

HCBS Intensive

HCBS Final Rule

**Where We Were, Where We are Now
& the Path to Final Approval**

August 2017

2014 HCBS Final Rule

- Published January 2014 – Effective March 17, 2014
- Addressed HCBS requirements across:
 - ❖ 1915(c) waivers
 - ❖ 1915(i) state plan
 - ❖ 1915(k) Community First Choice
 - ❖ 1115 Demonstrations
- Requirements apply whether delivered under a fee for service or managed care delivery system
- Guidance issued in May 2017 extended the transition period for settings in existence as of the effective date of the final regulation from March 2019 to March 17, **2022**. Extension of the transition period recognizes the significant reform efforts underway and is intended to help states ensure compliance activities are collaborative, transparent and timely.

Key Themes

- The regulation is intended to serve as a catalyst for widespread stakeholder engagement on ways to improve how individuals experience daily life
- The rule is not intended to target particular industries or provider types
- FFP is available for the duration of the transition period
- The rule provides support for states and stakeholders making transitions to more inclusive operations
- The rule is designed to enhance choice

HCBS State Transition Plans: Status of STP Reviews

- Four states have received final approval from CMS (TN, KY, AR, OK).
- 35 states have received Initial Approval.
- The majority of states who have not received Initial Approval are scheduled to update their STPs and resubmit to CMS within the next 6 months.
- Technical assistance continuing to support states
 - ❖ Individual calls
 - ❖ SOTA Calls
 - ❖ Effective Models of Key STP Components

HCBS Setting Criteria

Is integrated in and supports access to the greater community

Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources

Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS

Is selected by the individual from among setting options including non-disability specific settings

Ensures an individual's rights of privacy, respect, and freedom from coercion and restraint

Optimizes individual initiative, autonomy, and independence in making life choices

Facilitates individual choice regarding services and supports and who provides them

*****Additional Criteria for Provider-Controlled or Controlled Residential Settings*****

Home and Community-Based Setting Criteria

Provider Owned and Controlled Settings –

Additional Criteria

- Specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement
- Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity
- If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law

Home and Community-Based Setting Criteria

Provider Owned and Controlled Settings – Additional Criteria

- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- Setting is physically accessible to the individual

Home and Community-Based Setting Criteria

Provider Owned and Controlled Settings – Additional Criteria

- Modifications of the additional criteria must be:
 - ❖ Supported by specific assessed need
 - ❖ Justified in the person-centered service plan
 - ❖ Documented in the person-centered service plan

Home and Community-Based Setting Criteria

Provider Owned and Controlled Settings – Additional Criteria

- Documentation in the person-centered service plan of modifications of the additional criteria includes:
 - ❖ Specific individualized assessed need
 - ❖ Prior interventions and supports including less intrusive methods
 - ❖ Description of condition proportionate to assessed need
 - ❖ Ongoing data measuring effectiveness of modification
 - ❖ Established time limits for periodic review of modifications
 - ❖ Individual's informed consent
 - ❖ Assurance that interventions and supports will not cause harm

Public Engagement

- A state must provide at least a 30-day public notice and comment period regarding the transition plan(s) that the state intends to submit to CMS for review and consideration, as follows:
 - ❖ The public notice must be in electronic (e.g. state website) and non-electronic (e.g. newspaper, mailings, etc.) forms.
 - ❖ The state must:
 - provide two (2) statements of public notice and public input procedures.
 - ensure the full transition plan is available for public comment.
 - consider and modify the transition plan, as the state deems appropriate, to account for public comment.
- A state must submit to CMS, with the proposed transition plan:
 - ❖ Evidence of the public notice required.
 - ❖ A summary of the comments received during the public notice period, any modifications to the transition plan based upon those comments, and reasons why other comments were not adopted.

[Citation: Page 85 of the [Federal HCBS Settings Rule](#)]

Public Engagement: *Promising State Strategies*

Promising Practice	State Examples
Full Statewide Transition Plan (STP) must be made available to the stakeholders in electronic and non-electronic forms.	All States
Provides clear, easily digestible overview of the rule and context of the state's implementation process in the STP	Pennsylvania
Virtual and in-person orientation sessions and "town-hall" like meetings across state and stakeholders. Focus groups and feedback forums early on to help inform the design of the state's HCBS implementation strategy.	Ohio
Establishment of state working groups or committees that included balanced/equal representation of various stakeholders.	Delaware
List of all relevant services, settings, descriptions being captured in the HCBS implementation process.	North Dakota, Iowa
Use of multi-media to broadcast and disseminate information about public comment process(es).	South Carolina
Provides clear, informative summary of public comments received, including state's responses for how it addressed each comment or category of comments.	Alabama

Site Specific Assessment and Remediation

- States' Approach to Assessing HCBS Compliance of Individual Settings
- State Validation Strategies
- Settings Remediation

Distinguishing between Settings under the HCBS Rule

Settings that are not home and community-based

- Nursing Facilities
- Institution for Mental Diseases (IMD)
- Intermediate care facility for individuals with I/DD (ICF/IID)
- Hospitals

Settings presumed not to be home and community-based

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution

Settings that could be home and community-based with modifications

- Settings that require modifications at an organizational level, and/or modifications to the PCP of specific individuals receiving services within the setting.
- Settings that engage in remediation plans with the state, and complete all necessary actions no later than March 2022.

Settings presumed to be home and community-based and meet the rule without any changes required

- Individually-owned homes
- Individualized supported employment
- Individualized community day activities

Settings Assessment for HCBS Compliance: *Scope*

- States must identify all types of home and community based program settings in their state where HCBS are provided.
 - ❖ States should first list out all major categories of services provided under their various HCBS authorities.
 - ❖ Then, states should identify all settings in which each category of service(s) are provided.

Settings Assessment for HCBS Compliance: *Threshold*

- States are responsible for assuring that all HCBS settings comply with the final HCBS rule.
- Quality thresholds should not be used to reduce the state's requirement to assure compliance across all settings.

Review of HCBS Settings under Final Rule: *Key Components*

Assessment

Validation

Remediation

Review of HCBS Settings Compliance: *Initial Assessment*

- Most states opted to perform an initial provider self-assessment
 - ❖ States that did not receive 100% participation of providers in self-assessment process must identify another way the assessment process will be conducted.
 - ❖ Providers responsible for more than one setting need to complete an assessment of each setting.
- States must provide a validity check for provider self-assessments. A viable option for states that choose to initiate a provider self-assessment is to conduct a beneficiary/guardian assessment (or other method for collecting data on beneficiary experience) that mirrors or is similar to the provider assessment in order to have a comparable set of data from the beneficiary perspective.

Review of HCBS Settings Compliance: *Initial Assessment (continued)*

- Most states formulated their assessment tools using the Exploratory Questions for Residential and Non-Residential Settings published by CMS.
 - ❖ Questions in these documents are examples of ones that states could be asking of settings, but a state may use additional questions or methods to determine whether a setting complies with the settings criteria.

Highlighting Effective Practices in Assessing Setting Compliance: *State Examples*

Effective Practice/Strategy	State Examples
Provides clear, easy to understand listing of all HCBS authorities and categories of settings across state	Iowa Pennsylvania
Developed unique comprehensive assessment tools based on type of setting and target respondent	Maine South Carolina
Clearly laid out the specific details of the state's approach to the assessment process (including sample sizes). Also discussed how the state addressed any non-respondents.	Arkansas Oregon
Summarized assessment results in a digestible manner (based on the main requirements of the rule and additional provider-owned and controlled setting criteria) so as to inform state's strategy on remediation.	Iowa South Dakota

Review of HCBS Settings Compliance: Validation

- The state must assure at least one validation strategy is used to confirm provider self-assessment results, and should also identify how the independence of assessments is ensured where an MCOs validates provider settings.
- Validation strategies vary across states and can include several options
 - ❖ Onsite visits, consumer feedback, external stakeholder engagement, state review of data from operational entities, like case management or regional boards/entities
- The more robust the validation processes (incorporating multiple strategies to a level of degree that is statistically significant), the more successful the state will be in helping settings assure compliance with the rule.

Highlighting Effective Practices in Validating Setting Compliance: *State Examples*

Effective Practice/Strategy	State Examples
State outlines multiple validation strategies that addressed concerns and assured all settings were appropriately verified. Validation process included multiple perspectives, including consumers/beneficiaries, in the process.	District of Columbia Tennessee
State relied on existing state infrastructure, but laid out solid, comprehensive plan for training key professionals (case managers, auditing team) to assure implementation of the rule with fidelity.	Delaware Tennessee
State used effective independent vehicles for validating results.	Michigan New Hampshire
State clearly differentiated and explained any differences in the validation processes across systems.	Connecticut Indiana

Settings Assessment for HCBS Compliance: Remediation

- Statewide training & technical assistance is a strong option for states to consider.
 - ❖ State lays out clear plan within the STP of how it will strategically invest in the training and technical assistance needed to help address system-wide remediation actions of specific settings, as well as how it intends to build the capacity of providers to comply with the rule.
- Setting-Specific Remediation
 - ❖ Corrective Action Plans
 - ❖ Tiered Standards

Highlighting Effective Practices in HCBS Settings Remediation: *State Examples*

Effective Practice/Strategy	State Examples
<p>State simultaneously provided a comprehensive template for a corrective action or remediation plan to all providers as part of the self-assessment process.</p>	<p>Arkansas Tennessee</p>
<p>State has outlined a process for following up with settings that require remediation to comply with the rule, including but not limited to the negotiation of individual corrective action plans with providers that address each area in which a setting is not currently in compliant with the rule.</p>	<p>Indiana North Dakota Pennsylvania</p>
<p>State has outlined a comprehensive approach to apply tiered standards to elevate the quality and level of integration of one or more categories of HCBS settings.</p>	<p>Indiana Ohio Tennessee</p>
<p>State has identified those settings that cannot or will not comply with the rule and thus will no longer be considered home and community-based after the transition period. State has also established an appropriate communication strategy for affected beneficiaries.</p>	<p>Ohio North Carolina</p>

Implementation: Tiered Standards

- States have flexibility to set different standards for existing and new settings.
- Existing settings must meet the minimum standards set forth in the HCBS rules but the state “may suspend admission to the setting or suspend new provider approval/authorizations for those settings”
 - ❖ State may set standards for “models of service that more fully meet the state’s standards” for HCBS and require all new service development to meet the higher standards
 - ❖ The tiered standards can extend beyond the transition plan timeframe to allows states to “close the front door” to settings/services that only meet the minimum standard.

[Reference: [CMS FAQs dated 6/26/2015](#); page 11, Answer to Question #16]

STP Review: Key Questions

- Did the state accurately and clearly lay out all of the settings in each HCBS authority where HCBS is delivered?
- Are there any categories of settings for which a state is presuming to automatically meet all of the criteria of the HCBS rule? Are there any categories of settings that the state is automatically determining will require remediation to comply with the rule? Are there any categories that automatically rise to the level of heightened scrutiny?
- How are specific categories of settings structured in the state (for example, are there any that are required to be co-located inside of or on the grounds of an institutional setting)?

STP Review: Key Questions

■ Remediation Questions

- ❖ How does the state propose working with providers of settings that are not currently compliant with the rule but could be with appropriate remediation?
- ❖ Has the state proposed using tiered standards?
- ❖ What investments is the state making to provide technical support to help providers come into compliance?

Resources

- **Main CMS HCBS Website:** <http://www.medicaid.gov/HCBS>
 - Final Rule & Sub-regulatory Guidance
 - A mailbox to ask additional questions
 - Exploratory Questions (for Residential & Nonresidential Settings)
- **CMS Training on HCBS – SOTA (State Operational Technical Assistance) Calls:**
<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/hcbs-training.html>
- **Statewide Transition Plan Toolkit:**
<https://www.medicaid.gov/.../statewide-transition-plan-toolkit.pdf>

Resources

- **Exploratory Questions**
 - ❖ [Residential Settings](#)
 - ❖ [Non-Residential Settings](#)
- **FAQs**
 - ❖ [HCBS FAQs on Planned Construction and Person Centered Planning \(June 2016\)](#)
 - ❖ [HCBS FAQs on Heightened Scrutiny](#) dated 6/26/2015
 - ❖ [FAQs on Settings that Isolate](#)
 - ❖ [Incorporation of HS in the Standard Waiver Process](#)
- **ACL Plain-Spoken Briefs on HCBS Rule & Person Centered Planning:**
<http://www.acl.gov/Programs/CPE/OPAD/HCBS.aspx>

Resources: CMS HCBS STP Contacts

Central Office Contacts - Division of Long Term Services and Supports

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- ❖ Michele MacKenzie, Technical Director
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TN

***Final Approval of a Statewide
Transition Plan:
One State's Approach***

TM

What does “*final approval*” mean?

- Doesn't mean that...

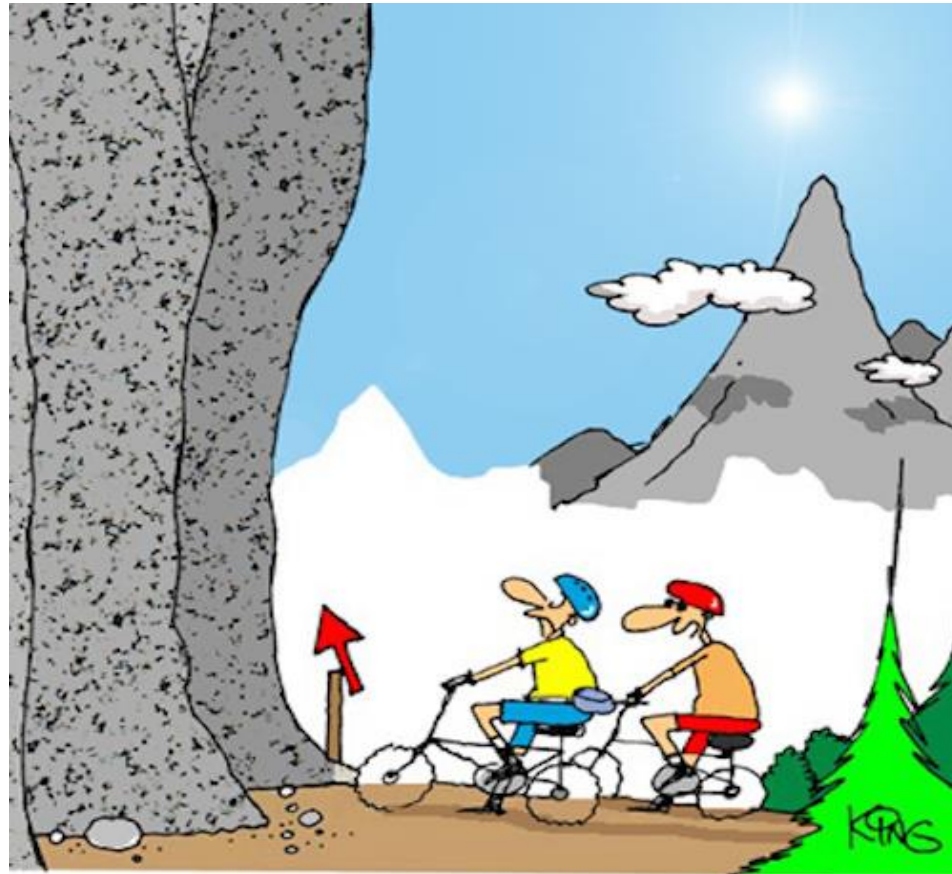


- Does mean that:

- Public comment, input and summary requirements are met
- STP has provided all necessary information including, but not limited to:
 - ✓ Systemic assessment
 - ✓ Site specific assessment
 - ✓ Settings presumed to have institutional characteristics
 - ✓ Information regarding heightened scrutiny or the state's decision to let the presumption stand
 - ✓ Clear remedial steps with milestones



After “*final approval*”...



“Here’s where it gets a little challenging.”

Context for today's discussion

- **Not** here to tell you “how to develop your plan” to get to final approval
 - No “one right way”
 - Every state must determine the approach that makes the most sense for *their* state and *their* HCBS system
- Goal is to talk about key aspects of Tennessee’s plan that helped us get to final approval and to provide tools and share experiences that may be helpful in formulating and implementing your state’s plan and approach
- Goal is also to learn things from one another that will benefit *all of us* as we continue moving forward together

Tennessee's Strategy

- Comprehensive statewide approach across Medicaid programs and authorities
 - 1115 MLTSS (**managed care**) program
 - 3 Section 1915(c) **fee-for-service** waivers
- Full compliance as soon as possible—*before* 2019 (or 2022)
- Leverage contracted partners to expand capacity
 - State I/DD Department, Managed Care Organizations
- Coordinate to minimize provider/other administrative burden, where possible
- Leverage technology for data collection and analysis
- Not just *what we think* but *what we know* (100% assessment and review/validation)

Tennessee's Strategy

- Find the “opportunity” in the midst of the challenge



**Not just compliance, but
*Better lives for
the people we support***



- Meet the *spirit and intent* of the regulation
- Inform and engage stakeholders in meaningful ways
- Embed in ongoing processes (not just “one and done,” but a continuous process)

Site-specific assessments

- **Number of Provider Settings to Assess: 1247**
 - Residential Provider Settings: 706
 - Non-Residential Settings: 541
- **Number of staff (at the outset): 5**
- **Develop a self-assessment tool**
- **How will know it is accurate?**
 - Require evidence
 - 100% review and validation, including site visits as needed
 - **Require stakeholder involvement**—persons served/self-advocates, staff, families, advocates, etc.
 - ***Ask the people receiving HCBS!***



Gathering information *directly* from consumers

Individual Experience Assessment (IEA)

- Developed from the CMS Exploratory Questions
- Administered by contracted case management entity
 - Independent Support Coordination agency
 - I/DD Dept. Case Manager
 - MCO Care Coordinator
- Phase I - individuals receiving residential and day services
- Phase II - embed in annual planning process for **all** persons receiving HCBS
- Data from IEA is cross-walked to the specific provider/setting in order to validate site-specific provider self-assessment results
- 100% remediation of any individual issue identified; thresholds established (by question) for additional remediation actions, e.g., potential changes in site-specific assessment, transition plan, policies, practices, etc.

Partnering for successful implementation

Provide *extensive* training

- **Train providers**
 - Detailed walk through of each tool and expectations
 - Self-assessment form (literally, each question)
 - Accessing the survey
 - Validation form
 - Transition plan template
 - Demonstration of the survey
 - Expectations for document submissions
 - Engaging stakeholders in a meaningful way
- **Train designated reviewers (contracted operating entities)**
- **Educate boards and families**
- **Provide ongoing guidance/technical assistance as needed**

Provider transition plans

- **Initial** Compliance (*after* review and validation):
 - 14% of settings assessed 100% compliant
 - 84% of settings with at least one “opportunity” for improvement (area of non-compliance); developed a transition plan
 - 2% (27 settings) non-compliant; elected to not develop a transition plan
- State-developed “HCBS Settings Transition Plan” template
- Each provider responsible for identifying remediation actions and timelines for each non-compliant area
- Flexibility to make adjustments based on learnings—*continuous* quality improvement
- Heightened scrutiny reviews provided an opportunity for engagement with staff and persons served in each setting and to brainstorm/problem-solve around opportunities for improvement

Keeping it “*real*”: Review and Validation

- **100% review and validation of provider self-assessments and transition plans required (versus smaller sampling approach)**
 - Leverage contracted entities
 - State I/DD Agency
 - MCOs
 - Develop standardized template
 - Provide training and ongoing technical assistance
- **TennCare validation**
 - TennCare validation of each designated reviewer’s initial reviews prior to sending to provider
 - Sample review at the conclusion of the process
 - Complicated settings
 - Upon request
- **On-site visits**

Supporting transformation

- **How can we make it more than a compliance exercise?**
 - Focus on the opportunity
 - Align with important system values and goals
 - Advance person-centered practices
 - Support people in achieving personal outcomes
 - Improve quality of services, quality of life
 - Engage people with a broad range of perspectives—persons served/self-advocates, staff, families, advocates, etc.
 - Look beyond policies and processes to how they impact the day-to-day experience of persons supported
 - Empower and equip providers, along with their stakeholders, to identify the changes that will help them improve



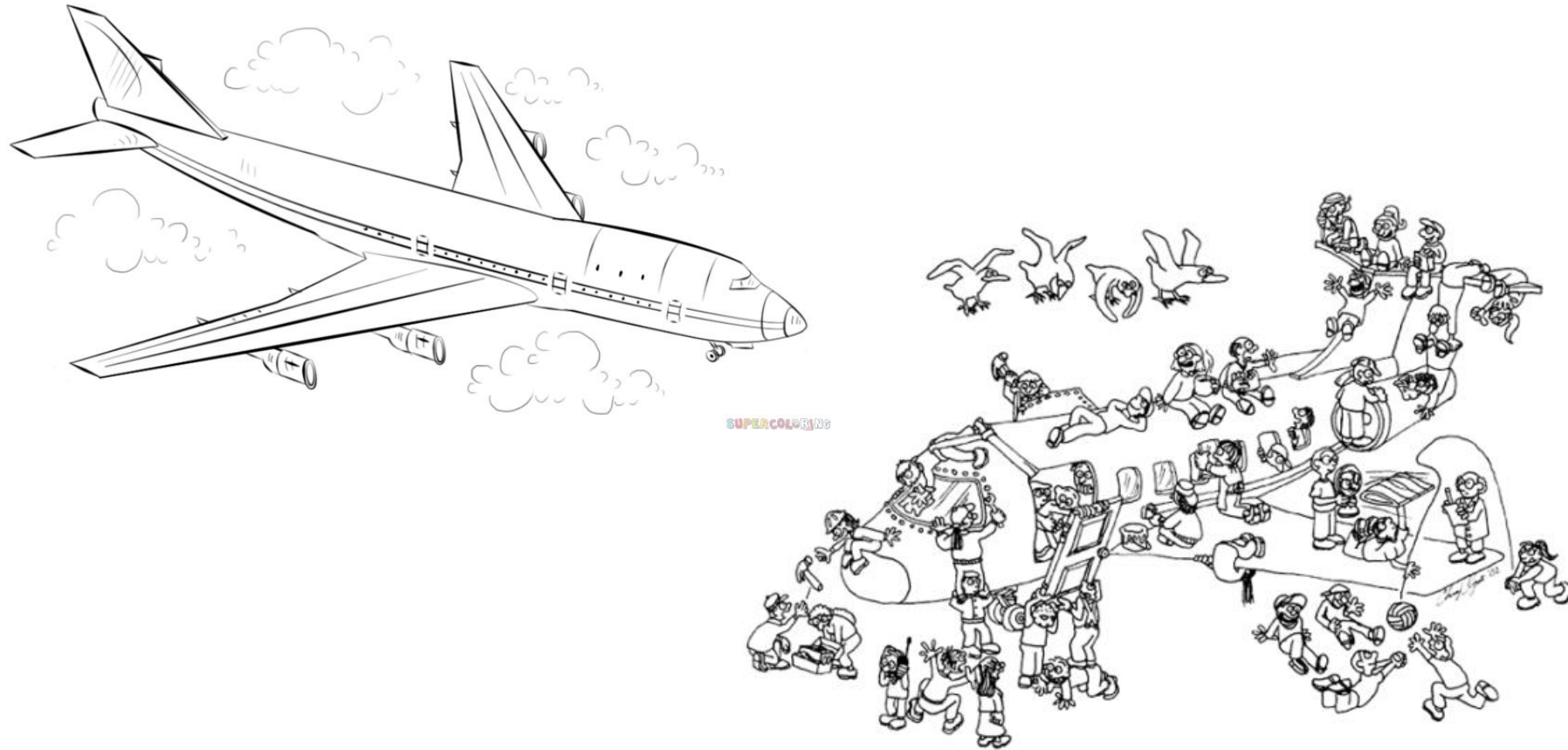
Supporting transformation

- **How can we make it more than a compliance exercise?**
 - Culture change (“transformation”) initiative
 - State leadership group (cross-program, cross-disability), including:
 - Self-advocates
 - Advocacy groups
 - Providers
 - Health plans
 - State Medicaid and I/DD agencies
 - Facilitated by Michael Smull/Support Development Associates
 - Identify provider, health plan and system level reforms that will advance person-centered practices and align with system values



A “two-pronged” (or tiered) approach

- **Building** and **“re-building”**



Employment and Community First CHOICES

- New MLTSS program implemented in July 2016
- All new enrollment directed to new program; HCBS waivers “closed”
- Operates under Tennessee’s 2+ decade long 1115 demonstration
- Integrates physical, behavioral health and LTSS for individuals with I/DD
- Aligns incentives to promote competitive integrated employment and community living as the first and preferred outcome for individuals with I/DD
- Array of 14 different employment services create a pathway to employment, even for people with significant disabilities
- No facility-based settings; all services provided in the home/community
- **Employment Informed Choice** process ensures that employment is the *first* option considered for every person of working age **before** non-employment day services are available
- Outcome-based reimbursement for up front services leading to employment; reimbursement for start-up tiered to support sustained employment; coaching rate incentivizes independence/fading of paid supports over time

Employment and Community First CHOICES

- Provider network developed based on “preferred contracting standards” designed to point MCOs to providers with proven track records of success in supporting individuals with I/DD in obtaining competitive, integrated employment and participating in community
- All settings must comply with settings rule from the outset
- Comprehensive person-centered assessment and planning process explores employment early in process and in significant depth
- Support Coordination staff recruited based on experience, attitude about employment, trained/supported in person-centered planning/practices and in facilitating employment conversations that lead to goals and next steps
- Standardized person-centered support plan template beginning with important to/for, decision making and rights, employment, education, relationships and community integration, etc. (even an HCBS settings compliance section)
- Person-centered organization training for all MCOs (including health plan leadership) conducted by Michael Smull/Support Development Associates

Aligning (“rebuilding”) existing programs

- Revisions to 1915(c) Employment and Day Services definitions/reimbursement:
 - Incentive payments for vocational-related outcomes such as:
 - A one-time payment for job placement
 - Co-worker stipends (for work place support beyond regular job duties)
 - A one-time payment for job retention (one year)
 - Flexibility in days/hours employment wrap-around services can be provided
 - Facility-based day services limitations
 - Time-limited
 - Chosen by the individual
 - Focused on development of individualized specific skills that will support person in pursuing and achieving employment and/or community living goals
 - Only utilized if person requires services that can’t be provided in the community
 - Ultimate goal of pre-vocational services must be CIE
 - Capacity for more integrated employment re-evaluated every six months
 - Facility-based day services must ensure opportunities for all persons supported to engage in the broader community consistent with needs/preferences

Aligning (“rebuilding”) existing programs

- 2nd round of more extensive revisions (in process) to Employment and Day Services definitions and reimbursement:
 - Clearly delineating CIE as the expected outcome of employment services
 - Limiting small group employment to no more than 3 persons/group
 - Transition from per diem to quarter hour units across all Employment/Day services
 - Completely restructuring reimbursement approach for Employment and Day Services based on key learnings from MLTSS program
 - Newly established rates for employment exploration, discovery, job development/customization or self-employment start-up, job coaching, and stabilization and monitoring
 - New category of Community-Based Day Services (called Community-Based Employment Wrap Services) with higher rates of reimbursement than Community-Based Day services that do not wrap integrated employment
 - Wrap-around rates vary depending on number of hours the person works in integrated employment to further incentivize maximization of employment outcomes

Tennessee's materials

- **Transition Plan documents** available at:
<http://tn.gov/tenncare/topic/transition-plan-documents-for-new-federal-home-and-community-based-services>
 - Updates
 - All posted versions of the Statewide Transition Plan with tracked changes to ease stakeholder review
 - Provider self-assessment tools and resources
 - Individual Experience Assessment
 - Heightened Scrutiny tools and resources
 - Training and education materials
- **Employment and Community First CHOICES** information available at:
<https://tn.gov/tenncare/topic/employment-and-community-first-choices>
- **1915(c) waiver amendments** will be posted on the TennCare website at tn.gov/tenncare



KENTUCKY

Cabinet for Health and Family Services

HOME AND COMMUNITY BASED SERVICES (HCBS) CONFERENCE

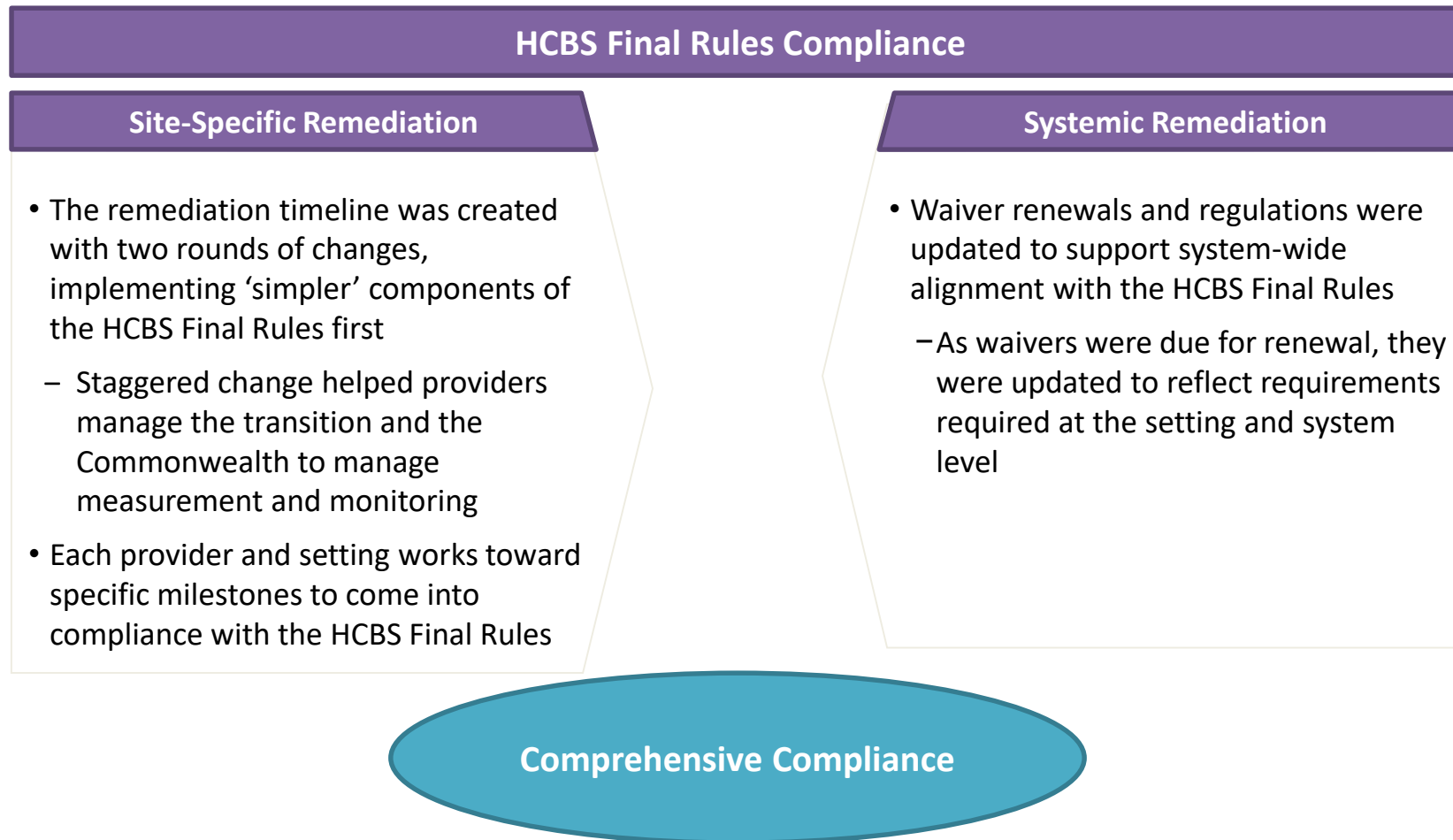
PRESENTED BY:

LORI GRESHAM, R.N. PROGRAM MANAGER
DEPARTMENT FOR MEDICAID SERVICES (DMS)

Remediation Alignment

Aligning Systemic and Site-Specific Remediation

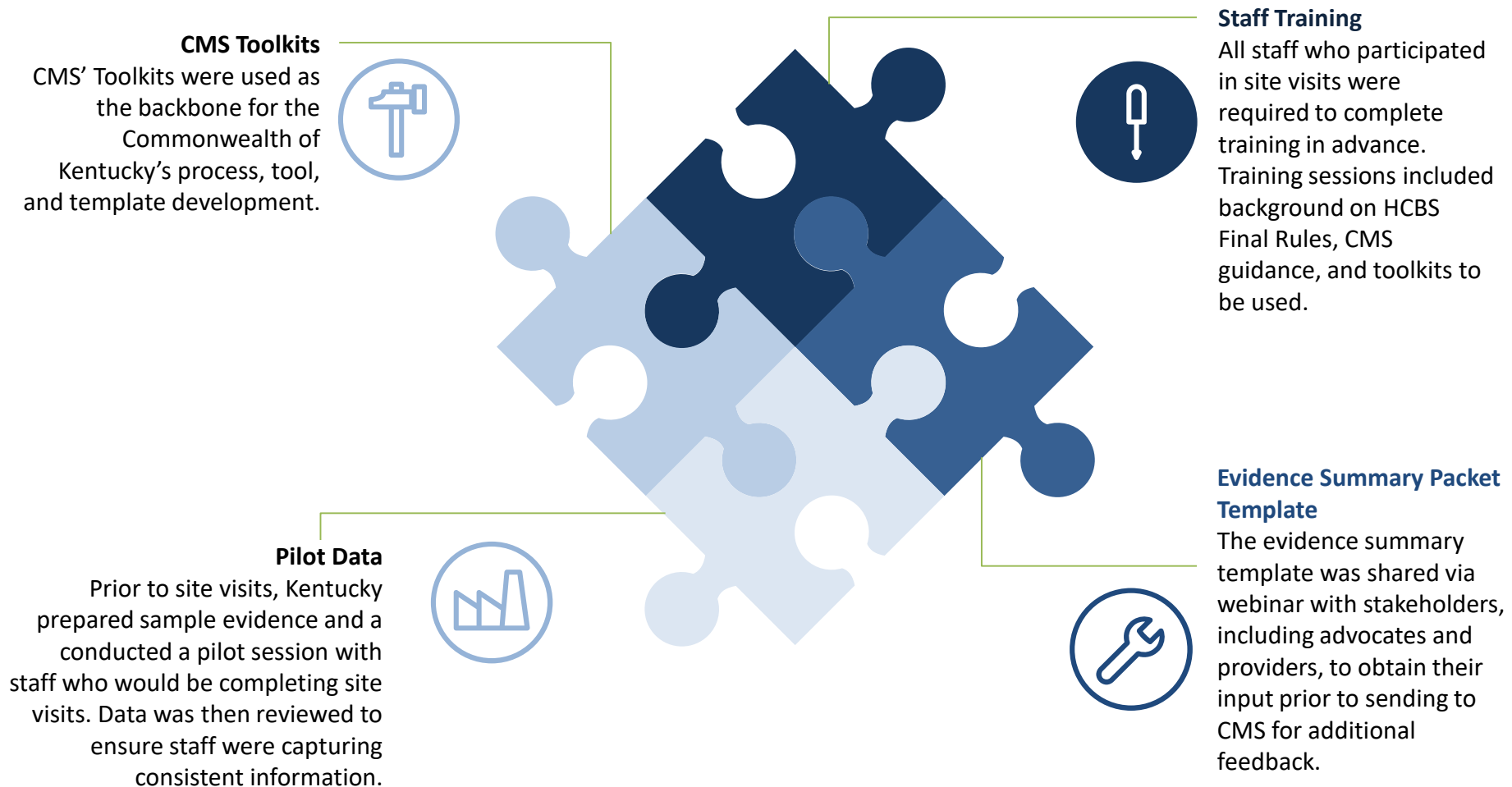
Kentucky aligned its waiver renewals, regulation revisions, and setting remediation to ensure that all of its HCBS programs come into compliance with the HCBS Final Rules.



Heightened Scrutiny Process

Kentucky's Heightened Scrutiny Process

Tools and site visit methods were prepared with CMS, staff, and stakeholder input to assure high quality and standardized data for evidence summary development.



Kentucky's Heightened Scrutiny Process

After site visits were conducted, Kentucky's HCBS work group reviewed collected evidence to identify which settings needed to develop transition plans to bring their policies and practices into full compliance with the HCBS Final Rules.

Evidence Review

- Each setting's evidence of home and community based characteristics was reviewed internally with a focus on participant interviews, staff interviews, and site observations
- During review, each setting was assessed individually to determine if they had sufficient evidence to overcome the presumption of being isolating (institution-like)

Transition Plan Development

- If the setting is not fully compliant with any of the HCBS Final Rules, the provider is notified and given an opportunity to submit a transition plan before their evidence package undergoes stakeholder review
- The transition plan must address all areas of non-compliance
- The transition plan is then included in the evidence package, which is shared with stakeholders for review prior to submission to CMS

The image displays three overlapping forms from the Kentucky Department of Community and Public Safety, related to HCBS Final Rules Compliance. The top form is the 'Home and Community Based Services (HCBS) Final Rules Compliance' provider questionnaire. The middle form is the 'Home and Community Based Services (HCBS) Final Rules Compliance' participant questionnaire. The bottom form is the 'Home and Community Based Services (HCBS) Final Rules Compliance' transition plan form, which includes sections for 'Transition Plan', 'Evidence Package', and 'Transition Plan'.

Kentucky's Heightened Scrutiny Process

After transition plans were collected, a stakeholder group consisting of self-advocates, family members, advocates, and provider representatives reviewed evidence packages before Kentucky submitted them to CMS for heightened scrutiny.

1

Pilot Submission Stakeholder Review Session

- 30 evidence packages were blinded so that the provider and setting were not known to the reviewer
- Stakeholders included self-advocates, families, advocates, and provider representatives
- The group reviewed the evidence packages and determined if each setting had sufficient evidence of home and community-based characteristics to be sent to CMS for heightened scrutiny
- Settings that did not have sufficient evidence then entered into the site-specific remediation process, which includes specific technical assistance

2

Second Submission Stakeholder Review Session

- 50 evidence packages were selected, blinded, and divided into groups of 10
- Stakeholders included self-advocates, families, advocates, and provider representatives (the provider representatives invited to the review are not associated with the settings under review)
- Stakeholders were assigned to groups where they reviewed 10 summaries in the morning and a different set of 10 summaries in the afternoon
- Settings that did not have sufficient evidence then entered into the site-specific remediation process, which includes specific technical assistance

Settings Remediation Strategies

Setting Remediation Strategies

Kentucky is working to provide technical assistance to its providers as areas requiring remediation are identified. Technical assistance includes suggested activities based on positive practices other providers or settings within the Commonwealth are currently using.

Developing Positive Practice Suggestions



- Positive practices were identified during review of collected setting evidence
 - Reviewers noted positive practices like including participants in new staff interviews when making hiring decisions or staff helping participants coordinate arrangements to see family or friends



- Positive practices are categorized by each component of the HCBS Final Rules for greater ease of use



- Any provider receiving TA gets a series of slides, during a DMS site visit, that identify current activities, areas where the transition plan is insufficient, and examples of positive practices to bring their setting(s) into compliance



- Ongoing monitoring includes DMS site visits, during which staff and participants are interviewed to determine compliance with HCBS Final Rules. Areas of non-compliance are noted and brought to DMS attention for ongoing TA

HCBS Settings: The Arkansas Experience

August 2017

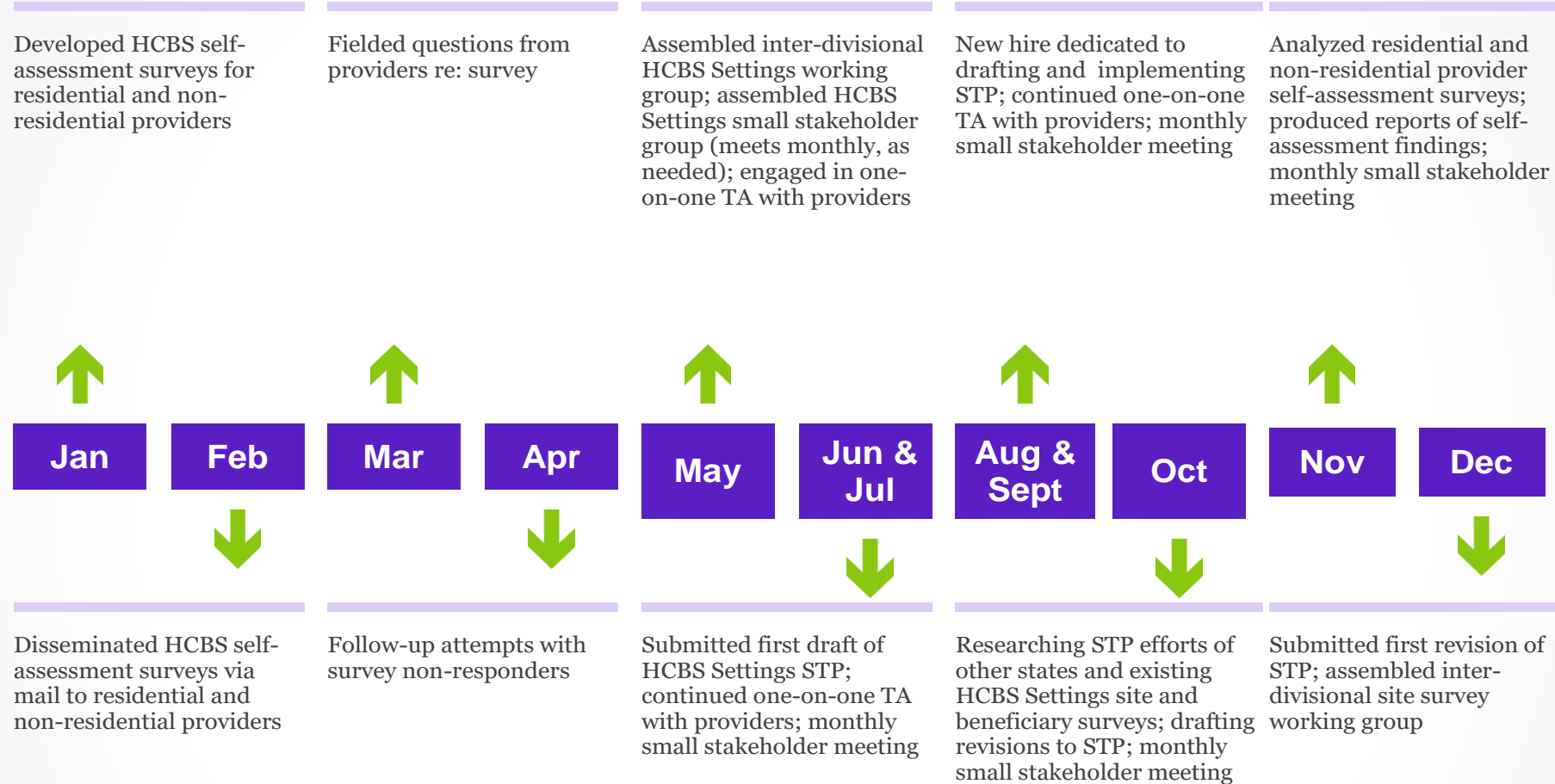
Acknowledgements

- Arkansas Department of Human Services
 - Dr. Victoria Evans, Program Manager (victoria.evans@dhs.arkansas.gov)
 - Shelby Maldonado, DDS Policy Coordinator (shelby.maldonado@dhs.arkansas.gov)
 - Members of inter-divisional HCBS Settings working group
- Members of HCBS Settings stakeholder group
 - Arkansas Health Care Association, Arkansas Residential Assisted Living Association, Disability Rights Association of Arkansas, Arkansas Autism Resource & Outreach Center, Arkansas Waiver Association, waiver providers and clients

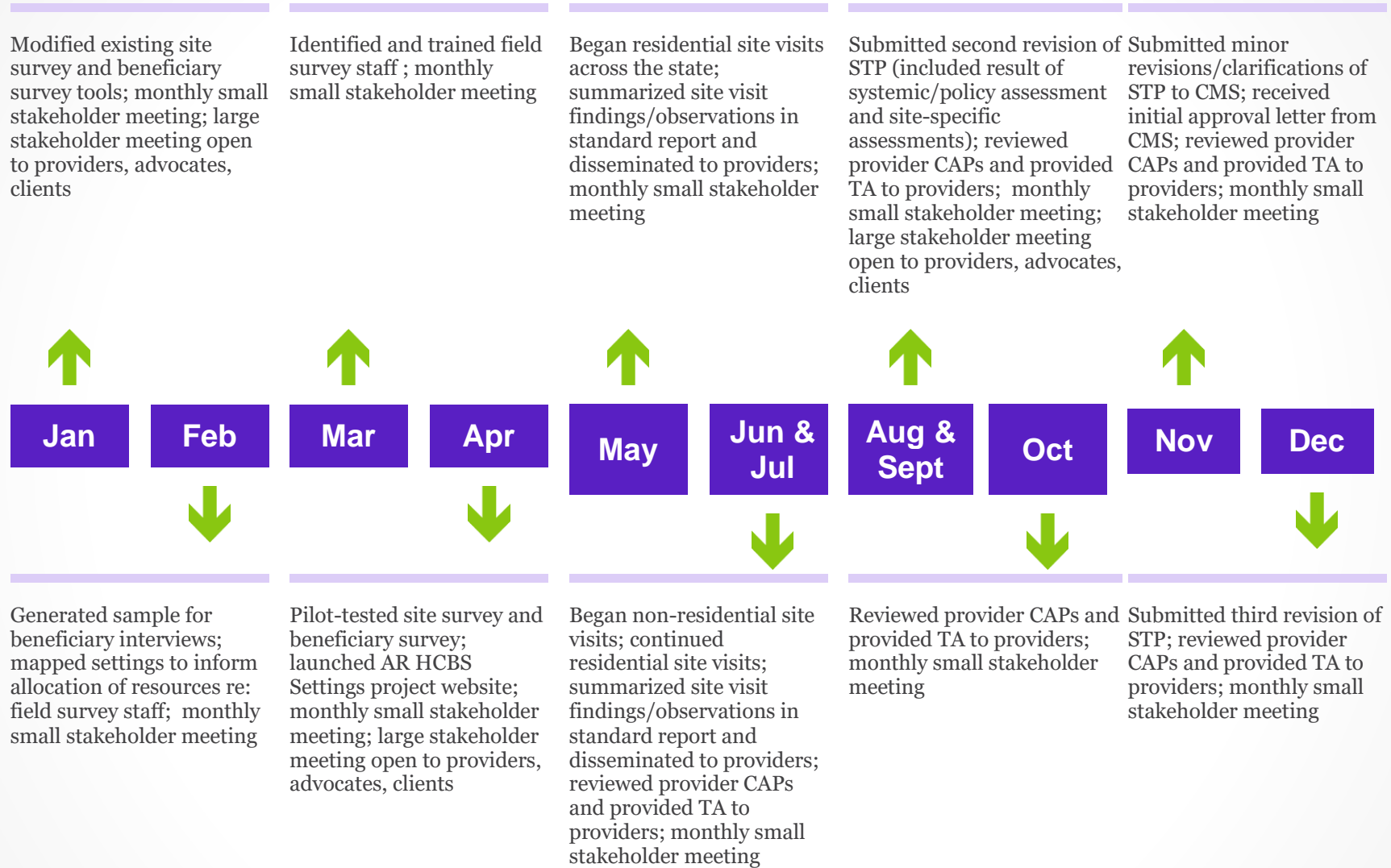
Presentation Objectives

- Present timeline of state activities
- Discuss state's approach to site-specific assessments for older adults
- Discuss state's approach to expanding non-disability specific options and increasing provider capacity
- Discuss state's strategies for transitioning beneficiaries (if necessary)

HCBS Settings Activities (2015)



HCBS Settings Activities (2016)



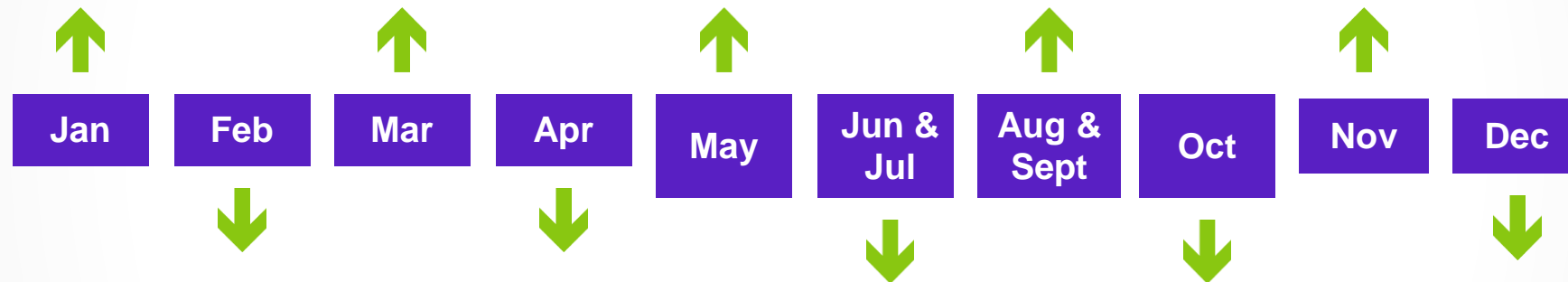
HCBS Settings Activities (2017)

Developed materials for statewide in-person training sessions; monthly small stakeholder meeting; large stakeholder meeting open to providers, advocates, clients

Mailed HCBS Settings compliance letters to residential providers; continued statewide in-person training sessions

Submitted fourth revision of STP; began residential and non-residential re-visits across the state to follow-up on CAP implementation; summarized site visit findings/observations in standard report and disseminated to providers; provided TA to providers

Reviewing provider CAPs re: re-visits and providing TA to providers



Launched statewide in-person training sessions (focused on heightened scrutiny, common issues re: Settings regs implementation and promising strategies for compliance)

Notified residential and non-residential providers of upcoming re-visits to follow-up on CAP implementation; mailed HCBS Settings compliance letters to non-residential providers; continued statewide in-person training sessions

Received final approval letter from CMS; continued residential and non-residential re-visits; summarized site visit findings/observations in standard report and disseminated to providers; provided TA to providers

Site-Specific Assessments

- 100% onsite visits
 - Assisted Living = 52 sites
 - Adult Day Care = 26 sites
- Beneficiary interviews
 - Interviewed 79% of Assisted Living target sample, representing all sites
 - Interviewed 39% of Adult Day Care target sample
 - Did re-visit sites that lacked beneficiary interviews and conducted some proxy interviews with guardians and/or family members, as necessary and appropriate

Site-Specific Assessments

- Statewide provider training sessions for both DAAS & DDS providers
 - Focused on common issues of partial or non-compliance identified during site visits, brainstormed strategies for compliance, discussed heightened scrutiny
 - Summarized strategies offered by providers during training sessions, disseminated to provider network
- Continue to update AR HCBS Settings project website with resources to supplement technical assistance
<http://humanservices.arkansas.gov/daas/Pages/HCBS-Settings-Home.aspx>

Expanding Non-Disability Specific Options

- Extended Habilitation (Employment Path) is a new service under Community Employment Supports (CES) waiver
 - Pre-vocational skills training in an integrated, non-disability specific setting
 - Attain employment in competitive, integrated setting for at least minimum wage
- Employment First State Leadership Mentoring Program
 - Developed process that allows DHS Divisions & ARS to utilize sequential funding to better leverage resources and provide unduplicated services to individuals with I/DD and/or physical disabilities
 - Developed pilot for provider transformation (DDTCS)

Expanding Non-Disability Specific Options

- Strengthened definition of adaptive equipment, recent amendment to Community Employment Supports waiver
 - New definition includes enabling technology, such as safe home modifications
 - Empowers participants to gain independence through customizable technologies, while still providing monitoring and response as needed
 - Allows participants to be proactive about their daily schedule, integrates participant choice, & provides greater flexibility and access to non-disability specific residential setting options

Building Provider Capacity

- Division of Provider Services and Quality Assurance
 - Workforce Development
 - Licensure & Certification
 - Quality Assurance (and provider training)
- Activities to expand DDS Provider capacity
 - Working with providers to develop a Direct Service Professional tier to increase quality of staff and improve retention rates
 - Encouraging cross-training between provider types to address special needs within specialized populations

Strategies for Transitioning Beneficiaries

- Transition strategy will include:
 - detailed transition process that provides reasonable notice and due process for beneficiaries;
 - a timeframe;
 - a description of the State's process to ensure sufficient services and supports are in place prior to the transition; and
 - assurances that affected beneficiaries will receive sufficient information, opportunity, and supports to make an informed choice regarding transition to a new compliant setting

Strategies for Transitioning Beneficiaries

- DAAS = 30-day (minimum) advance notice for transitions
- DDS = 90-day (minimum) advance notice for transitions
- DAAS Nurse or DDS Specialist conduct face-to-face meeting w/ beneficiary, case mgmt entity, caregiver/guardian/conservator if applicable
 - Official notification of transition process
 - Formal letter to follow
- Provider Certification Unit sends current service provider letter indicating intent to transition

Strategies for Transitioning Beneficiaries

- DAAS Nurse or DDS Specialist advise beneficiary (and others) on available and compliant settings, offer choice
 - Person-centered planning meeting will take place to define timelines for transition, identify supports and services needed to make safe transition
 - Caregivers, family members, friends, case mgmt entity invited to meeting
- DAAS Nurse or DDS Specialist notify new service provider of transition meeting
 - Written notification includes date transition meeting occurred, anticipated date of transition to new provider, names of transition meeting participants, and advise if current plan of care remains same.

Strategies for Transitioning Beneficiaries

- Current service provider remains responsible for service delivery during transition period, until transfer is made
- DAAS Nurse or DDS Specialist ensure that all supports and services are in place prior to transition
 - Occurs via on-site visit 7-10 days prior to beneficiary transition
 - May include beneficiary; caregiver/guardian/conservator, nurse, advocate (if applicable); and new provider
- After transition, DAAS Nurse or DDS Specialist ensure that nurse/case mgmt entity's 1st three monthly contacts will occur face-to-face

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Resources

Arkansas HCBS project website:

<http://humanservices.arkansas.gov/daas/Pages/HCBS-Settings-Home.aspx>

HCBS Intensive

Afternoon Session Regulation Implementation Current Issues and Direction

August 2017

Topics of Focus

- ❖ Person-Centered Planning
- ❖ Conflict of Interest
- ❖ Consolidating Waivers
- ❖ 21st Century CURES Act Provisions

Objectives: Person-Centered Planning

- ❖ Understand how Person-Centered Planning is incorporated as part of the Final Rule
- ❖ Discuss the process for Person-Centered Planning
- ❖ Discuss the Person-Centered Service Plan written elements
- ❖ Introduce concepts that promote person-centered systems

HCBS Final Rule for Person-Centered Planning

- ❖ Final rule relating to person-centered planning became effective on March 17, 2014
- ❖ Final rule includes changes to the provisions regarding person-centered service plans for HCBS waivers under 1915(c) and HCBS state plan benefits under 1915(i)
- ❖ Requires a person-centered service plan for each individual receiving Medicaid HCBS
- ❖ Person-centered planning principles also apply in 1915(k) Community First Choice state plan programs, and for HCBS provided in 1115 demonstrations

Person-Centered Thinking, Planning, and Practice

- ❖ **Person-centered thinking** helps to establish the means for a person to live a life that they and the people who care about them have good reasons to value
- ❖ **Person-centered planning** is a way to assist people needing HCBS to construct and describe what they want and need to bring purpose and meaning to their life
- ❖ **Person-centered practice** is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve individual goals and preferences

HCBS Person-Centered Service Plan: Approach

- ❖ Person-centered approach means the person will lead the process where possible and will play the largest role in planning their services
- ❖ Conducted to reflect what is important to the person to ensure delivery of services in a manner reflecting personal preferences and desired outcomes
- ❖ The person-centered service plan must be developed through a person-centered planning process

HCBS Person-Centered Service Plan: Process

- ❖ The person-centered planning process is driven by the person
- ❖ Includes people chosen by the person for whom the plan is being developed- if the person has selected providers, they should be included
- ❖ Provides necessary information and support to the person to ensure that they direct the process to the maximum extent possible
- ❖ Is timely and occurs at times/locations of convenience to the person

HCBS Person-Centered Service Plan

- ❖ Reflects cultural considerations
- ❖ Uses plain language and is understandable to the person
- ❖ Includes strategies for solving disagreements
- ❖ Offers choices to the person regarding services and supports they receive and from whom
- ❖ Provides methods to request updates

HCBS Person-Centered Service Plan: Documentation

The written plan reflects:

- ❖ That the setting is chosen by the person and is integrated in, and supports full access to the greater community
- ❖ Opportunities to seek employment and work in competitive integrated settings
- ❖ Opportunity to engage in community life
- ❖ Ability to control personal resources
- ❖ That the person receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS

HCBS Person-Centered Service Plan: Documentation

The written plan:

- ❖ Reflects the person's strengths and preferences
- ❖ Reflects clinical and support needs
- ❖ Includes goals and desired outcomes
- ❖ Reflects services/supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS
- ❖ Includes purchase/control of self-directed services if applicable.

HCBS Person-Centered Service Plan: Documentation

The written plan includes:

- ❖ Risk factors and measures in place to minimize risk
- ❖ Individualized backup plans and strategies when needed
- ❖ Individuals/ entities important in supporting the person

The written plan:

- ❖ Records who is responsible for monitoring the plan
- ❖ Includes informed consent of the person in writing
- ❖ Is signed by all individuals and providers responsible for its implementation and distributed to the person and others involved in the plan

HCBS Person-Centered Service Plan: Documentation

The written plan:

- ❖ Excludes unnecessary or inappropriate services and supports
- ❖ Is not a checklist of services
- ❖ Will look different for each person
- ❖ Must be reviewed and revised upon reassessment of functional need as required every 12 months, when the person's circumstances or needs change significantly, and at the request of the person.

HCBS Person-Centered Service Plan: Modifications

- ❖ Any modifications needed to the home and community-based settings criteria applicable to provider owned or controlled settings must be supported by a specific assessed need and justified in the person-centered plan.
- ❖ The following must be documented in the plan:
 - A specific and individualized assessed need
 - Positive interventions and supports used prior to modification
 - Less intrusive methods tried
 - A description of the condition that is directly proportionate to the specified need
 - Regular collection and review of data to review effectiveness
 - Established time limits for periodic review to determine if modification is still needed
 - Informed consent of the individual
 - Assurance interventions and supports will cause no harm

HCBS Person-Centered Service Planning for those who Exhibit Unsafe Wandering or Exit-Seeking Behavior

In addition to the previous processes described, these additional strategies can be useful:

- ❖ Assessing the patterns, frequency, and triggers through direct observation and by talking with the person exhibiting such behaviors, and, when appropriate, their families.
- ❖ Using this baseline information to develop a person-centered plan to address unsafe wandering or exit-seeking, implementing the plan, and measuring its impact.
- ❖ Using periodic assessments to update information about an individual's unsafe wandering or exit-seeking, and adjust the person-centered plan as necessary.
- ❖ Additional guidance can be found at <https://www.medicaid.gov/federal-policy-guidance/downloads/faq121516.pdf>

HCBS Person-Centered Planning Quality Outcomes

- ❖ Quality Person-Centered Service Plans will ensure that planning leads to important individually-defined outcomes
- ❖ People have control over the lives they have chosen for themselves
- ❖ People are recognized and valued for their contributions (past, current, and potential) to their communities
- ❖ People live the lives they want

HCBS Person-Centered Planning in Practice

In order to meet the criteria and the intent of the rule, Person-Centered Service Planning requires:

- ❖ The time needed to learn what is important to the person
- ❖ The time needed to support the person in having control over the process and content
- ❖ The skills that underlie strengths-based assessment, development, writing, and implementing the plan
- ❖ Structures that support development and implementation
- ❖ The skills and professional latitude to conduct discovery and planning dependent on the person they are working with

Strategies to Promote Moving Toward Person-Centered Service Systems

- ❖ Develop and promote a statewide vision & universal understanding of person-centeredness across all state agencies providing Medicaid HCBS
- ❖ Align practices, structures, and priorities for those who develop plans with the criteria for good person centered service plans
- ❖ Build quality measurement frameworks that link measurement to person-centered service plans

HCBS Person-Centered Service Planning Conflict of Interest Requirements

- ❖ Providers of HCBS for an individual must not provide case management or develop the person-centered service plan for that individual
- ❖ The only exception is when it is demonstrated that the only willing and qualified entity to provide case management/ develop the plan in a geographical area also provides HCBS

HCBS Person-Centered Service Planning Conflict of Interest Requirements

- ❖ When the exception is invoked, safeguards must include, at a minimum:
 - Separation of entity and provider functions
 - Full disclosure to participants and assurance they are supported with free of choice of providers
 - Clear & accessible alternative dispute resolution process
 - Direct approval of the state
 - State agency oversight of the process

Conflict of Interest- Person Centered Planning & Managed Care

- ❖ When managed care organizations (MCOs) are not direct service providers, they are not implicated by the HCBS conflict of interest provisions.
- ❖ However, because service planning, case management and service authorization reside within one entity, states should closely monitor person-centered planning implementation, appropriateness of service plans, gaps in services, service reductions, and potential underutilization of HCBS.
- ❖ If an MCO owns and operates direct services, it must comply with the conflict of interest standards for the HCBS authority under which the service is rendered.

Multiple Target Populations

- ❖ The Final Rule provides the option to combine multiple target populations within one 1915(c) waiver.
- ❖ 42 CFR 441.301(b)(6) specifies that a waiver request must “be limited to one or more of the following target groups or any subgroup thereof that the State may define:
 - Aged or disabled, or both.
 - Individuals with Intellectual or Developmental disabilities, or both.
 - Mentally ill.”

Multiple Target Populations

- ❖ 42 CFR 441.302(a)(4) specifies that, if a state chooses the option to serve more than one target group under a single waiver, the state must assure that it is able to meet the unique service needs that each individual may have regardless of the target group.
- ❖ 42 CFR 441.302(a)(4)(i) specifies that on an annual basis the state will include in the quality section of the CMS-372 form (or any successor form designated by CMS) data that indicates the state continues to serve multiple target groups in the single waiver and that a single target group is not being prioritized to the detriment of other groups.

Considerations

- ❖ States are not required to do this.
- ❖ The option removes barriers and enhances flexibility by allowing states to design a waiver that meets the needs of more than one target population.
- ❖ Allows for administrative simplification.
- ❖ This does not affect the cost neutrality requirement for section 1915(c) waivers, which requires the state to assure that the average per capita expenditure under the waiver for each waiver year not exceed 100 percent of the average per capita expenditures that will have been made during the same year for the level of care provided under the state plan had the waiver not been granted.

Cost Neutrality

- ❖ Cost neutrality would not become problematic in waivers with combined target groups as it is calculated based on the relevant level of care group in the waiver, not by target population.
- ❖ For example: people with physical disabilities who meet nursing facility level of care (LOC) would need to meet that cost neutrality level and people with intellectual disabilities would still need to meet the cost neutrality for ICF/IID LOC.
- ❖ Multiple levels of care are an option currently in waivers where a particular target population may include multiple levels of care within the same waiver.

Other Considerations

- ❖ All services in the waiver must be made available if there is a need for the service (for example, residential habilitation). Different sets of services or service packages based on target groups is not permissible.
- ❖ Including multiple target populations in one waiver does not change freedom of choice requirements that exist in Medicaid generally and in 1915(c) waivers specifically.
- ❖ States must still determine that without the waiver, participants will require the relevant institutional level of care.

Examples of States with Consolidated Waivers

- ❖ Pennsylvania
- ❖ Virginia
- ❖ New York

If a State is interested in consolidating waivers, please contact CMS early on so that we can discuss options, timing, and provide technical assistance.



21st Century CURES Act
Provisions Under Section 12006



Overview of the CURES Act

What is it?

The CURES Act is designed to improve the quality of care provided to individuals through further research, enhance quality control, and strengthen mental health parity.

How does the CURES Act apply to HCBS programs?

Section 12006 requires states to implement an EVV system for personal care services (PCS) and home health care services (HHCS).

How does this impact states?

All state Medicaid PCS and HHCS are required to comply with requirements by:

- ❖ **PCS:** January 1, 2019
- ❖ **HHCS:** January 1, 2023



Important Terms and Definitions

What are Personal Care Services?

Medicaid covers PCS for eligible individuals through Medicaid State Plan options and/or through Medicaid waiver and demonstration authorities approved by CMS.

Consists of non-medical services supporting Activities of Daily Living (ADL), such as movement, bathing, dressing, toileting, transferring and personal hygiene.

States also can include PCS for the following:

- ❖ Instrumental Activities of Daily Living (IADL), such as meal preparation, money management, shopping, telephone use, etc.
- ❖ Intermittent (i.e., less than 24/7 coverage) residential habilitation services that encompass services delineated under personal care.

What are Home Health Care Services (HHCS)?

Medicaid covers HHCS for eligible individuals as a mandatory benefit through the Medicaid State Plan and/or through a waiver as an extended state plan service approved by CMS.

This is known as the home health benefit, and CMS is equating HHCS as described in the 21st Century CURES Act with the longstanding home health benefit mentioned at section 1905(a)(7) of the Social Security Act.

Required Medicaid Authorities per Section 12006 of The CURES Act

Applicable Medicaid Authorities for PCS:

- ❖ 1905(a)(24) State Plan Personal Care benefit;
- ❖ 1915(c) HCBS;
- ❖ 1915(i) HCBS State Plan option;
- ❖ 1915(j) Self-directed Personal Attendant Care Services;
- ❖ 1915(k) Community First Choice State Plan option;
- ❖ 1115 Demonstration

Applicable Medicaid Authorities for HHCS:

- ❖ HHCS provided under section 1905(a)(7) of the Social Security Act or under a waiver of the plan.

Penalties for Non-Compliance to Section 12006 of The CURES Act

The Act (Section 12006(a)(1)(A)) requires that states that do not comply with the Act by the applicable deadlines will have their Federal Medical Assistance Percentage (FMAP) reduced as shown in the table below.

- ❖ Per 1915(c) Technical Guide, the **FMAP** is the “Federal Medicaid matching rate for medical assistance furnished under the state plan. FMAP rates are re-calculated annually under the formula set forth in §1903(b) of the Social Security Act.”

PCS & HHCS FMAP Reductions per Year

Year	PCS	HHCS
2019	0.25%	-
2020	0.25%	-
2021	0.50%	-
2022	0.75%	-
2023	1%	0.25%
2024	1%	0.25%
2025	1%	0.50%
2026	1%	0.75%
2027 & thereafter	1%	1%

EVV Requirements per Section 12006 of The CURES Act

EVV Systems Must Verify:

- ❖ Type of service performed;
- ❖ Individual receiving the service;
- ❖ Date of the service;
- ❖ Location of service delivery;
- ❖ Individual providing the service;
- ❖ Time the service begins and ends.

Department of Health and Human Services (DHHS) Role

- ❖ Required to provide training and educational materials related to best practices to state Medicaid directors by *January 1, 2018*.
- ❖ Details of CMS' plans are discussed in later slides.

EVV Requirements per Section 12006 of The CURES Act

Flexibility for States

Allows states to choose their EVV design and implement quality control measures of their choosing.

Stakeholder Input Required

Requires states that do not already have an established EVV system to consult other state agencies that provide PCS or HHCS

Requires states seek stakeholder input from:

- ❖ Family caregivers
- ❖ Individuals receiving and furnishing PCS/HHCS; and
- ❖ Other stakeholders

EVV Requirements per Section 12006 of The CURES Act

EVV systems must not do the following:

- ❖ Limit “the services provided or provider selection” or “constrain individuals’ choice of caregiver, or impede the way care is delivered.”
- ❖ Establish employer-employee contracts with the entity that provides PCS or HHCS.

Other Requirements for EVV systems:

- ❖ Be “minimally burdensome”.
- ❖ Be HIPAA-compliant.

State must consider best practices.

Exceptions for Non-Compliance per Section 12006 of The CURES Act

Per Section 12006(a)(4)(B) of the Act, FMAP reduction will *not apply* if the state has both:

- ❖ Made a “good faith effort” to comply with the requirements to adopt the technology used for EVV; **and**
- ❖ Encountered “unavoidable delays” in implementing the system

Discuss with CMS if the state believes that it meets both of these requirements.

Available Federal Support for States

If the system is operated by the state or a contractor on behalf of the state as part of a state's Medicaid Enterprise Systems, the state can be reimbursed through the Advanced Planning Document (APD) process. The "Federal Match" of state costs are the following:

- ❖ 90% Federal Match for costs related to the design, development and installation of EVV.
- ❖ 75% Federal Match for costs related to the
 - Operation and maintenance of the system
 - Routine system updates, customer service, etc.
- ❖ 50% Federal Match for
 - Administrative activities deemed necessary for the efficient administration of the EVV.
 - Education and outreach for state staff, individuals and their families

Available Federal Support for States cont.

- ❖ States planning to request funding for the development and implementation of EVV must prepare and submit an Advanced Planning Document (APD) for approval.
- ❖ States should/may contact their Regional Office MMIS system lead for assistance with APDs.
- ❖ Refer to 42 CFR Part C, 45 CFR Part 95, and the State Medicaid Manual Part 11 for additional information.

*Please contact Eugene Gabriyelov at eugene.gabriyelov@cms.hhs.gov if you have any questions regarding this process.

Benefits of EVV

Improves program efficiencies by:

- ❖ Eliminating the need of paper documents to verify services.
- ❖ Enhances efficiency and transparency of services provided to individuals through quick electronic billing.
- ❖ Supports individuals using self-direction services and facilitates flexibility for appointments and services.

Benefits of EVV- cont.

**Strengthens quality assurance for PCS and HHCS
by:**

- ❖ Improving Health and Welfare of individuals by validating delivery of services.

**It is important to note that EVV is not a complete replacement of on-site, in-person case management visits.*

Benefits of EVV – Continued

Aims to reduce potential Fraud, Waste, and Abuse (FWA).

- ❖ The DHHS Office of the Inspector General (OIG) identified Medicaid PCS and HHCS billings as an ongoing issue to monitor, but has recognized EVV as a “positive step towards safeguarding beneficiaries.”
- ❖ Validates services are billed according to the individual’s personalized care plan by ensuring appropriate payment based on actual service delivery.
- ❖ Is part of the pre-payment validation methods that allows individuals and families to verify services rendered.
 - EVV should be included in Appendix I-2-d of states’ HCBS waiver application as a billing validation test for financial accountability assurance.
 - For more information on billing validation and rates topics, refer to:

www.medicaid.gov/medicaid/hcbs/training/index.html

Resources

- ❖ HCBS Website – <http://www.medicaid.gov/hcbs>
 - Final HCBS regulation
 - Guidance
 - Fact Sheets
 - FAQ
 - Compliance Toolkit
 - Statewide Transition Plan Information
- ❖ State Technical Assistance
- ❖ Mailbox to send questions: hcbs@cms.hhs.gov

Questions?