this stakeholder engagement, CMS issued an Advanced Notice of Proposed Rule Making (ANPRM) and various proposed rules relating to home and community-based services authorized by different sections of the Medicaid law, including 1915(c) HCBS waivers, 1915(i) State Plan HCBS and 1915(k) Community First Choice State Plans. CMS' definition of home and community-based settings has benefited from and evolved as a result of this stakeholder engagement.

In this final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of individuals' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

Overview of the Settings Provision

The final rule requires that all home and community-based settings meet certain qualifications. These include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections;

- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.

The final rule excludes certain settings as permissible settings for the provision of Medicaid home and community-based services. These excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings.

The final rule identifies other settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings include those in a publicly or privately-owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. If states seek to include such settings in Medicaid HCBS programs, a determination will be made through heightened scrutiny, based on information presented by the state demonstrating that the setting is home and community-based and does not have the qualities of an institution. This process is intended to be transparent and includes input and information from the public. CMS will be issuing future guidance describing the process for the review of settings subject to heightened scrutiny through either the transition plan process (for settings already in states' HCBS programs) or the HCBS waiver review processes (for settings states seek to add to their HCBS programs).

The final rule includes a transitional process for states to ensure that their waivers and state plans meet the HCBS settings requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states must evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual states' circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing future guidance on requirements for transition plans.

Changes in the Final Rule

The final rule clarifies several major areas of confusion and concern expressed by some commenters and stakeholders engaged throughout the processes of rulemaking regarding the requirements for home and community-based settings. While CMS' responses to the specific comments are contained in the preamble to the final rule, below is a summary of the areas of the rule that received the most feedback and the changes in the final rule that address those comments:

- **Disability specific complex**. The proposed rule included "disability specific complex" in the list of settings presumed not to be home and community-based settings. Comments on the proposed rules suggested that the phrase "disability specific complex" had multiple meanings, and the continued use of the phrase could have unintended adverse impacts on affordable housing options. To avoid those consequences, CMS eliminated the use of the phrase from the final rule. The final rule includes the following language on other settings: "any other setting that has the effect of discouraging integration of individuals from the broader community..."

- **Rebuttable presumption**. The proposed rule indicated that CMS would exercise a "rebuttable presumption" that certain settings are not home and community-based. CMS has removed this phrase from the final rule and clarified in the final rule that certain settings are presumed to have institutional characteristics and will be subjected to heightened scrutiny if states seek to include these settings in their HCBS programs. The rule allows the state to present evidence to CMS that the setting is actually home and community-based in nature and does not have the qualities of an institution. CMS will consider input from stakeholders, as well as its own reviews, in applying heightened scrutiny. This process will require the state to solicit public input.

- **Choice of provider in provider owned or controlled settings.** The final rule clarifies that when an individual chooses to receive home and community-based services in a provider owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate. For any services that are not included in the bundled rate, the individual may choose any qualified provider, including the provider who controls or owns the setting if the provider offers the service separate from the bundle. For example, if a residential program provides habilitation connected with daily living and on-site supervision under a bundled rate, an individual is choosing the residential provider for those two services when he or she chooses the residence. The individual has free choice of providers for any other services in his or her service plan, such as employment services and other community supports.

- **Private rooms and roommate choice**. The final rule clarifies that states, as opposed to individual providers, have the responsibility for ensuring that individuals have options available for both private and shared residential units within HCBS programs. The rule further clarifies that an individual's needs, preferences and resources are relevant to his/her options for shared versus private residential units. Provider owned or operated residential settings will be responsible to facilitate individuals having choice regarding roommate selection within a residential setting.

- **Application of home and community-based settings requirements to non-residential settings.** CMS has clarified that the rule applies to all settings where HCBS are delivered, not just to residential settings. CMS will be providing additional information about how states should apply the standards to non-residential settings, such as day program and pre-vocational training settings.

Attachment #7

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

January 10, 2014

Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule
(CMS 2249-F/2296-F)

Background

Section 1915(c) of the Social Security Act (the Act) authorizes the Secretary of Health and Human Services to waive certain requirements in Medicaid law in order for states to provide home and community-based services (HCBS) to meet the needs of individuals who choose to receive their long-term care services and supports in their home or community, rather than in institutional settings. Final rules were published to implement this law on July 25, 1994.

On June 22, 2009, CMS published an advance notice of proposed rulemaking (ANPRM) that indicated CMS' intention to initiate rulemaking on a number of areas within the section 1915(c) program. On April 15, 2011, CMS published the Notice of Proposed Rule Making (NPRM) that addressed many of the same issues raised in the ANPRM. The final rule published today reflects the significant public comment received over the extensive rulemaking process related to these issues.

This final rule makes several important changes to the 1915(c) HCBS waiver program. It provides states the option to combine existing waiver targeting groups. The rule also establishes requirements for home and community-based settings under the 1915(c), 1915(i) and 1915(k) Medicaid authorities, and person-centered planning requirements for Medicaid HCBS participants under 1915(c) and 1915(i). In addition, it clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates. Finally, it describes the additional strategies available to CMS to ensure state compliance with the statutory provisions of section 1915(c) of the Act. Below is a summary of each of these provisions.

Flexibility to Combine Target Groups Under One Waiver

The final rule permits, but does not require, states to combine target groups within one HCBS waiver. Prior to that change, a single section 1915(c) HCBS waiver could only serve one of the following three target groups: older adults, individuals with disabilities, or both; individuals with intellectual disabilities, developmental disabilities, or both; or individuals with mental illness. This change will remove a barrier for states that wish to design a waiver that meets the needs of more than one target population. The rule includes a provision specifying that if a state chooses the option of more than one target group under a single waiver, the state must assure CMS that it is able to meet the unique service needs of individuals in each target group, and that each individual in the waiver has equal access to all needed services.

Home and Community-Based Settings

CMS' definition of home and community-based settings has evolved over the past five years, based on experience throughout the country and extensive public feedback about the best way to differentiate between institutional and home and community-based settings. Based on the comments received on the ANPRM and the proposed 1915(c) rules, and the comments received on the 1915(i) and 1915(k) proposed rules, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions and maximize the opportunities for waiver participants to have access to the benefits of community living, including receiving services in the most integrated setting. For more detail, please refer to the HCBS Settings Fact Sheet, available at http://www.medicaid.gov/HCBS.

The final rule includes a transition period for states to ensure that their waivers and Medicaid state plans meet the HCBS settings definition. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final rule home and community-based settings definition, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plans meet the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing future guidance regarding transition plans.

Person-Centered Planning

The final rule specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative that the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related community participation, employment, income and savings, health care and wellness, education and others. The plan should reflect the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services. This planning process, and

the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

Duration, Extension and Amendment of Waivers

In this final rule, CMS added a new provision to clarify guidance regarding the effective dates of HCBS waiver amendments with substantive changes. Substantive changes include, but are not limited to, changes in eligible populations; constriction of service, amount, duration, or scope; and other modifications as determined by the Secretary. The rule also adds regulatory language that waiver amendments with substantive changes may only take effect on or after the date when the amendment is approved by CMS. Substantive changes also must be accompanied by information on how the state has assured smooth transitions and minimal adverse impact on individuals impacted by the change.

In addition, the final rule includes a new provision to ensure that states provide public notice when they propose substantive changes to their methods and standards for setting payment rates for services. The final rule also includes a provision directing that states establish public input processes specifically for waiver changes.

Strategies to Ensure Compliance with Statutory Assurances

A primary concern in the oversight of 1915(c) HCBS waivers is the health and welfare of the individuals served within the programs. Section 1915(f) of the Act requires the Secretary to monitor implementation of waivers to assure compliance with all requirements and provides for termination of waivers where the Secretary has found noncompliance. This authority and the process for termination of waivers are addressed in this final rule. CMS has included provisions that describe additional strategies that CMS may employ to ensure state compliance with the requirements for a waiver.

Attachment #8

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

January 10, 2014

Fact Sheet: Summary of Key Provisions of the Final Rule for 1915(i) Home and Community-Based Services (HCBS) State Plan Option
(CMS 2249-F/2296-F)

Background

Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(i) to the Social Security Act (the Act) providing states the option to offer home and community-based services, previously available only through a 1915(c) HCBS waiver, through the state's Medicaid state plan. As originally enacted, states could only serve individuals eligible under the State plan with incomes at or below 150 percent of the Federal poverty level (FPL) or below and could offer some, but not all, HCBS services and supports available through 1915(c) HCBS waivers. In addition, states were not able to target 1915(i) state slan HCBS to particular populations within the state.

The Affordable Care Act expanded coverable services under 1915(i) to include any of the HCBS permitted under section 1915(c) HCBS waivers, certain services for individuals with mental health and substance use disorders and other services requested by a state and approved by the Secretary of Health and Human Services. In addition, the changes support ensuring the quality of HCBS, require states to offer the benefit statewide and enable states to target 1915(i) State Plan HCBS to particular groups of participants but not limit the number of participants who may receive the benefit. CMS published a proposed rule on May 4, 2012 for these 1915(i) provisions. This final rule responds to the public comments received on those proposed rules.

In addition to the above provisions, the final rule also establishes a set of requirements for home and community-based settings under the 1915(i), 1915(c) and 1915(k) Medicaid authorities, and a set of person-centered planning requirements for Medicaid HCBS participants under 1915(c) and 1915(i).

Home and Community-Based Settings

CMS' definition of home and community-based settings has evolved over the past five years, based on experience throughout the country and extensive public feedback about the best way to differentiate between institutional and home and community-based settings. Based on the comments received on the 1915(c) advance notice of proposed rulemaking (ANPRM), the proposed 1915(c) rule, and the comments received on the 1915(i) and 1915(k) proposed rules, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions and maximize the opportunities for waiver participants to have access to the benefits of

community living, including receiving services in the most integrated setting. For more detail, please refer to the HCBS Settings Fact Sheet available at http://www.medicaid.gov/HCBS.

The final rule includes a transition period for states to ensure that their waivers and state plans meet the HCBS settings requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that the specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing sub-regulatory guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, education and others. The plan should reflect the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

HCBS Statewide Transition Plan

The California Department of Health Care Services (DHCS) is developing a Statewide Transition Plan (STP) as a result of the new Federal Home and Community-Based (HCB) Setting requirements effective March 17, 2014. These regulations are CMS 2249-F and CMS 2296-F, which affect 1915(i) and 1915(c) HCB Services Waivers. Pursuant to the new rules, the State must develop an STP within 120 days of submission of any Waiver amendment or renewal. This trigger date was initiated with the submission of the Multipurpose Senior Services Program (MSSP) Waiver renewal on August 22, 2014. Please note there will be individual Waiver Transition Plans, and additional stakeholder input processes, required to be submitted to the Centers for Medicare and Medicaid Services (CMS) by March 16, 2015. Further, all 1915(i) and 1915(c) Waivers must be in full compliance with the new Federal rules by March 16, 2019.

DHCS has been working with partner agencies, including The Department of Developmental Services (DDS), the California Department of Aging (CDA), the California Department of Public Health (CDPH), and other interested parties to develop a STP draft for public and stakeholder input. The State has been reviewing all 1915(i) and 1915(c) Waiver services and provider-controlled residential settings for compliance with the new HCB Setting requirements.

The initial draft (September 19, 2014) of the STP that outlines the various services and identifies the specific provider types in the 1915(i) and 1915(c) that DHCS, DDS, CDA and CDPH consider needing special focus to ensure compliance. The State invites stakeholders to assist in the assessment of HCB Setting compliance with Federal requirements, and welcomes interested parties into the stakeholder input process for a transparent and effective transition of these critical Medi-Cal programs.

- Draft HCBS Statewide Transition Plan (PDF)

Stakeholder Comments

DHCS will review and analyze all stakeholder comments and will revise the STP accordingly. DHCS will post the STP on September 19, 2014 which initiates the 30-day public comment period. After our first STP stakeholder call, DHCS will post the revised STP for stakeholder review and final comments. After reviewing final public input, DHCS

intends to post the final STP on the DHCS website and submit the STP to CMS by December 20, 2014.

- The first stakeholder call will be scheduled for October 21, 2014, 10am – 12pm.
  - The call in number is: 888-829-8671 Participant passcode: 7335142

- The second stakeholder call will be scheduled for December 2, 2014, 10am – 12pm.
  - The call in number is: 888-829-8671 Participant passcode: 7335142

Public Comments

- The first public comment period will begin September 19, 2014 through October 19, 2014.

- The second public comment period will begin October 27, 2014 through November 26, 2014.

Summary of stakeholder comments and minutes from stakeholder calls will be posted online in tandem with revised STP drafts. Please submit all comments to: STP@dhcs.ca.gov.
We look forward to working with our stakeholders to ensure compliance with the new Federal rules. Please note that conference call dates, times, and phone numbers may change. Please check the website for any such changes.

Foreword

Background – 1915(c) Waivers

The Federal government authorized the "Medicaid 1915(c) Home and Community-Based Services (HCBS) Waiver program" in 1981 under Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35). It is codified in section 1915(c) of the Social Security Act. The original legislative intent of the HCBS Waiver program was to slow the growth of Medicaid (Medi-Cal in California) spending by providing services in less expensive settings. In order to contain costs, the federal legislation limited waiver services to individuals who would be institutionalized if the services were not provided. However, the costs of those waiver services cannot be higher than what they would cost in an institutional setting.

The law permitted states to waive certain Medicaid program requirements and in doing so, deviate from Medicaid requirements, such as providing services only in certain geographic areas ("waive statewideness"). The HCBS Waiver program also allowed states flexibility to offer different types of services to individuals with chronic disabilities. Prior to this, with the origin of Medicaid in 1965, beneficiaries could only receive comprehensive long-term care in institutional settings ("budget neutrality").

The initial waiver application is approved by the Centers for Medicare & Medicaid Services (CMS) for three years with additional renewal applications needing to be approved every five years. The waiver can be designed for a variety of targeted diagnosis-based groups including individuals who are elderly, and those who have physical, developmental, or mental health disabilities, or other chronic conditions such as Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). The waiver can be designed to offer a variety of services including case management, personal attendant services, adult day health care services, habilitation services, day treatment services, psychosocial rehabilitation services, mental health services, and other services specifically requested by the state. 1915(c) HCBS waivers have subsequently become mechanisms for many states, including California, to provide Medicaid-funded community-based, long-term care services and supports to eligible beneficiaries.

Background – 1915(i) State Plan

The Deficit Reduction Act of 2005 (DRA) gave states starting January 1, 2007 a new option to provide HCBS through a state plan amendment (SPA). Once approved by CMS, 1915(i) SPAs do not need to be renewed nor are they subject to some of the same requirements of waivers; for example, budget neutrality. Under this option, states set their own eligibility or needs-based criteria for providing HCBS. States are allowed to establish functional criteria in relation to certain services. The DRA provision eliminated the skilled need requirement and allowed states to cover Medicaid beneficiaries who have incomes no greater than 150 percent of the federal poverty level and who satisfy the needs-based criteria. The Patient Protection and Affordable Care Act of 2010 created several

amendments including elimination of enrollment ceilings, a requirement that services must be provided statewide, and other enrollment changes.

In early January 2014, CMS announced it had finalized important rules that affect HCBS provided through Medicaid/Medi-Cal, and subsequently published the regulations in the Federal Register on January 16, 2014. The rules became effective 60 days from publication, or March 17, 2014. These regulations are CMS 2249-F and CMS 2296-F.

Issues addressed in this Plan

This Statewide Transition Plan will present ways in which the State of California will evaluate home and community-based (HCB) settings where 1915(c) waivers and 1915(i) state plan program services are currently available. If it is determined that there are settings that do not meet the final regulations' HCB settings requirements, such HCB settings will be required to make changes that will bring them into compliance.

Information included in this document includes:

- Overview of State Responsibility
- HCB Settings
  - Summary of New Federal Requirements
  - Requirements for Modification of Compliance
- Overview of HCBS Programs
  - Multipurpose Senior Services Program (MSSP) Waiver
  - HIV/AIDS Waiver
  - HCBS Waiver for Persons with Developmental Disabilities (DD) Waiver
  - Assisted Living Waiver (ALW)
  - Nursing Facility/ Acute Hospital Transition and Diversion (NF/AH) Waiver
  - In-Home Operations (IHO) Waiver
  - San Francisco Community Living Support Benefit (SFCLSB) Waiver
  - Pediatric Palliative Care (PPC) Waiver
- Existing Settings in HCB Programs – Review and Analysis
  - California Plan for Determination of HCB Setting Compliance

Overview of State Responsibility

The State's HCBS program administrative teams are comprised of employees from the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the Department of Developmental Services (DDS), and the California Department of Aging (CDA). The San Francisco Department of Public Health (SFDPH) administers a 1915(c) waiver in accordance with terms of an Agreement with DHCS.

Existing waivers and corresponding state administrative teams are as follows:

1. MSSP Waiver (0141), CDA, Long Term Care & Aging Services
2. HIV/AIDS Waiver (0183), CDPH, Office of AIDS

3. DD Waiver (0336), DDS, Community Services
4. ALW (0431), DHCS, Long-Term Care Division
5. NF/AH Waiver (0139), DHCS, Long-Term Care Division
6. IHO Waiver (0457), DHCS, Long-Term Care Division
7. SFCLSB Waiver (0855), SFDPH
8. PPC Waiver (0486), DHCS, Systems of Care Division

Existing 1915(i) SPAs 09-023A and 11-041 are administered by DDS.

HCB Settings

Prior to the final rule, HCB setting requirements were based on location, geography, or physical characteristics. The final rules define HCB settings as more process and outcome-oriented, guided by the consumer's person-centered service plan by:

1. Being 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 HCBS.
2. Giving individuals the right to select from among various setting options, including non-disability specific settings and an option for a private unit in a residential setting.
3. Ensuring individuals' rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. Optimizing autonomy and independence in making life choices, including daily activities, physical environment and with whom to interact.
5. Facilitating choice regarding services and supports, and who provides them.

For Medi-Cal provider-owned or controlled HCB settings, the provider must offer:

- A legally enforceable agreement between the provider and the consumer that allows the consumer to own, rent or occupy the residence and provides protection against eviction.
- Privacy in units including lockable doors, choice of roommates and freedom to furnish and decorate units.
- Options for individuals to control their own schedules including access to food at any time.
- Individuals the freedom to have visitors at any time.
- A physically accessible setting.

Any modification(s) of the new requirements must be supported by a specific and individually assessed need and justified in the person-centered service plan. Documentation of all of the following is required:

- Identification of a specific and individualized assessed need.
- The positive interventions and supports used prior to any modification(s) to the person-centered plan.

- Less intrusive methods of meeting the need that have been tried but did not work.
- A clear description of the condition(s) that is directly proportionate to the specific assessed need.
- Review of regulations and data to measure the ongoing effectiveness of the modification(s).
- Established time limits for periodic reviews to determine if the modification(s) is still necessary or can be terminated.
- Informed consent of the individual.
- An assurance that interventions and supports will cause no harm to the individual.

Overview of HCBS Programs

California currently has two approved 1915(i) SPAs that allow the State to access federal financial participation for services provided to individuals with developmental disabilities who do not meet the institutional level-of-care criteria required for participation in the DD Waiver, which is described in greater detail below.

California currently administers eight 1915(c) HCBS waivers.

Descriptions of the individual waivers follow below.

- *Multipurpose Senior Services Program (MSSP) Waiver.* The objective of this program is to provide opportunities for frail seniors age 65 or older to maintain their independence and dignity in community settings by preventing or delaying avoidable nursing facility placement. Care management is the cornerstone of this waiver and involves beneficiary assessment; person-centered care planning; service arrangement, delivery and monitoring; as well as coordinating the use of existing community resources. The 39 MSSP sites maintain wait lists independently; average wait in days statewide is 91 (during 10/1/12 through 12/31/12). The current waiver was approved on July 1, 2009.

  MSSP Waiver provider types include all of the following:

  - Adult Day Care/ Support Center
  - Building Contractor or Handyman/Private Nonprofit or Proprietary Agency
  - Congregate Meals Setting
  - Home Health Agency
  - Licensed/Certified Professionals
  - Private Nonprofit or Proprietary Agency
  - Registered Nurse Care Manager (RN)
  - Social, Legal, and Health Specialists
  - Social Worker Care Manager
  - Title III (Older Americans Act)
  - Translators/Interpreters
  - Transportation Providers

- *HIV/AIDS Waiver.* The purpose of this waiver is to allow persons of all ages with mid- to late-stage HIV/AIDS to remain in their homes through a continuum of care designed to stabilize and maintain an optimal level of health, improve quality of life, and provide an alternative to institutional care in hospitals or nursing facilities. There is no waiting list for eligible beneficiaries. The current waiver was approved on January 1, 2012.

  HIV/AIDS Waiver provider types include all of the following:

  - Clinical Psychologist
  - Foster Parent
  - Home Health Agency
  - Licensed Clinical Social Worker
  - Local Pharmacy or Vendor
  - Marriage and Family Therapist
  - Masters Degree Nurse; Psychiatric and Mental Health Clinical Nurse Specialist or Psychiatric and Mental Health Nurse Practitioner
  - Private Nonprofit or Proprietary Agency
  - Registered Dietician
  - RN
  - Social Work Case Manager
  - Waiver Agency with Exception Approved by CDPH/Office of Aids

- *HCBS Waiver for Persons with Developmental Disabilities (DD Waiver).* The purpose of this waiver is to serve participants of all ages in their own homes and community settings as an alternative to placement in hospitals, nursing facilities or intermediate care facilities for persons with developmental disabilities (ICF/DD). Community-based services for individuals with developmental disabilities are provided through a statewide system of 21 private non-profit corporations known as regional centers. Regional centers provide fixed points of contact in the community for persons with developmental disabilities and their families. The DD Waiver has been in operation since 1982 to assist in funding services for individuals who live in the community and who meet the ICF/DD level-of-care requirements. DD Waiver participants live in the setting of their choice, such as with their families, in their own homes or apartments, or in licensed settings. There is no waiting list for eligible beneficiaries. The current waiver was approved on March 29, 2012.

  DD Waiver provider types include all of the following:

  - Activity Center
  - Adaptive Skills Trainer
  - Adult Day Care Facility
  - Adult Development Center
  - Adult Residential Facility
  - Adult Residential Facility for Persons with Special Health Care Needs

- Associate Behavior Analyst
- Behavior Analyst
- Behavior Management Consultant
- Behavior Management Program
- Behavioral Technician/Para-professional
- Building Contractor or Handyman
- Camping Services
- Certified Family Home
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Client/Parent Support Behavior Intervention Training
- Clinical Psychologist
- Community-Based Training Provider
- Contractor
- Creative Arts Program
- Crisis Intervention Facility
- Crisis Team – Evaluation and Behavioral Intervention
- Dentist
- Dental Hygienist
- Dietitian; Nutritionist
- Dispensing Optician
- Driver Trainer
- Durable Medical Equipment Provider
- Facilitators
- Family Home Agency: Adult Family Home/Family Teaching Home
- Financial Management Services Provider
- Group Home
- Hearing and Audiology Facilities
- Home Health Agency
- Home Health Aide
- Independent Living Program
- Independent Living Specialist
- Individual (Landlord, Property Management)
- Individual or Family Training Provider
- In-Home Day Program
- Licensed Clinical Social Worker
- Licensed Psychiatric Technician
- Licensed Vocational Nurse (LVN)
- Marriage Family Therapist
- Occupational Therapist
- Occupational Therapy Assistant
- Optometrist
- Orthoptic Technician
- Parenting Support Services Provider
- Personal Assistant
- Personal Emergency Response Systems Provider
- Physical Therapist

- Physical Therapy Assistant
- Physician/Surgeon
- Psychiatrist
- Psychologist
- Public Transit Authority
- Public Utility Agency, Retail and Merchandise Company, Health and Safety Agency, Moving Company
- Registered Nurse
- Residential Care Facility for the Elderly
- Residential Facility (Out-of-State)
- Respite Agency
- Small Family Home
- Social Recreation Program
- Socialization Training Program; Community Integration Training Program; Community Activities Support Service
- Special Olympics Trainer
- Speech Pathologist
- Sports Club: (e.g., YMCA, Community Parks and Recreation Program, Community-Based Recreation Program)
- Supported Employment
- Supported Living Provider
- Translators/Interpreters
- Transportation Providers
- Vehicle Modification and Adaptations
- Work Activity Program

- *Assisted Living Waiver (ALW).* This waiver offers eligible seniors and persons with disabilities age 21 and over the choice of residing in either a licensed Residential Care Facility for the Elderly or an independent publicly subsidized housing with Home Health Agency services as alternatives to long-term institutional placement. The goal of the ALW is to facilitate nursing facility transition back into community settings or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement. Eight care coordinator agencies serving seven counties independently maintain wait lists. The current waiver was approved on March 1, 2009.

  ALW provider types include all of the following:

  - Care Coordination Agency
  - Home Health Agency in Public Subsidized Housing
  - Residential Care Facility for the Elderly

- *Nursing Facility/Acute Hospital (NF/AH) Waiver.* This waiver combined three 1915(c) waivers into one waiver. The NF/AH Waiver offers services in the home to Medi-Cal beneficiaries with long-term medical conditions, who meet the acute hospital, adult

subacute, pediatric subacute, intermediate care facility for the developmentally disabled – continuous nursing care and Nursing Facility A/B levels of care with the option of returning and/or remaining in their home or home-like setting in the community in lieu of institutionalization. The current NF/AH Waiver was approved on January 1, 2012.

NF/AH Waiver provider types include all of the following:

- Durable Equipment Provider
- Employment Agency
- Home and Community-Based Continuous Care Facility
- Home Health Agency
- In-Home Support Services Public Authority
- Intermediate Care Facility for the Developmentally Disabled – Continuous Nursing Care
- Licensed Clinical Social Worker
- Licensed Psychologist
- LVN
- Marriage Family Therapist
- Non-Profit or Proprietary Agency
- Personal Care Agency
- Private Nonprofit or Proprietary Agency
- Professional Corporation
- RN
- Waiver Personal Care Services Provider

- *In-Home Operations (IHO) Waiver.* This waiver serves eligible individuals who: 1) were previously enrolled in a DHCS-administered HCBS waiver prior to January 1, 2002, and who require direct care services provided primarily by a licensed nurse; or 2) have been receiving continuous care in a hospital for 36 months or longer and have physician-ordered direct care services that are greater than those available in the NF/AH waiver for the participant's level of care. The current waiver was approved on January 1, 2010 .

  IHO Waiver provider types include all of the following:

  - Durable Medical Equipment Provider
  - Employment Agency
  - Home and Community-Based Continuous Care Facility
  - Home Health Agency
  - In-Home Support Services Public Authority
  - Licensed Clinical Social Worker
  - Licensed Psychologist
  - LVN
  - Marriage Family Therapist
  - Personal Care Agency

- Private Nonprofit or Proprietary Agency
- Professional Corporation
- RN
- Waiver Personal Care Services Provider

- *San Francisco Community Living Support Benefit (SFCLSB) Waiver.* This waiver utilizes certified public expenditures for provision of waiver services to persons with disabilities age 21 and over who reside in the City and County of San Francisco and who are either homeless, residing in a nursing facility, or are at imminent risk of entering a nursing facility. Eligible individuals can move into licensed Community Care Facilities (CCFs) or Direct Access to Housing (DAH) sites (e.g., private homes). Services consist of care coordination, community living support benefits, and behavior assessment and planning in both CCFs and DAHs; and home delivered meals and environmental accessibility adaptions in DAH sites.

  SFCLSB Waiver provider types include all of the following:

  - Adult Residential Facility
  - Clinical Psychologist
  - Durable Medical Equipment Provider, Building Contractor or Handyman Private Nonprofit or Proprietary Agency
  - Home Delivered Meal/Meal Preparation Vendor
  - Home Health Agency
  - Licensed Clinical Social Worker
  - Marriage Family Therapist
  - Not-For-Profit Case Management Agency
  - Private Nonprofit or Proprietary Agency
  - Residential Care Facility for the Elderly
  - Therapist (Various Specializations)

- *Pediatric Palliative Care (PPC) Waiver.* This waiver offers children with life limiting conditions a range of home-based hospice-like services while they maintain the option of receiving curative treatment. According to diagnosed need and an approved plan of care, services include: care coordination, expressive therapies, family training, individual and family caregiver counseling/bereavement services, pain and symptom management, personal care and respite care.

  PPC Waiver provider types include all of the following:

  - Agency Certified Nursing Assistant
  - Art Therapist
  - Associate Clinical Social Worker
  - Child Life Specialist
  - Congregate Living Health Facility
  - Home Health Agency

- Home Health Aide
- Hospice Agency
- Licensed Clinical Social Worker
- Licensed Psychologist
- LVN
- Masters Level Social Worker
- Massage Therapist
- Music Therapist
- RN

Existing Settings in HCBS Programs – Review and Analysis

California Plan for Determination of HCB Setting Compliance:

The standards, rules, regulations and other requirements for the following HCB settings will be analyzed and reviewed by DHCS, CDA, DDS and CDPH to determine the extent to which they comply with federal regulations. State departments will be responsible for ensuring appropriate provision of HCBS by all providers that serve Medi-Cal beneficiaries.

- Adult Family Home/Family Teaching Home
- Adult Residential Facility
- Adult Residential Facility for Persons with Special Health Care Needs
- Certified Family Home
- Congregate Living Health Facility
- Home and Community-Based Continuous Care Facility
- Foster Family Home
- Group Home
- Intermediate Care Facility for the Developmentally Disabled-Continuous Nursing Care
- Residential Care Facility for the Elderly
- Residential Facility (Out-of-State)
- Small Family Home

The compliance determination process includes all of the following:

- An initial State-level assessment of standards, rules, regulations, and other requirements to determine if they are consistent with the federal requirements. This will be completed within six months of CMS approval of the Statewide Transition Plan.

- This State-level assessment will be conducted jointly by DHCS and the State Department(s) responsible for operating each Waiver with stakeholder input.

- Results of this assessment will be available for public comment and will be used to determine and develop the remedial strategies that may be necessary to ensure that

all HCB settings conform to the federal requirements.

- In addition to the State-level assessment, on-site evaluations of individual settings will be conducted as follows:
    - On-site evaluations will be conducted at all settings that, per CMS guidance, are presumed not to be HCB settings.
    - For all other settings, a representative random sample of on-site evaluations will be conducted.
    - It is anticipated that the on-site evaluations will be completed within one year of CMS approval of the assessment tool.

- The on-site evaluations will be conducted by a survey team that includes one or more of the following: State personnel, service recipients or their family members, case managers or other representatives of case management entities, representatives of consumer advocacy organizations, and/or other stakeholders.

- The responsibility for ensuring completion of these evaluations rests with the program staff as specified under the "Overview of State Responsibility" section of this document. The State will support the provision of training for all participants of survey teams to ensure that HCB settings are built around the person-centered plan approach and are compliant with the new federal requirements.

- DHCS will develop an assessment tool for use in the on-site evaluations of HCB settings. The assessment tool will include each new federal requirement that will be used to determine if the HCB setting meets or does not meet the required federal rule. The completed assessment tool will be maintained in the appropriate State file for each waiver and will be used to verify compliance at the time of CMS renewal of the HCBS waiver.

  Note: this assessment tool shall be developed and circulated for stakeholder comments no later than 60 days after CMS approval of this Statewide Transition Plan.

- The assessment tool will be forwarded to each HCB setting selected for evaluation with instructions to complete a self-assessment prior to the evaluation completed by the survey team. The completed assessment will be forwarded back to the Waiver program for review.

- Using the completed assessments, each selected HCB setting (selected from the list identified under the "California Plan for Determination of HCB Setting Compliance" subsection of this document) will be evaluated by a survey team described above.

- Written results of each survey will be forwarded back to the HCB setting with specific information regarding improvements that will be required in order to come into compliance with the federal requirements and a timeline for completion.

- Completed assessments for all settings, including documentation of any required follow-up actions as a result of the on-site evaluations, will be maintained in the appropriate State file for each waiver.

- An appeal process, to be developed, which allows the HCB setting to dispute the HCB setting's compliance or the need to comply with the specific requirement when the HCB setting determines the requirement is not applicable to the particular setting.

  Note: the appeal process shall be developed and circulated for stakeholder comments no later than 60 days after CMS approval of this Statewide Transition Plan.

- All State-level and individual setting level remedial actions will be completed by no later than March 17, 2019.

- Progress on completion of this Statewide Transition Plan will be monitored at least every six months and will include public posting on the status with opportunity for public input.

Attachment #10

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

CMS
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-2014-01-16/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 pre-existing 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 long-term 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 community-based, 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:
    - 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]

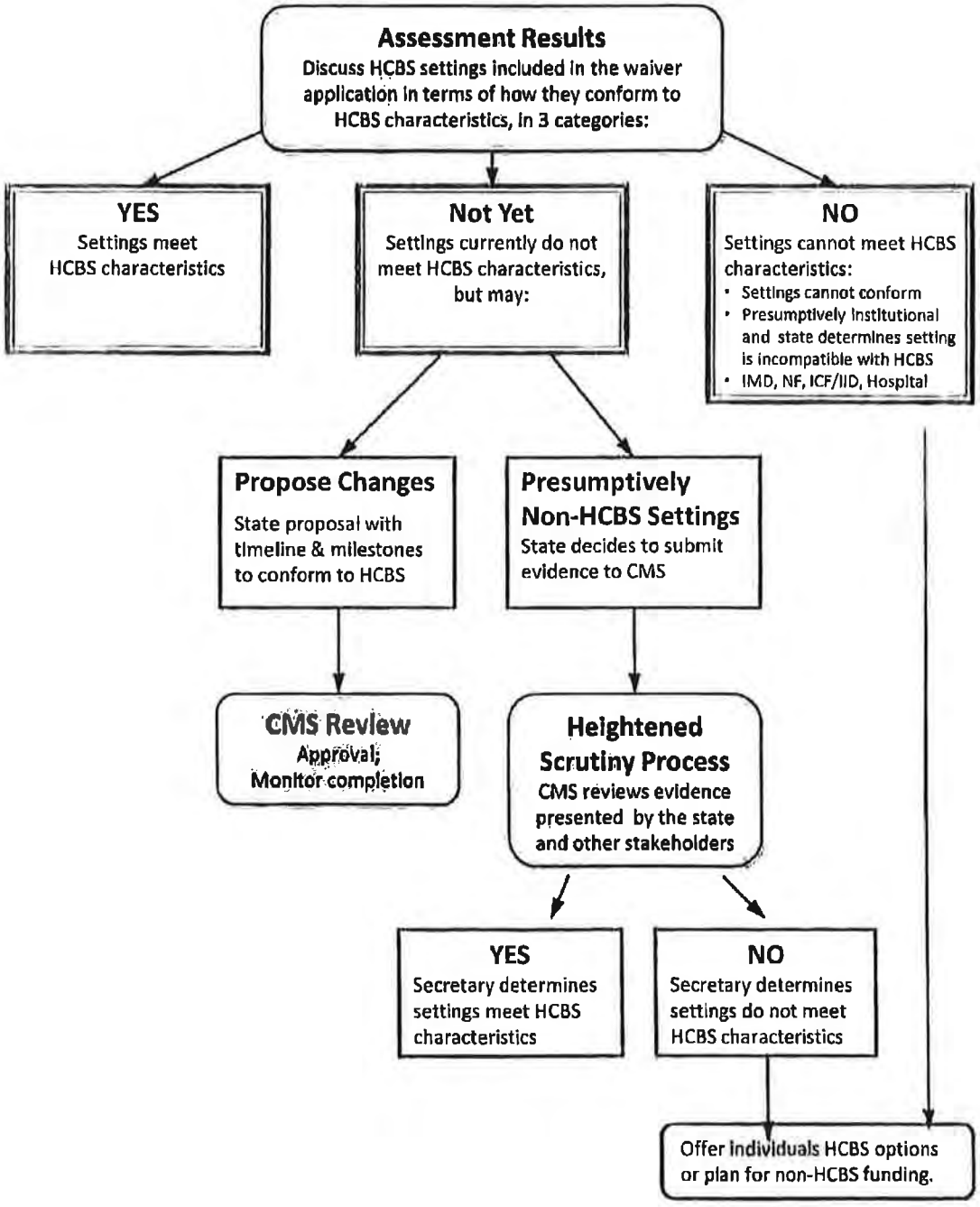
CMS wishes to ensure that states recognize the changes in the public notice and public input process required by this regulation. States must ensure the document is posted and, in the case of public forums, available or distributed for comment. States can use summary documents or offer explanations of 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

[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.

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.

STEPS TO COMPLIANCE FOR HCBS SETTINGS REQUIREMENTS IN A 1915(c) WAIVER and 1915(i) SPA



Exploratory Questions to Assist States in Assessment of Residential Settings

This optional tool is provided to assist states in assessing whether the characteristics of Medicaid Home and Community-based Services, as required by regulation, are present. The information is organized to cite anticipated characteristics and to provide suggested questions to determine if indicators of that characteristic are present.

Characteristics that are expected to be present in all home and community-based settings and associated traits that individuals in those settings might experience.

1. **The setting was selected by the individual.**
   - **Was the individual given a choice of available options regarding where to live/receive services?**
   - **Was the individual given opportunities to visit other settings?**
   - **Does the setting reflect the individual's needs and preferences?**
2. **The individual participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services.**
   - **Does the individual regularly access the community and is s/he able to describe how s/he accesses the community, who assists in facilitating the activity and where s/he goes?**
   - **Is the individual aware of or does s/he have access to materials to become aware of activities occurring outside of the setting?**
   - **Does the individual shop, attend religious services, schedule appointments, have lunch with family and friends, etc., in the community, as the individual chooses?**
   - **Does the individual come and go at any time?**
   - **Does the individual talk about activities occurring outside of the setting?**
3. **The individual is employed or active in the community outside of the setting.**
   - **Does the individual work in an integrated community setting?**
   - **If the individual would like to work, is there activity that ensures the option is pursued?**
   - **Does the individual participate regularly in meaningful non-work activities in integrated community settings for the period of time desired by the individual?**
4. **The individual has his/her own bedroom or shares a room with a roommate of choice.**
   - **Was the individual given a choice of a roommate?**
   - **Does the individual talk about his/her roommate(s) in a positive manner?**

- **Does the individual express a desire to remain in a room with his/her roommate?**
- **Do married couples share or not share a room by choice?**
- **Does the individual know how s/he can request a roommate change?**

5. **The individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.**
   - **How is it made clear that the individual is not required to adhere to a set schedule for waking, bathing, eating, exercising, activities, etc.?**
   - **Does the individual's schedule vary from others in the same setting?**
   - **Does the individual have access to such things as a television, radio, and leisure activities that interest him/her and can s/he schedule such activities at his/her convenience?**
6. **The individual controls his/her personal resources.**
   - **Does the individual have a checking or savings account or other means to control his/her funds?**
   - **Does the individual have access to his/her funds?**
   - **How is it made clear that the individual is not required to sign over his/her paychecks to the provider?**
7. **The individual chooses when and what to eat.**
   - **Does the individual have a meal at the time and place of his/her choosing?**
   - **Can the individual request an alternative meal if desired?**
   - **Are snacks accessible and available anytime?**
   - **Does the dining area afford dignity to the diners and are individuals not required to wear bibs or use disposable cutlery, plates and cups?**
8. **The individual chooses with whom to eat or to eat alone.**
   - **Is the individual required to sit at an assigned seat in a dining area?**
   - **Does the individual converse with others during meal times?**
   - **If the individual desires to eat privately, can s/he do so?**
9. **Individual choices are incorporated into the services and supports received.**
   - **Do Staff ask the individual about her/his needs and preferences?**
   - **Are individuals aware of how to make a service request?**
   - **Does the individual express satisfaction with the services being received?**
   - **Are requests for services and supports accommodated as opposed to ignored or denied?**
   - **Is individual choice facilitated in a manner that leaves the individual feeling empowered to make decisions?**
10. **The individual chooses from whom they receive services and supports.**
    - **Can the individual identify other providers who render the services s/he receives?**
    - **Does the individual expresses satisfaction with the provider selected or has s/he asked for a meeting to discuss a**

change?

- Does the individual know how and to whom to make a request for a new provider?

11. The individual has access to make private telephone calls/text/email at the individual's preference and convenience.
    - Does the individual have a private cell phone, computer or other personal communication device or have access to a telephone or other technology device to use for personal communication in private at any time?
    - Is the telephone or other technology device in a location that has space around it to ensure privacy?
    - Do individuals' rooms have a telephone jack, WI-FI or ETHERNET jack?
12. Individuals are free from coercion.
    - Is information about filing a complaint posted in an obvious location and in an understandable format?
    - Is the individual comfortable discussing concerns?
    - Does the individual know the person to contact or the process to make an anonymous complaint?
    - Can the individual file an anonymous complaint?
    - Do the individuals in the setting have different haircut/hairstyle and hair color?
13. The individual, or a person chosen by the individual, has an active role in the development and update of the individual's person-centered plan.
    - Is/are the individual/chosen representative(s) aware of how to schedule Person-Centered Planning meetings?
    - Can the individual explain the process to develop and update his/her plan?
    - Was the individual present during the last planning meeting?
    - Did/does the planning meeting occur at a time and place convenient for the individual to attend?
14. The setting does not isolate individuals from individuals not receiving Medicaid HCBS in the broader community.
    - Do individuals receiving HCBS live/receive services in a different area of the setting separate from individuals not receiving Medicaid HCBS?
    - Is the setting in the community among other private residences, retail businesses?
    - Is the community traffic pattern consistent around the setting (e.g. individuals do not cross the street when passing to avoid the setting)?
    - Do individuals on the street greet/acknowledge individuals receiving services when they encounter them?
    - Are visitors present?
    - Are visitors restricted to specified visiting hours?
    - Are visiting hours posted?
    - Is there evidence that visitors have been present at regular frequencies?
    - Are there restricted visitor's meeting area?
15. State laws, regulations, licensing requirements, or facility protocols or practices do not limit individuals' choices.

- **Do State regulations prohibit individuals' access to food at any time?**
- **Do State laws require restrictions such as posted visiting hours or schedules?**
- **Are individuals prohibited from engaging in legal activities?**

16. The setting is an environment that supports individual comfort, independence and preferences.

- **Do individuals have full access to typical facilities in a home such as a kitchen with cooking facilities, dining area, laundry, and comfortable seating in the shared areas?**
- **Is informal (written and oral) communication conducted in a language that the individual understands?**
- **Is assistance provided in private, as appropriate, when needed?**

17. The individual has unrestricted access in the setting.

- **Are there gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the setting?**
- **Are individuals receiving Medicaid Home and Community-Based services facilitated in accessing amenities such as a pool or gym used by others on-site?**
- **Is the setting physically accessible and there are no obstructions such as steps, lips in a doorway, narrow hallways, etc., limiting individuals' mobility in the setting or if they are present are there environmental adaptations such as a stair lift or elevator to ameliorate the obstruction?**

18. The physical environment meets the needs of those individuals who require supports.

- **For those individuals who need supports to move about the setting as they choose, are supports provided, such as grab bars, seats in the bathroom, ramps for wheel chairs, viable exits for emergencies, etc.?**
- **Are appliances accessible to individuals (e.g. the washer/dryer are front loading for individuals in wheelchairs)?**
- **Are tables and chairs at a convenient height and location so that individuals can access and use the furniture comfortably?**

19. Individuals have full access to the community.

- **Do individuals come and go at will?**
- **Are individuals moving about inside and outside the setting as opposed to sitting by the front door?**
- **Is there a curfew or other requirement for a scheduled return to the setting?**
- **Do individuals in the setting have access to public transportation?**
- **Are there bus stops nearby or are taxis available in the area?**
- **Is an accessible van available to transport individuals to appointments, shopping, etc.?**
- **Are bus and other public transportation schedules and telephone numbers posted in a convenient location?**
- **Is training in the use of public transportation facilitated?**
- **Where public transportation is limited, are other resources provided for the individual to access the broader**

community?

20. The individual's right to dignity and privacy is respected.

- **Is health information about individuals kept private?**
- **Are schedules of individuals for PT, OT, medications, restricted diet, etc., posted in a general open area for all to view?**
- **Are individuals, who need assistance with grooming, groomed as they desire?**
- **Are individuals' nails trimmed and clean?**

21. Individuals who need assistance to dress are dressed in their own clothes appropriate to the time of day and individual preferences.

- **Are individuals wearing bathrobes all day long?**
- **Are individuals dressed in clothes that fit, are clean, and are appropriate for the time of day, weather, and preferences?**

22. Staff communicates with individuals in a dignified manner.

- **Do individuals greet and chat with staff?**
- **Do staff converse with individuals in the setting while providing assistance and during the regular course of daily activities?**
- **Does staff talk to other staff about an individual(s) as if the individual was not present or within earshot of other persons living in the setting?**
- **Does staff address individuals in the manner in which the person would like to be addressed as opposed to routinely addressing individuals as 'hon' or 'sweetie'?**

Characteristics that are expected to be present in all provider owned or controlled home and community-based settings and associated traits that individuals in those settings might experience.

1. **Modifications of the setting requirements for an individual are supported by an assessed need and justified in the person-centered plan.**
    - **Does documentation note if positive interventions and supports were used prior to any plan modifications?**
    - **Are less intrusive methods of meeting the need that were tried initially documented?**
    - **Does the plan includes a description of the condition that is directly proportional to the assessed need, data to support ongoing effectiveness of the intervention, time limits for periodic reviews to determine the ongoing necessity of the modification, informed individual consent, and assurance that the intervention will not cause the individual harm?**

2. **Individuals have privacy in their sleeping space and toileting facility.**
    - **Is the furniture arranged as individuals prefer and does the arrangement assure privacy and comfort?**
    - **Can the individual close and lock the bedroom door?**
    - **Can the individual close and lock the bathroom door?**
    - **Do staff or other residents always knock and receive permission prior to entering a bedroom or bathroom?**
3. **The individual has privacy in his/her living space.**
    - **Are cameras present in the setting?**
    - **Is the furniture arranged as individuals prefer to assure privacy and comfort?**
    - **Do staff or other residents always knock and receive permission prior to entering an individual's living space?**
    - **Does staff only use a key to enter a living area or privacy space under limited circumstances agreed upon with the individual?**
4. **The individuals have comfortable places for private visits with family and friends.**
    - **Is the furniture arranged to support small group conversations?**
5. **Individuals furnish and decorate their sleeping and/or living units in the way that suits them.**
    - **Are the individuals' personal items, such as pictures, books, and memorabilia present and arranged as the individual desires?**
    - **Do the furniture, linens, and other household items reflect the individual's personal choices?**
    - **Do individuals' living areas reflect their interests and hobbies?**
6. **There is a legally enforceable agreement for the unit or dwelling where the individual resides.**
    - **Does the individual have a lease or, for settings in which landlord tenant laws do not apply, a written residency agreement?**
    - **Does the individual know his/her rights regarding housing and when s/he could be required to relocate?**
7. **Individuals are protected from eviction and afforded appeal rights in the same manner as all persons in the State who are not receiving Medicaid HCBS.**
    - **Do individuals know their rights regarding housing and when they could be required to relocate?**
    - **Do individuals know how to relocate and request new housing?**
    - **Does the written agreement include language that provides protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant laws?**

Attachment #11

From: Marty Omoto - CDCAN (CA Disability-Senior Community Action Network)<martyomoto@rcip.com>
To: <onoorzad@tri-counties.org>
Date: 10/20/2014 12:07 AM
Subject: CDCAN REPORT (OCT 19 2014): Stakeholder Call Oct 21 On Draft Statewide Transition Plan To Implement New Medicaid Home & Community-Based Services Regs

CDCAN Disability-Senior Rights Report: Important Public Stakeholder Conference Call Oct 21 Tue 10 AM to 12 Noon on Initial Draft Statewide Transition Plan by Dept Health Care Services To Implement Major New Federal Medicaid Home & Community-Based Services Regulations

CDCAN DISABILITY-SENIOR RIGHTS REPORT
CALIFORNIA DISABILITY-SENIOR COMMUNITY ACTION NETWORK
OCTOBER 19, 2014 – SUNDAY EVENING
Advocacy Without Borders: One Community – Accountability With Action
CDCAN Reports go out to over 65,000 people with disabilities, mental health needs, seniors, people with traumatic brain and other injuries, people with MS, Alzheimer's and other disorders, veterans with disabilities and mental health needs, families, workers, community organizations, facilities and advocacy groups including those in the Asian/Pacific Islander, Latino, American Indian, Indian, African-American communities; policymakers, and others across the State.
Sign up for these free reports by going to the CDCAN website. Website: www.cdcan.us (http://www.cdcan.us/)
To reply to THIS Report write:
Marty Omoto at martyomoto@rcip.com (mailto:martyomoto@rcip.com) or martyomoto@att.net (mailto:martyomoto@att.net) [new email - will eventually replace current martyomoto@rcip address]
Twitter: martyomoto
Office Line: 916-418-4745 CDCAN Cell Phone: 916-757-9549

STATE CAPITOL UPDATE:
FIRST OF TWO IMPORTANT PUBLIC STAKEHOLDER CONFERENCE CALLS SET FOR OCTOBER 21 TUESDAY FROM 10 AM TO 12 NOON ON INITIAL DRAFT STATEWIDE TRANSITION PLAN BY DEPARTMENT OF HEALTH CARE SERVICES TO IMPLEMENT MAJOR NEW FEDERAL MEDICAID HOME AND COMMUNITY-BASED SERVICES REGULATIONS
- New Federal Home and Community-Based Services Regulations Will Mean Sweeping Changes For Many Medicaid Home and Community-Based Services Programs Including Home and Community-Based Waiver Programs Impacting Hundreds of Thousands of Children and Adults with Developmental and other Disabilities, Mental Health Needs, the Blind, Seniors
- States Generally Have Up To 5 Years To Fully Comply From the March 2014 Date Regulations Went Into Effect – New Waivers Submitted Must Fully Comply Immediately
- Further Stakeholder Meetings On Individual Waivers Impacted by the New Federal Regulations To Be Scheduled By Departments Of Aging, Developmental Services, Public Health – Impact Could Be Enormous Especially To Site Based Programs & Residential Services

SACRAMENTO, CA [CDCAN LAST UPDATED 10/19/2014 – 09:30 PM] – The first of two important public stakeholder conference calls by the Department of Health Care Services is scheduled for October 21^st, Tuesday morning from 10:00 AM to 12 Noon, on California's initial draft Statewide Transition Plan to implement major new federal regulations requiring sweeping changes to several Medicaid funded special programs known as "Home and Community-Based Services" waivers, and options to a state's Medicaid Plan, that will impact a wide range of community-based services and programs serving hundreds of thousands of children and adults with disabilities – including developmental disabilities - mental health needs, the blind and seniors and hundreds of thousands of more people who provide supports and services through thousands of different provider organizations and agencies.
The call in number for the October 21^st public stakeholder conference call is: 888-829-8671 Participant passcode: 7335142
A PDF document copy (12 pages) of the Draft Statewide Transition Plan, dated September 19, 2014 can

be viewed or downloaded from the department's webpage on the regulation implementation (see below for links for other documents):
http://www.dhcs.ca.gov/services/ltc/Documents/HCBS_Statewide_Transition_Plan_9-19-14.pdf
The new federal Home and Community-Based Services regulations became effective March 17, 2014, and impacts Medicaid's 1915 (c) Home and Community-Based Services Waiver program, the 1915 (i) Home and Community-based State Plan Option, and the 1915(k) Community First Choice option (the numbers refer to various sections of the federal Medicaid laws that allows or authorizes a certain type of Home and Community-Based Service program).
The new regulations essentially redefine what home and community-based services are allowable for matching federal funding, though the states have up to five years from that date to comply with existing waivers, but must comply immediately for any new waivers submitted to the federal government.
The regulations include a requirement for the states to publicly release a statewide transition plan on how it will implement the federal regulations statewide and also requirements for the states to involve the public in the process. The initial Statewide Transition Plan released in September by the Department of Health Care Services and the resulting public comment periods and scheduled public stakeholder conference calls are meant to comply with that part of the new regulations.
The Centers and Medicare and Medicaid Services (CMS) – the federal agency that oversees nationwide both programs – said that the new federal regulations "...enhances the quality" of Medicaid funded Home and Community-Based Services and "...provides additional protections to...program participants", and "ensures" that individuals receiving services have "...full access to the benefits of community living."
Medicaid waivers are programs that provide additional services to specific groups of individuals, limit services to specific geographic areas of the state, and provide medical coverage to individuals who may not otherwise be eligible under Medicaid rules.
California has a number of Medicaid waivers or options to the state's Medicaid State Plan, that fund a wide range of programs, services and supports for children and adults with disabilities (including developmental), mental health needs, the blind and seniors – including services funded through the 21 non-profit regional centers, In-Home Operations Waiver , Nursing Facility/Acute Hospital Waiver, Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS) and more.

BIGGEST CHANGES TO CALIFORNIA'S MEDI-CAL PROGRAM SINCE 1965
Combined with major changes mandated by the federal Affordable Care Act, and implementation of the "Coordinated Care Initiative" in 8 counties that are shifting health care services and long term services and supports to Medi-Cal managed care plans, the new Medicaid Home and Community-Based regulations represent the biggest changes to California's Medi-Cal program since it was established in 1965.
These changes are in addition to other major changes impacting in many instances the same populations served and the same provider agencies and workers, including changes mandated by the US Department of Labor requiring overtime pay for most home care workers, including In-Home Supportive Services (IHSS) and Supported Living Services (SLS) and In-Home Respite services workers here in California beginning January 1, 2015; State minimum wage increases that went into effect July 1, 2014, with another scheduled for January 1, 2016, and further increases scheduled or coming in several local jurisdictions in the State; and new requirements from the new federal Workforce Innovation Opportunity Act that goes into effect July 2015;

HOW TO COMMENT ON THE DRAFT STATEWIDE TRANSITION PLAN
FIRST PUBLIC COMMENT PERIOD: The Department of Health Care Services is reviewing public comments on the initial draft Statewide Transition Plan received from the first public comment period (September 19^th through October 19, 2014), with the first of two public stakeholder conference call scheduled for October 21, 2014 (Tuesday) from 10:00 AM to 12:00 noon to receive additional comments and to also provide a brief overview of next steps and answer questions. The call in number is: 888-829-8671 Participant passcode: 7335142
SECOND PUBLIC COMMENT PERIOD: Follwing the October 21^st conference call, the Department of Health Care Services indicated that it will then post on its webpage a revised version that will be released by October 27^th, that will reflect changes and revisions including those from public comments received from the first public comment period and from the October 21^st conference call. Following the posting of that Revised Draft Statewide Transition Plan, the department will receive public comments from October

27, 2014 through November 26, 2014. That will be followed by a second public stakeholder call scheduled for December 2, 2014 (Tuesday) from 10:00 AM to 12:00 noon. The call in number is: 888-829-8671 Participant passcode: 7335142
WHERE TO SEND COMMENTS: Submit all comments to: STP@dhcs.ca.gov (mailto:STP@dhcs.ca.gov)

DEPARTMENT OF HEALTH CARE SERVICES RELEASED DRAFT STATE TRANSITION PLAN TO IMPLEMENT NEW REGULATIONS
As previously reported in September, the Department of Health Care Services, the agency that oversees State's massive Medicaid program called "Medi-Cal", - the largest in the nation - took an official step moving toward implementation, with the release on September 19th for public comment of a "Draft Statewide Transition Plan" – required by the federal regulations - that includes outlining the overall statewide process, what state departments are involved and what specific waivers and services are impacted.
A revised draft version of that Statewide Transition Plan will be released by the department after the October 21^st conference call, followed by another public comment period (see below for details) and a second public stakeholder conference call, scheduled for December 2^nd (see below for details). The department indicated that a summary of stakeholder public comments and minutes from the two public stakeholder conferences calls will be posted on the department's webpage with the revised drafts of the Statewide Transition Plan.
The Department of Health Care Services, after receiving and reviewing public comments from its initial and revised draft plans, intends to submit the final version to the federal Centers on Medicare and Medicaid Services (CMS) by December 20, 2014. The final Statewide Transition Plan will be posted on the department's webpage (see below for link).
The Department of Health Care Services said it has worked with and continues to work with "partner agencies", including the Department of Developmental Services (DDS), the California Department of Aging (CDA), the California Department of Public Health (CDPH), and others to develop the initial draft Statewide Transition Plan for public stakeholder input.
The State has been reviewing all impacted Medi-Cal waivers (1915(i) and 1915(c) Waiver services and provider-controlled residential settings) for compliance with the new federal requirements.
In addition to the specific stakeholder process for the Draft Statewide Transition Plan, the Department of Health Care Services, with the Departments of Aging, Developmental Services and Public Health, indicated that there will be in the coming weeks and months, also individual Home and Community Based Services Waiver transition plans – such as a plan specific for the Home and Community Based for Developmental Services that fund the majority of regional center funded services and supports for children and adults with developmental disabilities - that will be drafted, with each having an additional public stakeholder input processes. No draft plans or specific dates for meetings or conference calls have yet been officially announced yet.

WHAT ARE THE NEW FEDERAL REGULATIONS?
[CDCAN Note: Certain exceptions to some of the requirements, especially those regarding residential services could be permitted under the person centered planning process, though those specific exceptions, clarifications, and implementation questions (from both people receiving services and people providing them) should be addressed during the various waiver stakeholder process. CDCAN will send out information as any new guidance or information regarding the new regulations from the Department of Health Care Services (or other departments) or from the Centers on Medicare and Medicaid Services (CMS) becomes available].
The new federal regulations specifies that service planning for participants in Medicaid Home and Community Based Services Waiver program must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The federal regulations require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences.

The federal regulations established new requirements for the qualities of settings that are eligible for reimbursement under the Medicaid Home and Community-Based Services Waivers that require home and community based settings that are based on the experience and outcomes of individuals under person center planning rather than physical or other characteristics of a particular setting.
Specifically, the federal regulations requires that all home and community-based settings must:
- Be integrated in and support full access to the greater community;
- Be selected by the individual from among setting options;
- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimize autonomy and independence in making life choices; and
- Facilitate choice regarding services and who provides them

The federal regulations also include additional requirements for settings in where the community-based provider funded under a Medicaid Home and Community Services Waiver also owns or operates the residence of the individual who receives services under the waiver. In these settings, an individual who receives services under the waiver must:
- Have a lease or other legally enforceable agreement providing similar protections;
- Have privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- Control his/her own schedule including access to food at any time;
- Be able to have visitors at any time; and
- Have a setting that is physically accessible.

The federal regulations also defines other settings presumed to have institutional qualities that would not be in compliance with the home and community based services setting requirement, including any setting that has the effect, according to the Centers on Medicare and Medicaid Services of "...discouraging integration of individuals...from the broader community of individuals not receiving such services". Should states decide to include any of these other settings in their Medicaid HCBS programs, CMS will exercise "heightened scrutiny," meaning the state must demonstrate, via a process that includes public input, that the setting does not have the qualities of an institution and does have the qualities of a community based setting as defined and allowed in the new regulations. The federal regulations also clarifies that the home and community-based setting requirements apply to non-residential settings where home and community based services are delivered such as day programs and pre-vocational training settings.
While the new federal regulations tightens requirements for the states it also includes changes to make it easier for states to access Medicaid funds for home and community-based care including giving the states the option to combine under a single waiver, coverage for several different populations currently covered under separate waivers.

LINKS FOR MORE INFORMATION ABOUT THE FEDERAL REGULATIONS
INITIAL DRAFT STATE TRANSITION PLAN (DATED SEPTEMBER 19, 2014) – PDF DOCUMENT COPY (12 PAGES) FROM DEPARTMENT OF HEALTH CARE SERVICES WEBPAGE:
http://www.dhcs.ca.gov/services/ltc/Documents/HCBS_Statewide_Transition_Plan_9-19-14.pdf
WEBPAGES ON THE REGULATIONS:
WEBPAGE OF DEPARTMENT OF HEALTH CARE SERVICES HOME & COMMUNITY BASED SERVICES (HCBS) STATEWIDE TRANSITION PLAN:
http://www.dhcs.ca.gov/services/ltc/Pages/HCBSStatewideTransitionPlan.aspx
WEBPAGE OF CENTERS ON MEDICARE AND MEDICAID SERVICES HOME AND COMMUNITY BASE SERVICES:
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
ACTUAL FEDERAL REGULATION:
Final Federal Regulations from Federal Register on Medicaid Home and Community Based Services (January 16, 2014) - PDF Document Copy (93 Pages):
http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf
PRESENTATION, FACT SHEETS, Q&A, INFORMATIONAL BULLETINS FROM CMS:
Presentation (Slides) by Centers on Medicare and Medicaid Services of the new regulations (January 29, 2014) – PDF Document Copy (59 pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-

Supports/Home-and-Community-Based-Services/Downloads/Final-Rule-Slides-01292014.pdf
Overview of the Final Rule (Fact Sheet) from Centers on Medicare and Medicaid Services (January 10, 2014) – PDF Document Copy (3 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/final-rule-fact-sheet.pdf
Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule (January 10, 2014) - PDF Document Copy (3 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/1915c-Fact-Sheet.pdf
Fact Sheet: Summary of Key Provisions of the Final Rule for 1915(i) Home and Community-Based Services (HCBS) State Plan Option (January 10, 2014) - PDF Document Copy (2 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/1915i-fact-sheet.pdf
Summary of Key Provisions of the Home and Community Based Services Settings from the Centers on Medicare and Medicaid Services (January 10, 2014) – PDF Document Copy (4 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/HCBS-setting-fact-sheet.pdf
Informational Bulletin on Final Rule by Centers on Medicare and Medicaid Services (January 10, 2014) - PDF Document Copy (53 Pages):
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-10-14.pdf
Questions and Answers on the Final Rule from Centers on Medicare and Medicaid Services (January 10, 2014) – PDF Document Copy (5 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Final-Q-and-A.pdf
SETTINGS REQUIREMENTS, TOOLKITS & GUIDANCES FROM CMS:
Document Showing Outline of Heightened Scrutiny Process by Centers on Medicare and Medicaid Services (no date) - PDF Document Copy (1 Page):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Heightened-Scrutiny.pdf
Graph of Steps To Compliance For HCBS Settings Requirements In A 1915(C) Waiver And 1915(I) State Plan Amendment (SPA) from Centers on Medicare and Medicaid Services (no date) - PDF Document Copy (1 Page):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/HCBS-1915c-waiver-compliance-flowchart.pdf
Statewide Transition Plan Toolkit for Alignment with the Home and Community-Based Services (HCBS) Final Regulation's Setting Requirements (September 5, 2014) – from Centers on Medicare and Medicaid Services - PDF Document Copy (7 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Statewide-Transition-Plan-Toolkit-.pdf
Regulatory Requirements for Home and Community-Based Settings of those that comply and those settings that are excluded from Centers on Medicare and Medicaid Services -PDF Document Copy (3 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Requirements-for-Home-and-Community-Settings.pdf
Additional Technical Guidance On Regulatory Language Regarding Settings That Isolate from Centers on Medicare and Medicaid Services – PDF Document Copy (3 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Settings-that-isolate.pdf
Exploratory Questions to Assist States in Assessment of Residential Settings from Centers on Medicare and Medicaid Services - PDF Document Copy (6 Pages):
http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Downloads/Exploratory-questions-re-settings-characteristics.pdf

CDCAN/MARTY OMOTO YOUTUBE CHANNEL
A CDCAN (Marty Omoto) youtube channel was set up and has several videos dealing with current – and previous state budget issues, disability and senior rights, and advocacy.
To see the current videos, including March 2014 San Andreas Regional Center Aptos Legislative Breakfast, January 2014 panel discussion on services for adults with autism spectrum and related disorders in Palo Alto, and older videos including video of April 2003 march of over 3,000 people with developmental disabilities, families, providers, regional centers and others from the Sacramento Convention Center to the State Capitol (to attend and testify at budget hearing on proposed massive permanent cuts to regional center funded services, go to the CDCAN (Marty Omoto) Channel at:
https://www.youtube.com/channel/UCEySEyhnr9LQRiCe-F7ELhg
More videos – including new current videos (an interview with long time advocate Maggie Dee Dowling is planned, among others) – plus archive videos of past events – will be posted soon.

Photo of Marty Omoto PLEASE HELP!!!!!!
SUNDAY EVENING - OCTOBER 19, 2014
HELP CDCAN CONTINUE ITS WORK
CDCAN Townhall Telemeetings, CDCAN Reports and Alerts and other activities cannot continue without YOUR help. To continue the CDCAN website and the CDCAN Reports and Alerts sent out and read by over 65,000 people and organizations, policy makers and media across the State, and to continue and resume CDCAN Townhall Telemeetings, trainings and other events, please send your contribution/donation (please make check payable to "CDCAN" or "California Disability Community Action Network" and mail to:
CDCAN – NEW MAILING ADDRESS:
1500 West El Camino Avenue Suite 499
Sacramento, CA 95833
[replaces 1225 8th Street Suite 480, Sacramento, CA 95814]
Office Line: 916-418-4745 CDCAN Cell Phone: 916-757-9549 (replaced 916-212-0237)

Many, many thanks to all the organizations and individuals for their continued support that make these reports and other CDCAN efforts possible!

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Our mailing address is:
Marty Omoto - ** martyomoto@rcip.com (mailto:martyomoto@rcip.com)

ARCA ASSOCIATION OF REGIONAL CENTER AGENCIES
915 L Street, Suite 1440, Sacramento, California 95814 • 916.446.7961 • Fax: 916.446.6912 • www.arcanet.org

October 18, 2014

Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 95814

RE: Draft Statewide Transition Plan for Home and Community-Based Services (HCBS)

To Whom It May Concern:

The Association of Regional Center Agencies (ARCA) represents the state's community-based network of regional centers which serves over 270,000 individuals with developmental disabilities, including more than 100,000 individuals receiving services funded through the HCBS Waiver for Persons with Developmental Disabilities and thousands more receiving services funded in part through the 1915(i) state plan amendment. ARCA appreciates the opportunity to comment on the proposed STP, which once approved by the Centers for Medicare and Medicaid Services (CMS), will serve as California's roadmap to ensuring continued federal financial participation for vital community support services.

ARCA recommends the following modifications to the proposed Statewide Transition Plan in order to best capitalize on the limited time that the state is being given to make significant policy and programmatic changes:

- This document provides an outline of the process that will be used to evaluate residential settings funded under 1915(c) waivers and 1915(i) state plan amendments. California also needs to develop a process to determine which non-residential services will continue to qualify for federal funding. While CMS has not issued specific guidance for non-residential settings, federal standards established by the 1999 United States Supreme Court Olmstead decision and recent Department of Justice enforcement sets clear expectations. Delaying addressing this issue shortens the timeframe to make any needed changes to programs as all programs must be compliant with the new CMS rules no later than March 17, 2019.

- Recent CMS guidance indicates that states should make initial assessments about whether they believe each service meets the new expectations, cannot meet the new expectations, or can meet the new expectations with modifications. Making these initial "cuts" would help the state to determine how best to spend its energy moving forward.

- Timelines for the completion of modifications to state regulations and the development of evaluation tools must be aggressive to allow as much time as possible for the difficult task of service modification.

- In order to get the clearest sense of the total landscape, all providers whose services the state anticipates will or could meet the new standards should complete the self-assessment tool that is developed. Guidance from CMS indicates that confirming visits to a statistically significant number of sites should also occur. ARCA would recommend that each site visit team be comprised of at least one professional and one service recipient or family member with specialized knowledge of that specific service system. For instance, for services under the HCBS Waiver for Persons with Developmental Disabilities, service provider and regional center staff should be included in each review team. This is consistent with current practice.

- Under the HCBS Waiver for Persons with Developmental Disabilities the development of assessment tools, evaluation of service settings, program redesign, and supporting individuals through service transitions will require a tremendous amount of time and energy on the part of service provider and regional center staff alike. The state must commit sufficient resources to make this process smooth and seamless for individuals with developmental disabilities who rely on these services to enable them to live rich lives in the community.

- California must make a separate policy decision about whether it will continue to fund services that will become ineligible for federal funding after March 2019. This is a complex decision that often involves long-term relationships between individuals and service providers. If California decides to transition current services to new service models, there must be a commitment of sufficient financial and technical assistance resources to make this possible.

Thank you for the opportunity to provide comment. The CMS HCBS Final Rules provide an exciting opportunity to increase community integration for thousands of individuals. While we look forward to this final outcome, California's Statewide Transition Plan should be reflective of the hard work that it will take for our service systems to get there. Should you have any questions regarding these suggestions, please don't hesitate to contact Amy Westling in our office at awestling@arcanet.org or (916) 446-7961.

Sincerely,
/s/
Eileen Richey
Executive Director

Cc: Santi Rogers, Director, Department of Developmental Services

October 20, 2014

Toby Douglas, Director
Department of Health Care Services
Sacramento, CA

Re: Comments on California HCBS Statewide Transition Plan

Dear Director Douglas:

Thank you for the opportunity to comment on California's draft statewide transition plan for complying with the new Medicaid home and community-based services (HCBS) regulations.

Below, please find our joint comments on the draft plan. We hope to meet with your staff to discuss the draft and our suggestions for the transition plan. Please contact Eric Carlson ((213) 674-2813; ECarlson@nsclc.org) with questions and to set up a time to discuss.

Sincerely,

The Arc of California
California Foundation for Independent Living Centers
Disability Rights California
Disability Rights Education & Defense Fund
National Health Law Program
National Senior Citizens Law Center

Draft Transition Plan Comments from The Arc of California, California Foundation for Independent Living Centers, Disability Rights California, Disability Rights Education & Defense Fund, National Health Law Program, and National Senior Citizens Law Center:

Thank you for the opportunity to comment on California's draft statewide transition plan for complying with the new Medicaid home and community-based services (HCBS) regulations. We believe strongly in the principles behind the regulations — that HCB settings are truly community based and participants enjoy respect and freedom of choice in HCBS programs. After reviewing the draft, we conclude that the plan is, at this point, primarily a proposal for the Department's future development of a draft plan. Moreover, the current document offers stakeholders an opportunity to comment on those components that are contained in the draft framework, but not on the underlying assumptions and process behind the draft.

We would like to ask the Department to take a step back and adopt an inclusive stakeholder approach that mirrors the CMS final rule, which places the person-centered planning process at the heart of how HCB settings should be evaluated. Stakeholder involvement, and consumer input in particular, must play an originating and not merely validating role in the planning process. The new Medicaid HCBS regulations mark a sea change for HCB settings. An adequate transition plan must first take full account of how current HCB residents and consumers experience community inclusion and freedom of choice, in order to plan for the regulatory changes and implementation strategies needed for compliance with the new rules. The single best source of consumer experience are the consumers. As consumer and advocacy organizations, we would like the opportunity to work closely with the Department and our constituents to envision a new roadmap forward on developing and finalizing California's HCBS transition plan.

We appreciate the Department initiating the process for complying with the rule. Our comments focus on two parts:

Part 1: Framework Recommendations for Draft Transition Plan

Part 2: Essential Elements to Include in Transition Plan

We look forward to working with the Department to ensure that the regulations' promise is realized.

PART 1: FRAMEWORK RECOMMENDATIONS FOR DRAFT TRANSITION PLAN

I) Adopt A Realistic Timeline That Allows For Necessary Consideration Of Stakeholder Input

The current framework is incomplete. A one month comment period on a general framework is insufficient to conduct the outreach and assessment required of a draft transition plan. As indicated by our subsequent comments, we believe the State has yet to develop a draft plan, and the development of a draft plan cannot possibly be complete by the limited period of time currently allocated by the Department. Instead, we propose that stakeholders, including consumers of the services at issue, be included in the development of the transition plan. The transition plan should set realistic timelines for completion of certain activities, along with benchmarks for incremental changes so that consumers do not have to wait until the final product to realize the benefits of the new regulations.

We understand that the Department is working under a 120-day time frame set by the regulations, but also observe that, in practice, CMS and the states are operating under timelines in which transition decisions will be made long after the expiration of the 120-day deadline. In most states — arguably, in all states — the "transition plan" is in reality a work plan that contemplates that most substantive decisions regarding transition will be made months or years after approval of the "transition plan."

Under Georgia's proposed transition plan, for example, the state proposes to develop a "transition plan package" over the 18 months concluding at the end of 2015. Colorado's proposed transition plan, similarly, contemplates that many important activities will not *begin* until 2015 or 2016. In most cases, for example, the work to revise the Colorado HCBS waiver applications or relevant state regulations will not begin until November 2015; likewise, development of a model lease will not begin until January 2016.

In California itself, according to the Department's proposed transition plan, many important decisions regarding transition are not scheduled to be made until 2015 or later. For example, the Department has proposed a deadline of six months after CMS approval of the transition plan for "initial State-level assessment of standards, rules, regulations, and other requirements," and development both of an assessment tool and a provider appeal process.

The reality is, as CMS and the states are experiencing, that development of a comprehensive transition plan is a process requiring multiple years. Given that long time frame, and the importance of starting with a solid work plan, it is unwise for the Department to build a transition plan on this very general framework and only allow one week for consideration of stakeholder feedback, prior to the scheduled release of a second draft on or about October 27.

The HCBS regulations were released and therefore known on January 16, 2014, and the Department thus had several months to solicit stakeholder input generally, and develop a collaborative transition plan, prior to September 19. The Department's inability to do so should not deprive stakeholders of a meaningful draft HCBS plan, with a realistic opportunity to have input considered for the next iteration.

The current process for stakeholder input, and the failure to include clear opportunities for such input in the proposed plan, cannot be considered to be "sufficient in light of the scope of the changes proposed, to ensure meaningful opportunities for input for individuals serviced, or eligible to be served, in the waiver," as is required.[1]

For all these reasons, we request that the Department modify its current framework and allow the time and resources necessary to develop a draft transition plan. If necessary, we suggest that the Department request from CMS a reasonable extension of the 120-day time frame. It is in the interests of stakeholders, the Department, CMS, and particularly Medi-Cal HCBS participants, that the Department have a realistic opportunity to

[1] 42 C.F.R. § 441.304(f)(1)

develop a plan that has built-in opportunities for stakeholder involvement and formal feedback.

II) Develop A Plan Based On Robust Stakeholder Outreach And Feedback

As the state develops the draft transition plan, we have several recommendations for seeking stakeholder feedback. First, accepting comments only by email is not as effective as reaching out to consumers directly to solicit input directly from consumers in other ways, including, minimally, providing a mailing address for comments. Given the challenges of electronic communication (requires literacy, consumers often need their providers to help which may chill their honest input, requires access to a computer and computer literacy), we fear that the Department is missing an important opportunity to hear directly from consumers. On October 2, we wrote to you encouraging you to attend the October 9-10 Supported Life Conference, where several hundred people with developmental disabilities would be in attendance. We also encouraged you to reach out to consumer groups such as CFILC, SILC, and People First groups in the state to work collaboratively to obtain the most robust consumer input possible. We hope that you are working on how to best solicit and consider consumer input, which should include in-person, individual and small group opportunities to share their personal experiences.

Moreover, we encourage you to increase consumer involvement in the following additional ways:

1) Educate participants about their rights to fully integrated settings so that they may provide meaningful feedback on their own experiences. This information is crucial to the State's compliance in the short and long term. Other states' plans include participant education. Georgia's plan, for example, provides for stakeholder training and education from September 2014 through April of 2015 to make sure that individual HCBS participants, their families, and similarly situated stakeholders will understand changes they can expect to see and which will affect services.

2) Ensure that the assessment teams that are described in the draft transition plan always include consumer representation and meaningful consumer participation.

3) Develop a means for consumers to participate in their own self-assessment of the settings in which they live or spend their days. Participant assessments must be accessible to the individual, free from provider influence, and part of the assessment validation process. We do not believe that provider self-assessment is at all adequate to determine compliance with the HCBS regulations.

III) Use Person-Centered Planning to Inform Consumers, Approach Compliance, and Gather Information About Settings

Person centered planning requirements in the HCBS regulations are currently in effect. Under those requirements, consumers' planning processes should comprehensively evaluate their current settings to determine if they comply with the HCBS regulations. To do so, the teams should consider whether the settings where consumers reside and spend their days are community-based, are the most integrated setting appropriate to their needs, whether they have sufficient supports for the most appropriate setting, and whether changes need to be made to their plans. If needed to address the address the issues above, the consumer's person-centered plan should identify whether a new setting and/or new supports are needed, what can be done immediately, tasks and assignees, and a timeline that will redress the issues as quickly as possible.

In addition, the person centered planning provides opportunities for information gathering about consumers' experiences in their current settings and their preferred settings; this information will help identify compliance issues and help ensure the Department has a proper array of HCB services and settings. This should be a priority issue.

IV) Involving Other State Departments In Developing The Draft Transition Plan And Ongoing Review

We are reassured by the draft's initial identification of the California Department of Public Health (CDPH), the Department of Developmental

Services (DDS), and the California Department of Aging (CDA) as members of the state's current HCB program administrative teams. Given the importance of these state partners during the transition period, and especially for the purposes of regulatory review and ongoing licensing and monitoring of HCB settings, they require an explicit role within the transition plan itself. CMS' new HCBS rule involves not only a transition for HCB settings and providers, but also for the state departments and on-the-ground personnel who will be responsible for administering the rule within California. All departments that have responsibility for the review, licensing and assessment of HCB settings, and who work with HCBS program consumers, will have expertise and best practices to share, as well as the capacity to take on specific responsibilities during and after the transition period. The State entities identified should also include those collaborating or partnership entities, such as for housing and employment, where they will be part of implementing services or where they have information that will aid in a smooth, complete implementation of true community services.

The particular ongoing involvement of the Department of Social Services (DSS) and DDS with certain HCB settings also should be included in the State's plans to monitor settings for compliance. As we explain below, establishing settings' compliance should not be a one-time activity; to best protect Medi-Cal HCBS participants, they must have access to a mechanism that can investigate complaints and compel compliance. Because DSS has a preexisting duty to monitor the settings that it licenses, and DDS performs quality assurance reviews, these departments are well-equipped to include compliance with the HCBS regulations as a component of their ongoing interactions with owners and operations of HCB settings.

Other states' transition plans have included the relevant licensing agencies. In Georgia, for example, the transition plan includes the Healthcare Facility Regulation Division of Georgia's Department of Community Health. Under the plan, Georgia intends to review licensing standards, consider potential changes to licensure regulations, and implement a plan to achieve provider compliance with licensure standards. Colorado's transition plan similarly includes Colorado's Department of Public Health and Environment. One section of Colorado's transition plan addresses "Modifications to Licensure and Certification Rules and Operations." California should take a similar approach and involve both DDS and DSS in this process.

PART 2: ELEMENTS TO INCLUDE IN THE DRAFT TRANSITION PLAN

We urge the Department to incorporate our recommendations in developing the Transition Plan. In addition to our process recommendations above, we offer suggestions of substantive elements the Department should address as it develops the draft transition plan. Based on a review of other states' plans, we believe the draft transition plan should not only identify issues and action items, but should indicate the expected start and end dates, a description of the activity, the State agencies and departments responsible, stakeholder groups involved, and the expected outcome. While not an exhaustive list, here are key issue areas that must be addressed in the draft transition plan:

ISSUE AREA	DESCRIPTION
Identification of Stakeholder Involvement	Clear identification of stakeholder involvement, including when and how stakeholders will be involved in development, when there will be opportunities for comment, and other opportunities for participation. Processes that need feedback loops, such as assessments of providers, will be clearly identified. Specific processes for robust consumer involvement, including individual and group interviews and focus groups, must be included, as well as consumer self-assessment of their living arrangements and day programs.
Identification of HCBS Providers	Including site information and category of service provided. Provided to the public, this information will allow the Department to gather information about the settings.
Address Non-Residential Settings	That CMS has yet to provide specific guidance regarding non-residential settings does not absolve the state from its obligation to include non-residential settings in the compliance determination process. Forthcoming CMS guidance will not alter the fact that the regulations apply to all HCBS settings, including non-residential settings. Gathering information from the public and stakeholders on this issue, evaluating rules of

	such settings, and doing an inventory of non-residential settings will give the departments an informed basis for action when forthcoming CMS guidance is issued.
Identify Settings that are Presumptively Institutional	Prioritize types and specific settings—both residential and non-residential-- that are "presumptively institutional" to share with the public for input and comment. Evaluate rules and policies related to such settings, including provider qualifications, on an expedited basis.
Prioritize Assessments for Settings Presumed Institutional	Prioritize individual assessments of programs and facilities that are identified as presumptively institutional. This will allow the Department to take speedy steps to come into compliance with the HCBS regulations. A plan for compliance must provide for opportunities for stakeholder input and must focus on participant experience and access to the community. This would include evaluating individual placement in such settings pursuant to the person-centered planning process, and making any appropriate adjustments toward increasing community integration. Such process must incorporate such elements as the individual's wishes and goals, medical opinion, and a review of HCBS options.
Individual Transition Plans for Consumers	The Department must identify a timeline for developing a process to help consumers who may need to transition to different services. This timeline must coincide with provider review such that consumers are not losing service providers before a process is available to help them smoothly transition to new services or providers. The transition plan for HCBS must ensure stability for individual consumers and not decrease their community interaction.
Appeals of Determination that a Setting Is/Is Not HCB Compliant; Individual Consumer Appeals	In addition to the provider appeal described in the draft transition plan, in which a provider may appeal a determination that a setting is not HCBS regulation-complaint, consumers should have the opportunity to appeal a determination that a setting is HCBS regulation-compliant. In addition, a specific process needs to be developed so there is an individual appeal process available for consumers whose

	planning teams determine that they should remain in or leave a presumptively institutional setting, as well as for consumers who are determined to not have the supports they need to move to a more integrated setting.
Comprehensive Assessment Process Conducted by an Independent Third Party	Comprehensive assessment process for all settings that provide HCBS, including residential and non-residential settings. The on-site evaluation process is a critical component of a comprehensive assessment, and cannot be administered only on a representative random sampling basis. Stakeholders must be involved in the development and implementation of the assessment process, including active and meaningful participation by consumers. This assessment process should be completed by an independent third party. If it is not completed by a third party, the process must include a system to verify the assessment tool and a sampling process that will test the veracity of the assessment process. Assessments must rely on information from participants and family members. Assessments that rely solely on providers will not reliable given that the focus is on the experience of the residents/participants. Any independent sampling process must be driven by, and include, input from consumers and stakeholders.
Transparency in Classification of Settings	Classification of settings as community or non-community must be transparent. Because the focus of the HCBS regulations is on the individual's experience, any appeal process for settings determined to not meet the HCBS standards must include information from the residents or participants and be sufficiently transparent so that stakeholders/HCBS participants can provide information about the setting.
Stakeholder Education	HCBS participants, family members, providers, and community members must be educated about the transition process, what is changing, and the opportunities for involvement. As the process goes on, education and opportunities for feedback must continue. Education is not

	only for the early stages, but is critically important when the Department begins determining what needs to change and the processes developed for compliance.
Review of Provider Policies	Review of provider policies, including enrollment and applications. All sources of standards for providers of HCBS must be evaluated for necessary changes to enforce compliance with HCBS standards. This would include administrative rules, policies, credentialing, licensing policies, required trainings, enrollment forms, compliance processes and reviews, and other provider resources. This identification process and subsequent changes should involve stakeholders.
Ongoing Monitoring and Compliance	Identification, revision, and creation of necessary policies and procedures to address monitoring and compliance during and after the transition period. Compliance with HCBS regulations will be ongoing and the Department must develop a mechanism to receive and act on complaints during the transition period itself as well as in 2019 and beyond. Participants must be able to submit complaints regarding settings, have those complaints investigated, and receive resolution of the issue where there is evidence of fundamental systemic or individual violations such as a lack of choice in roommates, access to food, schedules, visitors, or means of effective communication. This complaint process must go outside of the setting. There must also be a system that requests information regarding participant satisfaction, possibly incorporated into the person centered planning process so as to avoid conflict of interest issues and allow for an examination of other options. Compliance monitoring may incorporate provider recertification, service coordination activities, and more.
Plan for System-Wide Compliance	The Department should require that HCBS settings honor the new HCBS standards regardless of a participant's source of payment (including private payment and non-HCB Medicaid payment). A contrary interpretation would condone payment-

	source discrimination that would be contrary to both the letter and the spirit of the new regulations.
Updates and Communication Plan	The Department should develop a communication plan that identifies stakeholders and appropriate education mechanisms to reach stakeholders. A communication plan should clearly lay out when the transition plan will be updated and that justification for changes will be provided. The Department may consider setting regular intervals for plan updates to continue stakeholder engagement.
Accessibility of Transition Planning and HCB Settings	It is critical that both the stakeholder input process be made accessible to people with sensory impairments, and that the assessment process consider accessibility (physical, sensory, and programmatic) as a key issue.

Attachment #14

Tri-Counties Association for the Developmentally Disabled
VENDOR ADVISORY COMMITTEE

CMS FINAL RULE TASK FORCE COMMITTEE AGENDA
Thursday, November 6, 2014 / 9:00AM – 10:00AM

TCRC Annex (Across the street from TCRC at 520 E. Montecito St., SB)
Video conferencing available at the San Luis Obispo and Oxford offices of TCRC
(Call for directions: SLO 543-2833; Oxnard 485-3177)

CONFERENCE CALLING NUMBER: 1-877-262-0913 – Conference ID: 5802721#

AGENDA

9:00am	Review of information provided by ARCA and the Autistic Self Advocacy Network • CMS HCBS Final Rule and Implications for California • Guide for Advocates and Families
9:20am	Debrief of DHCS Stakeholder call
9:35am	Discussion-Next Steps
9:50am	Transformation Institute Conference reminder
10:00am	Adjourn

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

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

CMCS Informational Bulletin

DATE: July 7, 2014

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services

SUBJECT: **Clarification of Medicaid Coverage of Services to Children with Autism**

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

Background

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD. [1]

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine. [2] While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)[3]. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

[1] http://www.cdc.gov/ncbddd/autism/facts.html
[2] http://www.cdc.gov/ncbddd/autism/treatment.html
[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

State Plan Authorities

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such state-wideness and comparability must also be met.

Other Licensed Practitioner Services

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider's qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state's Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state's Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

Preventive Services

Preventive Services, defined at 42 CFR 440.130(c) are "services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency"

A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long at the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include

but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child's needs; that is, all services that can be covered under section 1905(a), including licensed practitioners' services; speech, occupational,

and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to AutismServicesQuestions@cms.hhs.gov.

STATE PLAN CHART

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c	Preventive services (cont) Behavioral Health Treatment (BHT)	Covered as medically necessary services based upon a written prescription of a licensed physician or psychologist for Applied Behavioral Analysis (ABA) Therapy, to develop or restore, to the maximum extent practicable, the functioning of an individual with a diagnosis of Autism Spectrum Disorder (ASD). Under this state plan only for the following beneficiaries: infants, children and adolescents age 0 to 21, who are an eligible beneficiary of the EPSDT program, that exhibit excesses or deficits of behaviors that significantly interfere with home and community services. Individuals must have a comprehensive diagnostic evaluation that indicates ABA-based therapy services are medically necessary and recognized as therapeutically appropriate.	ABA-based therapy services require prior authorization for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for reimbursement except in the case of retroactive Medi-Cal eligibility. Services must be provided under a treatment plan developed and approved by a "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3), treatment maybe administered by one of the following: 1. A qualified autism service provider. 2. A qualified autism service professional supervised and employed by the qualified autism services provider. 3. A qualified autism service paraprofessional supervised and employed by a qualified autism service provider. ABA-based therapy services shall be rendered in accordance with the individual's treatment plan. The treatment plan shall: 1. Be person-centered and based upon individualized goals over a specific timeline; 2. Be developed and approved by the qualified autism service provider for the patient being treated; 3. Delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors; 4. Identify long, intermediate, and short-term goals and objectives that are behaviorally defined; 5. Identify the criteria that will be used to measure achievement of behavior objectives; 6. Have objectives that are specific, measurable,

* Prior authorization is not required for emergency service.
* *Coverage is limited to medically necessary services

TN No. 14-026
Supersedes TN No. NONE

Approval Date: _____

Effective Date: 7/1/2014

STATE PLAN CHART

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c	Preventive services (cont) Behavioral Health Treatment (BHT)		based upon clinical observations, utilize evidence-based practices with demonstrated clinical efficacy, in treating ASD, include outcome measurement assessment, and are tailored to the individual; 7. Ensure that interventions are consistent with ABA techniques; 8. Clearly identify the service type, number of hours, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at which the individual's progress is reported, and the individual providers responsible for delivering the services; 9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and 10. Include parent/caregiver training, support and participation.

* Prior authorization is not required for emergency service.
**Coverage is limited to medically necessary services

Attachment #17

DHCS
TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

DATE:

All Plan Letter 14-xxx

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: INTERIM POLICY FOR THE PROVISION OF BEHAVIORAL HEALTH TREATMENT (BHT) COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with interim policy guidance for providing BHT services to Medi-Cal children and adolescent beneficiaries 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

BACKGROUND:
ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called Autism Spectrum Disorder. Currently, the Centers for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine. While much of the current national BHT discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD.

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT services pursuant section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Section 1905(r) of the Act defines the EPSDT benefit to

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include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to provide coverage to individuals eligible for the EPSDT benefit for any Medicaid covered service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to ensure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible.

All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and avoiding the assumption that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to ensure children receive the health care they need, when they need it.

The Department of Health Care Services (DHCS) intends to provide BHT services as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government. DHCS will seek federal approval to provide BHT as it is defined by Section 1374.73 of the Health and Safety Code. The DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with stakeholders. The department will further develop and define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for ABA services, subject to the limitations allowed under federal law and provide final policy guidance to Plans as soon as possible.

Pursuant to Section 14132.56 of the Welfare & Institutions Code, DHCS is required to perform the following in development of the benefit:

(1) Obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal.
(2) Seek statutory authority to implement the benefit in Medi-Cal.
(3) Seek an appropriation that would provide the necessary state funding estimated to be required for the applicable fiscal year.
(4) Consult with stakeholders.

In consultation with stakeholders, the department will develop and define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for BHT services, subject to the limitations allowed under federal law. DHCS may enter into exclusive or nonexclusive contracts on a bid or negotiated basis, including contracts for

the purpose of obtaining subject matter expertise or other technical assistance in implementing this service. Contracts may be statewide or on a more limited geographic basis.

INTERIM POLICY:
In accordance with existing contracts, Medi-Cal MCPs are responsible for the provision of EPSDT services and EPSDT Supplemental Services for Members 0 to 21 years of age, including those who have special health care needs. Plans shall inform members that EPSDT services are available for beneficiaries 0 - 21 years of age, provide comprehensive screening and prevention services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, and lead toxicity screening), and provide treatment for all medically necessary services including but not limited to BHT.

Plans shall cover all medically necessary mandatory and supplemental EPSDT services for beneficiaries 0 to 21 years of age including health education services, vision, dental and hearing services, and various therapies and other long-term services and supports. In addition to ensuring coverage of EPSDT services, Plans shall ensure an adequate level of benefits and services. Plans shall also ensure that appropriate EPSDT services are initiated in a timely fashion - as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

Medi-Cal MCPs are responsible for the provision of EPSDT services for beneficiaries 0 to 21 years of age. Effective September 15, 2014, this includes medically necessary ABA services for children or adolescents with ASD that meet eligibility criteria for services.

Future guidance will be issued pertaining to the provision of other BHT services not addressed in this APL.

CONTINUITY OF CARE:
MCP beneficiaries 0 to 21 years diagnosed with ASD who are currently receiving BHT services including ABA services through a Regional Center will continue to receive these services through the Regional Center until such time that the department and the Department of Developmental Services develop a plan for transition. In addition, for Medi-Cal beneficiaries receiving ABA services outside of the MCPs' network for Medi-Cal services, the MCPs shall ensure continuity of care for up to 12 months in accordance with existing contract requirements.

HEALTH PLAN READINESS:
DHCS and the Department of Managed Health Care (DMHC) will coordinate efforts to conduct readiness reviews of MCPs for purposes of ensuring that MCP are timely providing medical necessary ABA services. DHCS and DMHC will engage in a joint decision making process when considering the content of any licensing filing submitted to either Department. The Departments will work together to issue template language to MCPs, as needed.

Guidance pertaining to readiness review requirements will be provided to MCPs separate from this APL.

DELEGATION OVERSIGHT:
MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements as well as DHCS guidance, including APLs.

REIMBURSEMENT:
The department will engage in conversations with the MCPs in order to develop capitation rates for the costs associated with the provision of ABA services. Any rate adjustments will be retroactively applied to September 15, 2014.

To the extent beneficiaries received ABA services from licensed providers between July 7 and up to and including September 14, 2014, and incurred out-of-pocket expenditures for such services, these expenditures shall be submitted to the Fiscal Intermediary for reimbursement of expenditures through the existing *Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)* process (http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx). On and after September 15, 2014, beneficiaries must receive ABA services from the MCP unless they are receiving their ABA services from a Regional Center.

PROGRAM DESCRIPTION AND PURPOSE :
BHT means professional services and treatment programs, including but not limited to ABA and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with ASD. ABA-based therapy is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. ABA-based therapies teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. ABA-based therapies are based on reliable evidence and are not experimental.

RECIPIENT CRITERIA FOR ABA-BASED THERAPY SERVICES:
In order to be eligible for ABA-based therapy services, a Medi-Cal beneficiary must meet all of the following coverage criteria. The recipient must:

1. Be 0 to 21 years of age and have a diagnosis of ASD;
2. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to aggression, self-injury, elopement, etc.);
3. Be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID);

4. Have a comprehensive diagnostic evaluation that indicates ABA-based therapy services are medically necessary and recognized as therapeutically appropriate; and
5. Have a prescription for ABA-based therapy services ordered by a licensed physician and surgeon or a licensed psychologist.

COVERED SERVICES AND LIMITATIONS:
Medi-Cal covered ABA-based therapy services must be:
1. Medically necessary as defined by Welfare & Institutions Code Section 14059.5.
2. Prior authorized by the Medi-Cal Program or its designee; and
3. Delivered in accordance with the recipient's treatment plan.

Services must be provided under a treatment plan developed and approved by a "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3), 1374.73(c)(4), and 1374.73(c)(5). Treatment may be administered by one of the following:
1. A qualified autism service provider.
2. A qualified autism service professional supervised and employed by the qualified autism services provider.
3. A qualified autism service paraprofessional supervised and employed by a qualified autism service provider.

ABA-based therapy services must be based upon a treatment plan and prior authorized for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.

ABA-based therapy services shall be rendered in accordance with the individual's treatment plan. The treatment plan shall:
1. Be person-centered and based upon individualized goals over a specific timeline;
2. Be developed and approved by a qualified autism service provider for the patient being treated;
3. Delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors;
4. Identify long, intermediate, and short-term goals and objectives that are behaviorally defined;
5. Identify the criteria that will be used to measure achievement of behavior objectives;
6. Have objectives that are specific, measureable, based upon clinical observations, utilize evidence-based practices with demonstrated clinical efficacy in treating ASD, include outcome measurement assessment, and are tailored to the individual;
7. Ensure that interventions are consistent with ABA techniques.
8. Clearly identify the service type, number of hours, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at

which the individual's progress is reported, and the individual providers responsible for delivering the services;
9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
10. Include parent/caregiver training, support, and participation.

Service Limitations:
1. Services must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.
2. Services must be delivered in a home or community-based settings, including clinics.
3. Any services delivered must be under the supervision of a qualified autism service provider.
4. ABA-based therapy services shall be discontinued when the treatment goals and objectives are achieved or are no longer appropriate.

The following services do not meet medical necessity criteria, nor qualify as Medi-Cal covered ABA-based therapy services for reimbursement:
1. Therapy services rendered when measureable functional improvement is not expected or progress has plateaued;
2. Services that are primarily respite, daycare or educational in nature and are not used to reimburse a parent for participating in the treatment program;
3. Services that are duplicative services and equal to the medically necessary frequency and duration under an individualized family service plan (IFSP) or an individualized educational program (IEP), as required under the federal Individuals with Disabilities Education Act (IDEA);
4. Treatment whose purpose is vocationally- or recreationally-based;
5. Custodial care;
   a. for purposes of these provisions, custodial care:
      i. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
      ii. is provided primarily for maintaining the recipient's or anyone else's safety; and
      iii. could be provided by persons without professional skills or training.
6. Services, supplies, or procedures performed in a non-conventional setting including, but not limited:
   a. resorts;
   b. spas; and
   d. camps.
7. Services rendered by a parent, legal guardian, or legally responsible person.

For questions about this APL, contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Margaret Tatar
Acting Deputy Director
Health Care Delivery Systems

Attachments

ARCA ASSOCIATION OF REGIONAL CENTER AGENCIES
915 L Street, Suite 1440, Sacramento, California 95814 • 916.446.7961 • Fax: 916.446.6912 • www.arcanet.org

September 25, 2014

Department of Health Care Services
1500 Capitol Avenue
Sacramento, CA 95814

RE: Draft State Plan Amendment (SPA) for Applied Behavior Analysis (ABA) as a Covered Medi-Cal benefit for individuals under 21 years of age

To Whom It May Concern:

The Association of Regional Center Agencies (ARCA) represents the state's community-based network of regional centers which serves over 270,000 individuals with developmental disabilities, including approximately 70,000 individuals diagnosed with Autism Spectrum Disorder (ASD). ARCA appreciates the opportunity to comment on the proposed SPA that would add ABA as a Medi-Cal covered benefit for individuals with ASD under the age of twenty-one.

ARCA has the following significant concerns with the draft SPA:

- The draft SPA would only expand current Medi-Cal benefits to include the funding of ABA services for individuals with ASD. As noted in the Center for Medicaid and CHIP Services Bulletin dated July 7, 2014, "there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan[1]." While ABA is a crucial ASD treatment modality, children and families must have access to an array of evidence-based treatments to meet their particular clinical needs. They should not have to wait for California to seek approval of a later SPA application to access these services.

- The proposed eligibility criteria for Medi-Cal funding of BHT that requires "the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities" is more restrictive than the requirement that EPSDT services be available if they are "determined to be medically necessary to correct or ameliorate any physical or behavioral conditions." At times, EPSDT services may also be required to maintain current skill levels. While the All Plan Letter issued on September 15, 2014 provides additional examples of behaviors that might warrant intervention, more inclusive eligibility criteria consistent with EPSDT standards should be applied.

[1] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

Thank you for the opportunity to provide comment. Should you have any questions regarding these suggestions, please don't hesitate to contact Amy Westling in our office at awestling@arcanet.org or (916) 446-7961.

Sincerely,
/s/
Eileen Richey
Executive Director

Cc: Santi Rogers, Director, Department of Developmental Services

STATE PLAN CHART

	TYPE OF SERVICE	PROGRAM DESCRIPTION**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13c	Preventive services (cont) Behavioral Health Treatment (BHT)	Covered as medically necessary services based upon a written prescription of a licensed physician or psychologist for Applied Behavioral Analysis (ABA) Therapy, to develop or restore, to the maximum extent practicable, the functioning of an individual with a diagnosis of Autism Spectrum Disorder (ASD). Under this state plan only for the following beneficiaries: infants, children and adolescents age 0 to 21, who are an eligible beneficiary of the EPSDT program, that exhibit excesses or deficits of behaviors that significantly interfere with home and community services. Individuals must have a comprehensive diagnostic evaluation that indicates ABA-based therapy services are medically necessary and recognized as therapeutically appropriate.	ABA-based therapy services require prior authorization for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for reimbursement except in the case of retroactive Medi-Cal eligibility. Services must be provided under a treatment plan developed and approved by a "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3), treatment maybe administered by one of the following: 1. A qualified autism service provider. 2. A qualified autism service professional supervised and employed by the qualified autism services provider. 3. A qualified autism service paraprofessional supervised and employed by a qualified autism service provider. ABA-based therapy services shall be rendered in accordance with the individual's treatment plan. The treatment plan shall: 1. Be person-centered and based upon individualized goals over a specific timeline; 2. Be developed and approved by the qualified autism service provider for the patient being treated; 3. Delineate both the frequency of baseline behaviors and the treatment development plan to address the behaviors; 4. Identify long, intermediate, and short-term goals and objectives that are behaviorally defined; 5. Identify the criteria that will be used to measure achievement of behavior objectives; 6. Have objectives that are specific, measurable,

* Prior authorization is not required for emergency service.
* *Coverage is limited to medically necessary services

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