

## **Diversion Work Group Policy Priorities**

Olmstead Advisory Committee Meeting, Diversion Work Group  
Presentation to Full Committee: September 15, 2006

**Summary:** The Diversion work group met on July 18 and August 15 to develop and focus existing priorities to present at the September 15, 2006 meeting. These policies were identified using the state's Olmstead Plan, as well as other best practices not included within the plan. The five policy priorities are as follows, and as outlined in the below document (not listed in any particular order of importance):

1. Expand MSSP to the Under-65 Population and Reform MSSP Rate Structure
2. Develop Hospital-to-Home Pilot Projects through the Department of Aging's Linkages Program
3. Re-establish and Modify the Special Circumstances Program
4. Establish an Olmstead Outreach and Public Education Campaign
5. Establish Home and Community-Based Services as part of the State Medicaid Plan
6. Create incentives for Counties to Divert and Transition Individuals from institutions
7. Caregiver Support

**Background:** The Diversion Work Group selected the following policies to present to Secretary Kim Belshé for her consideration at the September 15, 2006 full committee meeting. Some of the priorities were presented at previous meetings but have been further modified, and other priorities have been identified in recent work group meetings. The work group selected the policies using the following criteria:

1. Immediate, wide-ranging and direct impact on the State's implementation of Olmstead.
2. An opportunity to shift funds or to provide alternative funds for community-based services.
3. Immediate opportunity at the federal level for this policy initiative with the possibility of federal funding.
4. Immediate opportunity at the state level to build on this policy initiative, with possibility of state and/or alternative sources of funding.
5. A direct impact on current Health and Human Services Agency issues, i.e. something the Agency can influence.

*The following policy priorities are categorized under broader issues identified by the work group, and are not presented in any particular order of importance.*

## **ISSUE 1: IMPROVING ACCESS TO AND INCREASING FUNDING FOR HOME AND COMMUNITY-BASED SERVICES**

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### **POLICY GOAL**

To design a long-term care system that promotes the delivery of home and community-based services over institutional care, and ensures that consumers and caregivers can access an array of services in the community.

### **PROBLEM**

Consumers and caregivers often cannot access the necessary services and supports that promote community living, resulting in premature or unnecessary institutionalization.

### **BARRIERS**

- **Medicaid Institutional Bias:** Medicaid law requires states to provide institutional services to all eligible persons as a mandatory benefit, and permits (but does not require) states to offer home and community-based services.
- **Inadequate Funding Formulas:** Resources dedicated to home and community-based services with flat-funding formulas often cannot keep pace with increasing costs.
- **Lack of Case Management Services Available on Statewide Basis:** Case management assists consumers with accessing the services and supports that help them remain in the community. Medi-Cal does not offer case management as an optional state plan benefit; some home and community-based waivers offer these services, but the availability of services varies throughout the state and eligibility is frequently based on age.

## **DIVERSION WORK GROUP POLICY PRIORITIES**

**1. Expansion of MSSP to Under-65 Population and Rate Reform:** The Work Group supports expanding MSSP to the under-65 population and exploring rate reform to adjust the funding formula and enable providers to keep up with rising program costs on an ongoing basis.

### **Background**

Forty-one Multipurpose Senior Service Program (MSSP) sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who choose to live at home with MSSP support. The goal of the program is to prevent or delay premature nursing home placement of these very frail clients. The program has operated under a federal Medicaid 1915 (c) waiver since 1983. MSSP clients are 35% less costly to the State than those living in skilled nursing facilities (under federal rules, cost must not exceed 95% of nursing home costs). The program can serve up to 11,789 clients per month.

Clients eligible for the program must be 65 years of age or older, live within a site's service area, meet Medi-Cal eligibility criteria, and are at-risk for placement in a nursing facility. MSSP site staff make this certification determination based upon Medi-Cal criteria for placement. The services that may be provided with MSSP funds include the following:

- Adult Day Care / Support Center
- Housing Assistance
- Chore and Personal Care Assistance
- Protective Supervision
- Care Management
- Respite (includes supervision and care of a client while the family or other individuals who normally provide full-time care take short-term relief)
- Transportation
- Meal Services
- Social Services
- Communications Services

**MSSP Rate Increase in the 2006-07 Budget:** The work group unanimously supported the budget augmentation included in the 2006-07 for MSSP sites. MSSP programs reported an urgent need for funding to enable sites to continue offering services to frail elders. Previously, MSSP had one funding increase since its inception in 1983 whereas nursing facilities have received a rate increase each year resulting in a 96% increase over the past 15 years.

**Need for MSSP Rate Reform:** While the work group is encouraged by the rate increase provided to MSSP sites in the 2006-07 budget, concern remains over administrative and waiver-related obstacles that prohibit flexibility in how waiver funds are used in the program. The diversion work group supports reforming the MSSP rate structure to allow for increased flexibility and increased program effectiveness.

**MSSP Expansion to the Under-65 Population:** MSSP services provide critical case management and purchase-of-services for persons over 65 years of age who are at-risk of institutionalization. The work group strongly supports expanding these services to the under-65 population who are also at-risk of institutionalization. MSSP's case management services are of critical importance to helping individuals avoid institutionalization and connect to the necessary home and community-based services. The work group strongly supports provision of case management services based on need, rather than solely on age. The work group would like feedback from the Department of Aging regarding the expansion of MSSP services to persons under the age of 65, including related costs and benefits of such an expansion.

**2. Develop and Implement Hospital-to-Home Pilot Projects through the Department of Aging's Linkages Program:** The Diversion work group supports the establishment of two pilot programs that would focus primarily on diverting individuals who are hospitalized and at risk of institutionalization.

### **Background**

Individuals often cannot access home and community-based services in times of crisis, particularly after an acute care episode. Without connection to critical home and community-based services after an acute care episode, an individual is more likely to be placed in a nursing home. Or, for individuals who are admitted to nursing homes for a short-term stay, it is

critical that there be access to and awareness of the necessary home and community-based services.

Hospitalization can be a turning point in the lives of seniors (and younger persons with disabilities) whose physical and mental health often deteriorates after discharge. Many older adults experience breakdowns in care during the transition from hospital to home. This results in high rates of poor outcomes and re-hospitalization. Patients and caregivers are on the receiving end of a badly fragmented system of care, with inadequate medical, social and caregiving support during the hospital-to-home transition.

Without case management services facilitating a connection to critical home and community-based services, individuals in acute care hospitals and long-term care facilities often cannot access the services necessary to return home. Individuals and family members facing crisis-time decisions about acute care after-treatment frequently learn only of institutional services and feel ill-equipped to investigate home and community-based services.

### **Review of Literature: What *Doesn't* Work**

- 30 years of hospital-only discharge planning interventions showed no definitive change in patients' status: same mortality, same hospital readmission rates, same cost of care, same length of stay and mixed findings for patient satisfaction (Sheppard et al. 2004).
- Why the intervention showed no definitive change:
  - The interventions used a single discipline/medical framework
  - Availability and type of payment dominates the discharge process

### **Review of Literature: What Works**

- Multi-disciplinary team interventions at the hospital led to increased patient satisfaction, quality of life, improved health outcomes
- Supported discharge case management with post-acute care leads to improved outcomes, and reduced re-hospitalization

**Linkages Hospital-to-Home Pilot Projects:** The work group supports development of pilot projects through the Department of Aging's Linkages program that would connect individuals in hospitals with the services they need for a safe return to the community. The Linkages program operates

in 36 sites throughout California and links functionally impaired adults aged 18 and over and frail elderly clients to services that assist them in maintaining independence in their own communities. The Linkages program is similar to MSSP but is funded entirely out of the General Fund, and does not require Medi-Cal eligibility for receipt of services. This program is a low-cost alternative to more costly institutional placement for these clients. The work group supports development of Linkages pilot projects in which local Linkages sites would collaborate with hospitals and identify individuals at-risk of institutionalization or in need of case management prior to discharge to the home or community. The committee would like technical assistance from the Department of Aging regarding issues associated with the establishment of these pilot projects, as well as any additional issues to consider.

### **3. Re-Establish the Special Circumstances Fund/One-time Needs**

**Fund** - **Background**: The Special Circumstances Program was a state-funded, DSS-supervised, county-administered special needs assistance program for SSI/SSP recipients. The program provided emergency payments to SSI/P recipients and IHSS recipients for special non-recurring needs. These one-time payments were intended to meet immediate needs in order to maintain individuals in their homes rather than institutions. The program recognized that in poverty households, such events as a fire or the breakdown of an appliance could be catastrophic. Special circumstance funds could be used to include replacement of essential household furniture (refrigerator or oven), necessary housing repairs (e.g., a leaky window or roof), and unmet shelter needs.

The Special Circumstances Program was reinstated on August 21, 1998 after being suspended since 1992. The Budget Act of 1998 allocated \$8.3 million for this program. In 2001-02, the Governor vetoed \$3.3 million from the program's budget, leaving \$5million in the overall program budget.

**Program Problems**: The LAO reported that the program had high administrative costs- 40 cents of every \$1 were spent on administrative costs. Given the relatively high fixed costs of administration, the Legislature determined that the program was not a cost-effective means of providing one-time cash assistance. The program was pulled from the budget in 2002.

The work group supports re-establishment of a program similar to the Special Circumstances Fund that would provide for critical one-time costs for community-residing individuals who are at-risk of institutionalization or individuals who are institutionalized and seeking a return to the community. Such a program could help individuals address urgent one-time expenses that are needed to help them remain at or return to the home.

## **ISSUE 2: *INCREASING EDUCATION AND AWARENESS ABOUT HOME AND COMMUNITY-BASED OPTIONS***

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### **POLICY GOAL**

- To change the public perception that people who need long-term care should be institutionalized, and instead replace it with an awareness that consumers can receive services in a community-based setting.
- To provide consumers, caregivers, family members, and providers with readily accessible information and education about the availability of home and community-based services as an alternative to institutionalization.

### **PROBLEM**

The effectiveness and availability of community-based options for long-term care are relatively unknown and misunderstood, often resulting in premature or inappropriate institutionalization.

### **BARRIERS**

- Resources: Educating the public requires investment in resources, including electronic, print and televised media to ensure individuals are educated about home and community-based alternatives.
- Cross-Program Coordination: While some programs engage in education and outreach activities, efforts are not coordinated and do not reach all consumers.

### **DIVERSION WORK GROUP POLICY PRIORITIES**

#### **4. Establish an Olmstead Outreach and Public Education Campaign:**

The Diversion Work Group places a high priority on the development of a public education campaign as a way to increase public awareness and education about the alternatives to institutionalization and the availability of home and community-based services. The campaign could educate the public, providers, state workers, advocates, family members, caregivers, and consumers about the Olmstead decision and an individual's right to home and community-based care as well as caregiver issues. The campaign could raise awareness of home and community-based alternatives to institutionalization, using print, digital and televised media resources and seek out methods to reach isolated individuals. The initiative could include an evaluation of the outcome/impact of education and outreach efforts on consumers' ability to remain at home and avoid institutionalization. The effort could coordinate with existing education efforts, including those at the local levels with In Home Supportive Services, the Area Agencies on Aging's Info Vans that focus on consumer outreach and education, as well as the Department of Rehabilitation's public education campaign outlined in its State Plan for Independent Living. In addition, the work group supports promotion of local community-based forums that would provide a lower-cost grassroots approach to engage the public through education, outreach, and culture change.

Impact of Outreach and Education Campaign: In order to follow the intent of the Olmstead Policy Filter and "achieve measurable progress towards diverting individuals from institutions and transitioning individuals from less-integrated to more-integrated settings," several members of the committee noted that with an outreach and education initiative, services and supports must be available to meet the increased demand that a successful initiative would generate.

### **EXAMPLES OF STATE OUTREACH INITIATIVES**

#### **Pennsylvania**

To make information readily accessible, Pennsylvania offers a 24-7 toll-free hotline for its *Community Choice Program*. An Elder Abuse Hotline, which already was in operation, now performs this extra function. Operators route calls about long-term care services to assessors who are on call to respond to inquiries and to conduct assessments for long-term care services.

## **Vermont**

In 2002, Vermont mounted the “Options Education” campaign to publicize the availability of options for long-term care services. The Department of Aging and Disabilities developed a set of outreach materials that could be used statewide and locally and also conducted a statewide media campaign (through television ads, radio, and print media). These materials urged state residents to call the Senior HelpLine and talk with information assistance specialists. Grant funds were used to develop the materials and mount the initial campaign.

## **Washington**

Washington conducted a community education campaign to help people become more familiar with the long-term care system and options to remain at home and avoid unnecessary institutionalization.

# ***ISSUE 3: DEVELOPING A COMPREHENSIVE SERVICE DELIVERY SYSTEM THAT INTEGRATES SERVICES***

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## **POLICY GOAL**

To design a comprehensive assessment system and coordinated system of care that integrates the full continuum of both acute and long term care financing and service delivery that emphasizes home and community-based services in lieu of institutional placements.

## **PROBLEM**

California's acute and long term care system has long been impacted by system fragmentation stemming from a multiplicity of funding streams, assessment procedures, and lack of coordination between the medical and social systems of care. This fragmentation can lead to higher-than-necessary rates of hospitalization, nursing home expenditures, with a lack of coordination between primary, acute, long term care systems.

## BARRIERS

- Multiple funding streams and silos of services
- Lack of coordination between medical and social systems of care

## DIVERSION WORK GROUP POLICY PRIORITIES:

### **5. Establish Home and Community-Based Services as Part of the State Medicaid Plan:**

The work group places a high priority on the establishment of policies that include home and community-based care within the range of services outlined in the state's Medicaid Plan.

Opportunities are presented by the Federal Deficit Reduction Act (DRA) to develop home and community-based services that are part of the state Medicaid plan, rather than the waiver (please see last section of this document for more information). The Deficit Reduction Omnibus Reconciliation Act of 2005 authorizes a new home and community-based services (HCBS) initiative. Under the DRA, states will be able to submit a state plan amendment to cover home and community based services (HCBS), effective January 1, 2007, as outlined in the attached draft paper released in April of 2006 by the National Academy of State Health Policy (see pages 14-19). The State continues to work with the Centers for Medicare/Medicaid Services to understand the provisions of this new law, and what it would mean for California.

While the work group supports the inclusion of HCBS within the State plan rather than a waiver, some issues remain that have yet to be resolved, as follows:

- **Comparability:** States may establish one HCBS state plan benefit, but cannot waive comparability of Medicaid benefits. Therefore, states can limit the number of people that can enroll in the HCBS state plan benefit, but technically the benefit would be available to any Medicaid beneficiary and the benefit cannot be targeted to a specific population as is done through waiver programs. States would be required to develop needs-based criteria to determine eligibility for the services, and beneficiaries would have to demonstrate the need for the requested service prior to it being provided.

- **Services:** Under current HCBS Waiver provisions, states can provide a variety of waiver services, and have the ability to define each service offered and include “other services”. Under the HCBS state plan benefit provisions, however, states are not allowed to provide other services and can only include services specifically outlined in current law. Therefore, states do not have the same flexibility to design HCBS state plan services as they do with current waiver provisions. CMS is working to create some flexibility for states within given categories of services. This flexibility is to be a component of the regulations that CMS is developing for this new option.
- **Income Eligibility:** HCBS state plan provisions are only applicable to individuals with income levels below 150% of Federal Poverty Level (states do not have the choice to extend eligibility to anyone above 150% FPL).
- **Institutional Deeming rules** do not apply to the HCBS state plan provisions, unless a person falls into the “medically needy” category (these individuals are required to “spend down” on health care services prior to Medicaid covering their care). Background: Current provisions in Medi-Cal regulations prevent spousal impoverishment in situations where, for example, one spouse is placed in a skilled nursing facility while the other spouse continues to live on her/his own in the community. These “spousal impoverishment” provisions also apply to the state’s current HCBS waiver participants. However, existing Medi-Cal regulations that protect spousal impoverishment would not apply to the HCBS state plan provisions unless the person is “medically needy”. Without the application of the spousal impoverishment provisions, in most instances spousal cash assets are limited to the sum of \$3,000. As such, the income of the ill spouse (i.e., the spouse who is accessing HCBS SPA services) could trigger a significant share of cost without allocation to the community spouse, thereby leaving the community spouse with a very limited income on which to survive. If the spousal impoverishment provisions were implemented in this setting, the spouse at home (i.e., the “community spouse”) would be able to have \$99,540 (2006) in cash assets in addition to the other exempt resources. In addition, the minimum monthly maintenance allowance for the “community spouse” would be \$2,489 per month, thus allowing allocation from the ill spouse’s income if the facts so warrant. In addition, the ill spouse would be able to have another \$2,000 in cash assets (42 USC §1396r-5 and CA Welfare & I C §14005.12(d)(5)).

## **6. Address the Institutional Bias and Establish Incentives for Counties to Divert Individuals from Institutions:**

The Work Group places a high priority on establishment of policy options that would address the institutional bias at the local level and provide incentives to counties for diversion and transition efforts. Under the current realignment system, counties are required to pay a 17.5% match for IHSS services, the state pays 32.5%, and the federal government pays 50%. For nursing facility services, however, counties do not pay a share-of-cost; the state pays 50% and the federal government pays 50% of the cost of services under Medicaid. The work group supports developing incentives for counties to divert and transition people out of nursing homes as has been done in other states.

### **Other States**

Wisconsin offers incentives to counties that assist individuals in transitioning out of nursing facilities. The state adds an amount to the county's allocation of HCBS waiver funds for each occupied nursing facility bed closed in which the person moves into the community. The state increases the county's allocation by the amount necessary to meet the needs of each person who leaves a nursing facility while using the HCBS waiver funds. Once this person no longer needs waiver services, the funds will remain available for other people in that county who need home and community based services. This earmarked relocation funding is an incentive for counties to seek out people in institutions wishing to relocate. At the same time, Wisconsin's budget for Medicaid nursing facility residents is reduced, so the result is a transfer of funds from nursing facilities to home and community-based services.

The Wisconsin program would be difficult to replicate in California, as California's counties are not responsible for HCBS waiver programs and therefore, do not control these aspects of an individual's plan of care. The committee will continue to consider alternatives that would provide incentives to counties for diversion and transition purposes.

## ***ISSUE 4: SUPPORTING PAID AND UNPAID CAREGIVERS***

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### **POLICY GOAL**

To improve the availability of and access to paid caregivers, and to support non-paid family caregivers through provision of respite services and other means of caregiver support.

### **PROBLEM**

Consumers are not aware of or cannot access public or private caregiver programs, often leading to premature or inappropriate institutionalization. In addition, family caregivers suffer from stress and burnout, impacting their ability to provide care for a loved one.

### **BARRIERS**

- Lack of awareness of available caregiver services
- High demand for and short supply of paid and un-paid caregivers
- Need for expanded caregiver respite services
- Difficulty accessing emergency back-up caregiver services

### **Policy Priorities**

While the work group has identified caregiver support as one of central importance to Olmstead efforts, the work group has not yet reached consensus on how to focus the policy priority. Some members expressed concern that caregiver support be crafted in a way that it meets the intent of the Olmstead Policy Statement and Policy Filter, particularly regarding self-determination and consumer choice. One member noted that if a conflict were to arise between consumer support and caregiver support, support for consumer choice and consumer self-determination should trump support for the caregiver.

The work group will continue to work on this issue and bring forward a recommendation at the next full committee meeting.

## **ADDENDUM: BACKGROUND INFORMATION**

### **Home and Community Based Services**

### **State Plan Amendment Provisions of the Deficit Reduction Act**

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The following summary of the HCBS SPA provision is an excerpt from “*Deficit Reduction Act: HCBS State Plan Option Draft for background and discussion purposes only*” Prepared by: Robert L. Mollica, National Academy for State Health Policy, April 2006

This summary of the Home and Community Based Services (HCBS) State Plan Amendment (SPA) option is based on a review of the Deficit Reduction Act (DRA) and discussion during a conference call with CMS staff and Real Choice grantees on April 3, 2006. The content reflects our understanding of the legislation and questions raised by grantees.

Several provisions of the legislation are being reviewed CMS and will be clarified by regulation. CMS plans to issue interim final regulations with comments by December 2006. A State plan amendment pre-print and instructions will be issued during the summer through a State Medicaid Directors letter. The intent of this summary is to highlight what is known about the DRA and some questions about how it will affect States that elect this option. Continuing discussions with CMS and States are likely to raise new perspectives and interpretations of the DRA from what is described below. We will forward additional information as it becomes available.

#### **Eligibility**

The new section 1915(i)(1) allows States to provide home and community based services through a State Plan Amendment to individuals who are eligible for medical assistance under the State plan and whose income does not exceed 150% of the federal poverty level. This provision does not establish a new eligibility group. Rather, the 150% income limit is an eligibility requirement which must be met in addition to meeting the requirements of some eligibility group covered under the State Plan.

The legislation permits States to waive section 1902(a)(10)(C)(i)(III) of the Social Security act pertaining to income and resource eligibility rules for the medically needy in the community. In other words, a State may elect to waiver community deeming rules and use institutional deeming rules for medically needy individuals. When determining a child’s eligibility for Medicaid in the community, the parent’s income is counted (deemed).

However, if the State elects to use institutional rules, the parent's income is not counted (deemed). To cover medically needy under this option, the State must cover the medically needy under its State Plan.

Under the State Plan option, institutional eligibility rules may only be applied to the medically needy. Categorically needy individuals are eligible under the State's Medicaid Plan under community eligibility groups (e.g., SSI) using community rules (e.g., paternal and spousal deeming apply). Additionally, the spousal impoverishment rules and post eligibility rules do not apply to the categorically needy under the State Plan option.

### **Possible impact on HCBS waiver participants**

If the State continues to offer a §1915 (c) waiver and the individual receives a waiver service in addition to the SPA services, it would appear that they are eligible in the community for the SPA option. If they do not receive waiver services, they may lose their eligibility for SPA services.

States asked how the DRA affects an individual with income between 101-150% of poverty. Individuals who qualify as medically needy, or under the Medicaid buy-in options would likely be eligible if their income is between 100-150% of poverty. Individuals eligible under the 100% of poverty group might be eligible if the state used §1902 (r)(2) to disregard additional income. This section might be applied to other groups but the disregard would apply to all members of the group and could not be limited to individuals who receive HCBS state plan option services.

The SPA option does not allow States to cover individuals with income between 150% of FPL (\$1225 a month for a single person household) and 300% of the Federal SSI benefit (\$1809 a month in 2006) unless they also receive an HCBS 1915 (c) waiver service.

### **Services**

The DRA allows States to cover all services listed in Section 1915 (c) (4) (B). This section includes a list of services – case management, homemaker, personal care, adult day health, habilitation, respite care, and day treatment. It also includes the phrase “and other services approved by the Secretary. However, the DRA language says:

“.... described in paragraph (4) (B) of subsection (c) for which the Secretary has the authority to approve a waiver and not including

room and board or such other services requested by the State as the Secretary may approve.”

The absence of a comma after room and board means that States may not cover any service beyond those that are specifically listed. A technical correction bill may be passed that allows States to include services beyond those that are specifically listed.

Section §1915 (c) also requires that waiver services must supplement and not duplicate services available under the State plan. Since the HCBS option is a State plan amendment, these provisions continue to apply. States may set limits on a State plan service but if they continue to operate a §1915 (c) waiver, the waiver services must supplement the SPA services. States could design SPA limits to serve individuals with less intense needs and design waiver services to serve individuals with more intensive needs.

States that already cover personal care under the State plan could replace it with the DRA SPA option or design the service under the SPA to supplement what is already available under the State plan.

### **Needs criteria**

The SPA option removes the requirement that individuals meet the institutional level of need criteria to receive HCBS services. States are required to set needs based criteria for HCBS SPA services. They are also required to set more stringent criteria for institutional services (hospital, ICF-MR and nursing home) than for the SPA services. This requirement may be met by raising the institutional level of need criteria and retaining (or lowering) the community level of need; or by keeping the current institutional level of care and lowering the community level of need criteria.

The criteria for institutional and HCB services requires an assessment of the individual’s support needs, and may take into account the individual’s inability to perform 2 or more ADLs (bathing, dressing, eating, transferring, toileting and continence), or the need for significant assistance to perform ADLs and other risk factors as the State may determine. Another section of the DRA says that States shall use the 2 ADLs criteria.

### **Grandfather provisions**

Since the level of need criteria for institutional services must be more restrictive, the law allows individuals in institutions or individuals who

receive waiver services and no longer meet the new institutional criteria to continue to receive services until they leave the institution or the waiver or they no longer require the level of care prior to the change.

The more stringent institutional level of need criteria apply to individuals entering an institution or enrolling in a waiver program after the effective date of the State plan amendment.

### **Changing the level of need criteria**

States may modify the level of need criteria by giving 60 days notice to the public and CMS if enrollment exceeds the estimated number of participants. Participating individuals who no longer meet the modified criteria may continue to receive services for at least 12 months from the date they first received services, not from the date of the modification. The regulations will clarify whether States may continue to serve beneficiaries for longer than 12 months.

### **Targeting**

The DRA does not allow States to target groups of beneficiaries such as aged or disabled or individuals with developmental disabilities. All Medicaid beneficiaries who meet the level of need criteria for the SPA option must be served within limits described below. However, it appears that States might be able to indirectly target a specific group of individuals by carefully designing the benefits that are covered. If a State wanted to serve individuals with mental illness, they might limit the SPA option benefit to habilitation or day treatment and define the service in a way that only someone with a mental illness would use it. However, if a State tried to limit who will be served in this way, it may affect eligibility for others who receive HCBS waiver services. Because the State will have established more stringent level of need criteria for the waiver, even if it limits the service(s) covered under the State plan, it would appear that the more stringent criteria would have to apply to all waiver beneficiaries.

### **Enrollment**

Unlike other State plan services, the DRA allows States to limit the number of individuals that will be served under the HCBS SPA. States submit an estimate of the number of individuals who will be served. If the number served exceeds the estimate, States may either establish a waiting list or revise the level of need criteria. CMS will develop regulations that address waiting lists and the rights of beneficiaries who are on the waiting list.

Revisions to the level of need criteria made because participation exceeded the estimate may be implemented with 60 days notice to the public and CMS. Approval by CMS is not required for this revision. Changes made to the level of need for other purposes must be approved by CMS.

Individuals receiving HCBS SPA services prior to the effective date of the level of need revision may continue to receive services “for at least 12 months.” The language implies that States may decide to continue services for longer than 12 months for individuals that no longer meet the criteria.

### **Evaluation and assessment**

The DRA requires that applicants for institutional services and SPA services receive an independent evaluation of their eligibility and an independent assessment of their service needs.

States must use an independent assessment for individuals eligible for HCBS SPA services to determine the level of services and supports to be provided; to prevent unnecessary and inappropriate services; and establish an individualized care plan.

States must establish safeguards to prevent conflict of interests which presumably means that the person or organization completing the evaluation of the level of need and the assessment and care plan have no financial interest in the services provided. Questions were raised on the conference call as to whether States have a conflict of interest and therefore need to contract with an outside entity to perform this activity. States recommended that conflict be limited to the financial interest in determining eligibility for services for which the entity is reimbursed. While the State may be deemed to have a financial interest in the outcome, they do not receive a payment based on the decision. Individuals who qualify for institutional services or the HCBS State plan option would retain the right to choose which service they prefer based on their eligibility.

The assessment must be conducted face to face by a trained assessor. The assessment includes, where appropriate, consultation with the family, spouse, guardian or other responsible individual and consultation with appropriate treating and consulting health and support professionals caring for the individual. The care plan is based on consultation with the individual’s physician, other professionals, and where appropriate, family members, care giver or representative; and takes into account the care

provided by family members. The DRA does not require that physicians sign the level of need or approve the care plan.

The care plan is reviewed at least annually and when there is a significant change.

### **Presumptive eligibility**

The DRA allows States to presume eligibility for SPA HCBS services. Eligibility must be verified within 60 days and the presumption of eligibility only applies to the evaluation of eligibility, the assessment process and the services delivered within the 60 day period. The presumed eligibility does not apply to State plan services that are not part of the HCBS SPA.

### **Impact on existing waivers**

States that submit an HCBS SPA have the authority to continue to operate §1915 (c) waivers, as well as §1915 (b) and §1115 demonstration waivers that cover long term care services. As noted above, the SPA services must supplement and not duplicate services covered by §1915 (c) waivers.

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