TRI-COUNTIES REGIONAL CENTER
EXECUTIVE DIRECTOR REPORT
September 5, 2014

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

- **Attachment #1: CMS Informational Bulletin**
- **Attachment #2: CMS Fact Sheet: Home and Community Based Services**
- **Attachment #3: CMS Fact Sheet: Summary of Key Provisions of the Home and Community Based Services (HCBS) Settings Final Rule**
- **Attachment #4: Summary of Key Provisions of the 1915(c) Home and Community Based Services (HCBS) Waiver Final Rule**
- **Attachment #5: Summary of Key Provisions of the 1915(i) Home and Community Based Services (HCBS) State Plan Option**

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 Developmental Services landscape in the future. 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.

Informational Bulletin **(Attachment #1)** and several fact sheets addressing Overview of Regulation **(Attachment #2)**, 1915(c): Changes to HCBS Waiver Program **(Attachment #3)**, 1915 (i): Key Provisions for HCBS State Plan Option **(Attachment #4)** and Summary of Key Provisions of the HCBS Settings Final Rule **(Attachment #5)** 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

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.

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

- **Attachment #6: CMS Informational Bulletin on Medicaid Coverage of Services to Children with Autism Spectrum Disorder**
- **Attachment #7: State Plan Amendment to CMS to Add ABA as a Medi-Cal Benefit**
- **Attachment #8: DCHS Letter to Medi-Cal Managed Care Plans on Implementation of ABA as a Medi-Cal Benefit**

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 #6)**. 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 #7)**. 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 #8)**. 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).

In preparation for implementing expanded Medi-Cal services for individuals under age 21 with ASD, DHCS has asked DDS for information about regional center behavioral vendors and the rates they are paid. As these services are provided under a few service codes (and in some cases the service codes may include non-behavioral services), DDS has offered regional centers the opportunity to review the lists for accuracy and completeness before they are provided to DHCS. DDS will be in touch with regional centers regarding the information that they need help to verify.

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.

TCRC and Association of Regional Center Agencies (ARCA) will be monitoring these developments and will provide input to DDS and DCHS as necessary.

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III. <u>TCRC TRAINING OVERVIEW REPORT</u> (Presentation By Mary Beth Lepkowsky, Assistant Director of Training and Organizational Development)

- **Attachment #9: Tri-Counties Regional Center Training Overview Report**

IV. <u>QUESTIONS & ANSWERS</u>

Attachment #1

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

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.

Attachment #2

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201

FACT SHEET

FOR IMMEDIATE RELEASE
January 10, 2014

Contact: CMS Media Relations
(202) 690-6145

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 #3

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 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 #4

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 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 #5

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

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.

Attachment #6

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

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

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

State of California—Health and Human Services Agency

Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

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

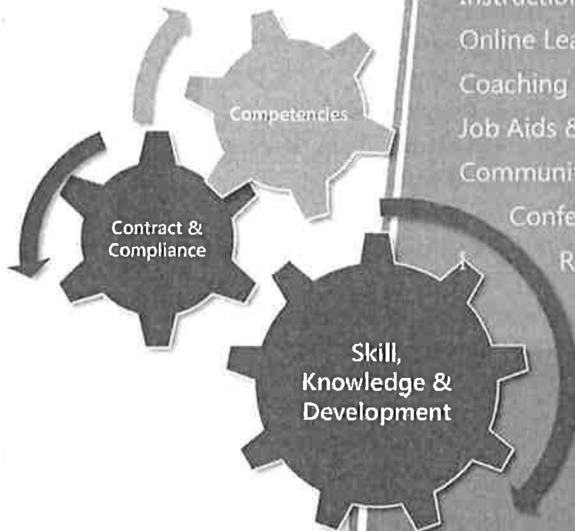
Attachments

Attachment #9

Tri-Counties Regional Center Training Report

July 2013 – June 2014

TCRC embraces a culture of learning, excellence, and continuous improvement by providing high quality training to employees, service providers and individuals and families receiving services and supports.



Training Events

106 Instructor Led

12 Online Courses

"The most viable organizations are the ones that understand that taking time to learn is never a waste of time."

~ Jeanne M. Plas

Why

- People we support deserve our very best.
- We are pleased to be an employer of choice.
- We invest in developing our future leaders.
- Change is rapid and ongoing.

Who

91 People Receiving Services

478 Service Providers

1188 Regional Center Staff

How

All Departments & FRCs assist with creating and delivering training

Classroom-based Instruction

Online Learning

Coaching

Job Aids & Articles

Communities of Practice

Conferences

Refreshers

What

Service Coordinator Orientation

New Manager Orientation

Service Provider Orientation

Behavioral Services Orientation

Monthly Residential Provider Meetings

Project LEAD

Person Centered Thinking

TBL Changes

Recent Initiatives & Emerging Priorities

2014

7 Habits of Highly Effective People
Manager / Steward PCT Training
Positive & Productive Meetings
Benefits & Employment
Behavioral Interviewing
Cultural Competency
Stress Management
One Page Profiles
Conservatorship
IPP Refresher
Title 19
NVRA
IHSS
Box

2015

Ethics
HIPAA
MS Excel
DocuSign
IT Security & Privacy
Project Management
Emotional Intelligence
ADP Performance Review
Principles of Self-Determination
Leadership & Succession Planning
Person Centered Employment Planning

Tri-Counties Regional Center Training Report

New Employee Welcome

TCRC conducts a New Employee Welcome bi-weekly in Santa Barbara, provided that there are a minimum of three new employees to participate in the class.

The course provides an overview of the California Department of Developmental Services, the Lanterman Act and the Regional Center system, including information about the mission, vision and values of TCRC and its organizational and operational structure.

New Employee Welcome introduces new employees to principles of person centered thinking, ethics, and communicating with people with disabilities. In addition new employees receive information about TCRC benefits, performance review practices, SEIU, sexual harassment prevention, and safety in the workplace.

Service Coordinator Orientation

New Service Coordinators receive training on the following:

- Introduction to the Regional Center System
- Intake & Eligibility/Early Start Services
- Getting to Know the People You Serve
- Introduction to Person Centered Thinking
- Generic and Local Resources
- Lanterman Act / Notice of Action / Fair Hearings
- Cultural Competency
- Individualized Program Plan (IPP)
- Individualized Family Service Plan (IFSP)
- Health and Clinical Resources
- Resource Development
- Medicaid Waiver/CDER/T-19/Entering CDER in SANDIS
- SIR – Special Incident Reporting
- Federal Programs
- SANDIS/POS (Purchase of Service)
- Funding Criteria and Exceptions
- Pharmacology
- Mandated Reporting
- Quality Assurance
- Legal Issues/Conservatorship
- Records & Confidentiality
- Annual Family Program Fee
- FMS – Financial Management Services
- National Voter Registration Act
- Transportation Access Plans
- Maximizing Generic Education Services
- Area Board 9
- Communicating in Challenging Situations
- Emergency Preparedness & Response

Service Provider Orientation

is required for all residential providers and optional for non-residential providers.

DAY 1: (all Providers)

- Welcome & Overview of TCRC Organizational Structure
- Resource Development Processes
- Vendorization Requirements & Program Design
- Contracts & Universal Service Expectations
- Service Authorization & Payment
- Overview of E-Billing
- Understanding Lanterman Act & Title 17
- Special Incident Reporting
- Mandated Reporting
- Rights of People with Developmental Disabilities
- Person Centered Thinking
- Ethics

DAY 2: (Residential Providers Only)

- Health and Wellness
- Placement Process
- Record Maintenance
- Reporting Requirements
- Overview of Quality Assurance Monitoring Processes

A Service Provider Orientation for Family Home Agencies is customized and offered twice annually.