

HCBS BASICS AND ASSURANCES

DSAMH PROMISE'S PROGRAM

WAIVER BASICS

Medicaid is a joint federal/state funding program that pays for most long term care provided to low income, older persons and persons with disabilities. For many years, nursing facilities and institutions were the only options for persons needing long term assistance. But when given the choice, many people choose to live in the community rather than in an institution.

Recognizing that preference, Congress established the Home and Community Based Services (HCBS) waiver as an alternative to care provided in institutions. The HCBS waiver allows states to use Medicaid funding to provide services and supports to persons living in their homes or in other community-based settings, such as group homes, adult foster homes or assisted living facilities. Persons are eligible to receive HCBS waiver services if they meet federal qualification criteria and if the cost of their home or community-based care does not exceed limits established by a state.

WAIVER BASICS CONTINUED

A state must apply to the Centers for Medicare & Medicaid Services (CMS) through an HCBS waiver application for permission to operate an HCBS waiver. States can be flexible in how they design their HCBS waiver with respect to:

Target populations to be served

Number of people to be served

Services provided

Self-direction ([click here for more information about self direction](#))

Some states may choose to offer participants the ability to direct their own services under HCBS waivers. Self-direction promotes personal choice and control over the delivery of HCBS waiver services. Self-direction means that the participant can make decisions over some or all of her/his HCBS waiver services and accepts the responsibility for taking a direct role in managing them. The participant decides who provides services and how they are delivered. For example, the participant may, with support, recruit, hire, and supervise individuals who furnish daily supports. Self-directed HCBS waivers offer expanded opportunities for participant control but do not change a state's responsibility to meet federal HCBS waiver assurances.

Geographic areas served

Administrative structure for operating the HCBS waiver

BACKGROUND CONTINUED

Regardless of the HCBS waiver design, every application must address how a state intends to meet specific CMS requirements known as the HCBS waiver assurances. The assurances were put into place by Congress to address the unique challenges of assuring the *quality* of services delivered to vulnerable persons living in their community.

A state's HCBS waiver application must include the following:

Waiver Design: The population and geographic area to be served, the mix of services offered, the quality standards, including provider qualifications, policies and payment methods.

Performance Measures: The standards a state will use to evaluate how well the HCBS waiver is meeting each of the federal assurances.

Discovery Methods: The data a state collects to measure how well it is meeting each performance measure; the method and frequency of data collection and analysis; and the person or entity responsible for using the data for decision-making.

Remediation: How a state will take action when individual problems are found.

System improvement: Method to prevent similar problems from happening to others or to make the HCBS waiver more effective and efficient.

BACKGROUND CONTINUED

The first time a state submits an HCBS waiver application, CMS approves the program for three years; when a state submits a renewal application, CMS approves it for five years.

After its HCBS waiver is approved, a state must submit **evidence** to CMS documenting that the HCBS waiver program is operating as approved and is in compliance with each of the six assurances.

Challenges in assuring quality in home-based settings

HCBS waivers are person centered. They invite individuals to play active roles in deciding the services they want to receive and when. This can make a big difference in quality of life. But delivering services in home and community settings raises new challenges to assure the quality of these programs.

There is no one on site to monitor care and services at all times.

Participants rely on many people for their care and safety.

Participants may be vulnerable and unable to seek help.

People may be afraid of losing their services if they report problems.

So what are the assurances, and how do they relate to you?

FEDERAL HCBS WAIVER ASSURANCES

The six assurances, and the subject of this training, are:

Level of Care: Participants enrolled in the HCBS waiver meet the level of care criteria consistent with those residing in institutions.

Service Plan: A person's needs and preferences are assessed and reflected in a person-centered service plan.

Qualified Providers: Agencies and workers providing services are qualified.

Health and Welfare: Participants are protected from abuse, neglect and exploitation and get help when things go wrong or bad things happen.

Financial Accountability: A state Medicaid Agency pays only for services that are approved and provided, the cost of which does not exceed the cost of a nursing facility or institutional care on a per person or aggregate basis (as determined by the state).

Administrative Authority: A state Medicaid Agency is fully accountable for HCBS waiver design, operations and performance.

Why is it important for you to know about the six assurances?

Because the assurances have an impact on your work each and every day. Much of what you are asked to do, and particularly how you are asked to document what you do, tie back to the assurances.

ASSURANCE 1 - LEVEL OF CARE

Delaware must assure that people getting services under the HCBS waiver would otherwise qualify for Medicaid-reimbursed services. Before CMS approves an HCBS waiver, a state must provide detailed descriptions of how level of care determinations will be made.

The state must show that it has:

Criteria and methods for determining qualifications for services.

Although federal assurances require that an assessment be done as part of level of care determination, the regulations do not specify how to conduct the assessment, what it should include, who completes it, or what criteria are used. Criteria and methods vary across states. However, CMS requires that a state use the same criteria for determining eligibility for HCBS waivers. In determining whether a person qualifies for care, a state may consider some of the following factors: the individual's general health, emotional/behavioral health, cognitive ability, and the ability to perform activities of daily living (e.g., ability to bathe, walk, eat).

Qualified agencies to conduct the level of care evaluations.

A state designates specific agencies or organizations to determine if an individual meets institutional level of care. This entity may be different from the one responsible for service plan development.

A schedule for evaluating, at least annually, that a person continues to meet the level of care.

If a person is approved for the HCBS waiver, the evaluation and level of care determination must be carried out at least once every year or, in some states, whenever there is a change in the participant's status.

Medicaid participants who meet an the level of care may receive HCBS waiver services, provided there is a **funded opening**. If there is no opening, the person may be put on a state's waiting list, even though they are eligible for services now. If a person is found not to be eligible, he/she can appeal the decision to the state.

COMPLY WITH THE LEVEL OF CARE ASSURANCE?

A state confirms that the entities responsible for conducting level of care determinations are following the state's policies and procedures. A state may also review participant records to assess whether:

The individual meets the level of care criteria.

Level of care determinations were made before the participant received HCBS waiver services.

A review of an individual's continued eligibility for level of care was conducted at least annually.

A state summarizes their findings in an evidence report to CMS. Examples of evidence that the state is meeting the level of care assurance may include:

The percent of participants who had a comprehensive level of care evaluation by an appropriate agency prior to HCBS waiver service delivery.

For participants on the HCBS waiver for more than one year, the percent of individuals on HCBS waiver services who received annual Level of Care assessments.

MEETING THE LEVEL OF CARE ASSURANCE?

Care managers may conduct level of care assessments/re-assessments or you may contribute indirectly to the level of care process by:

Requesting re-assessments by entities responsible for level of care determinations when an assessment is due or when there is a significant change in the participant's status.

Explaining the re-assessment process to participants including their rights to due process.

Scheduling re-assessments for the participant.

Alerting responsible entities when a participant may have a change in condition that necessitates a new level of care determination.

ASSURANCE 2 - SERVICE PLANNING

A person's needs and preferences are assessed and reflected in a person-centered service plan.

Service planning is one of the most critical aspects of the HCBS waiver program. It is through this process that the needs, goals, and preferences of participants are expressed. Risks are also identified and addressed.

A care manager plays a key role in assuring that participants actively engage in the planning process, have the information they need to make decisions, and understand the choices available to them.

SERVICE PLANNING

Every HCBS waiver participant must have a written service plan. The service plan must address all of the participant's assessed needs and personal goals, including health and safety risk factors.

Health and Safety Risk Factors - Risks are often categorized into

- 1) health risks (e.g. malnutrition, seizures, cardiac or respiratory diseases, chronic conditions such as diabetes),**
- 2) behavioral risks (e.g. poor decision-making about safety and health issues as a result of a brain injury or cognitive limitation; violent or criminal behavior; substance abuse; and suicide), or**
- 3) risks to personal safety (e.g. abuse or exploitation).**

The service plan must reflect the full range of a participant's needs and include both Medicaid and non-Medicaid services as well as informal supports.

Arrangements for back-up when workers do not show up or when emergencies occur must be discussed as part of service planning

The service plan must include the type, scope, amount, duration, and frequency of services authorized.

Service plans developed by care managers are distinct from plans developed by providers for specific services.

The service plan must be updated at least annually, or when the needs of the participant change.

SERVICE PLANNING CONTINUED

Services must be delivered in accordance with the service plan. The state Medicaid Agency will only pay for services that are first authorized through the service plan.

Participants must be able to choose between getting services at home/in the community versus getting services in an institution. Each participant must sign a statement indicating he or she has chosen to be served under the HCBS waiver.

Participants must be able to choose between/among HCBS waiver services and providers.

SERVICE PLANNING CONTINUED

A state monitors whether service plans are developed and implemented in accordance with established policies and procedures. For example:

Assessments are comprehensive and accurately reflect participant needs.

Service plans address the assessed needs, goals, preferences, and health and safety risk factors of participants.

Service plans include the type, amount, scope and frequency of services.

Services are delivered in accordance with and only after the service plan is authorized.

Service plans are updated at regular intervals or when needs change.

Back-up plans are developed and responsible parties understand their roles in emergencies.

Participants are informed of available services and are provided choice of services.

Frequency of the case manager contact with a participant (either by phone or in person).

ASSURANCE 3 - QUALIFIED PROVIDERS

A state must establish qualification requirements for individuals and agencies that provide each type of service offered under the HCBS waiver. Specific qualifications may differ from state to state; general requirements are described below.

A state must verify that provider agencies and the workers they employ, if applicable, meet the state's licensure and certification standards initially and on an ongoing basis. The specific licensing or certification standards may vary from state to state. Examples of licensure or certification requirements for agencies:

Minimum staffing ratios; Qualification credentials of staff; Administrative capacity and reporting and Training.

Delaware must monitor non-licensed and non-certified providers. State licensure or certification standards may not apply to all types of provider agencies and workers. A state may have other requirements or standards for non-licensed and non-certified providers. These minimum standards include background checks, maintenance of an abuse registry, and/or requirements related to basic competencies such as language or age.

A state must have policies and procedures related to provider training and must monitor that the policies are implemented. This may include on-going training requirements in certain competencies.

ASSURANCE 4 - HEALTH AND WELFARE

Participants are protected from abuse, neglect and exploitation and get help when things go wrong or bad things happen.

This assurance emphasizes the role of HCBS waivers in reporting, investigating, and resolving serious incidents which include, at a minimum, cases of abuse, neglect and exploitation

ASSURANCE 4 - HEALTH AND WELFARE CONTINUED

Delaware must have a system for reporting and investigating critical events including, at a minimum, cases of abuse, neglect, and exploitation. The system must describe:

The definition of critical events that must be reported.

The identification of individuals/entities that must report critical incidents.

The timeframes within which the critical event must be reported.

The method of reporting (e.g., phone, written form, web-based reporting system).

The entity (or entities) that receives reports of each type of critical event or incident.

The entity that is responsible for evaluating reports and how reports are evaluated.

The entity that is responsible for conducting investigations and how investigations are conducted.

The timeframes for conducting an investigation and completing an investigation.

The process and timeframes for informing the participant (or the participant's family or legal representative as appropriate) and other relevant parties (e.g., the HCBS waiver providers, licensing and regulatory authorities, the HCBS waiver operating agency) of investigation results.

ASSURANCE 4 - HEALTH AND WELFARE CONTINUED

Delaware must provide training and/or information to participants or their informal caregivers concerning protections from abuse, neglect and exploitation. Training must include information on how to notify appropriate authorities. As part of its HCBS waiver application to CMS, a state must specify the entity responsible for providing training and/or information and the frequency of training.

A state must identify the entity responsible for reviewing:

How well the reporting system is working,

The type and frequency of methods used to determine if critical incidents are being properly reported and investigated, and

If data are being effectively used to prevent re-occurrence of incidents

STATES MUST ALSO:

Assure that participants (and involved family or other unpaid caregivers, as appropriate) are informed about their rights and protections, including how they can safely report an event and receive the necessary intervention or support.

Assure that HCBS waiver agencies, vendors and workers (including care managers) are well informed of their responsibilities to identify and report all critical incidents. Provider responsibilities are typically described in licensure requirements, contracts or service agreements, job descriptions and agency policies. Responsibilities are also reinforced through periodic state training.

Evaluate the nature, frequency and circumstances of reported cases and determine how the HCBS waiver can prevent or reduce similar occurrences in the future.

ASSURANCE 5 - FINANCIAL ACCOUNTABILITY

A state Medicaid Agency pays only for services that are approved and provided, the cost of which does not exceed the cost of a nursing facility or institutional care on a per person or aggregate basis (as determined by the state).

ASSURANCE 5 - FINANCIAL ACCOUNTABILITY CONTINUED

Financial Integrity

A state must have methods to ensure that the payments made to provider agencies, vendors and workers are accurate and are for services that were actually provided.

Provider Rates and Bills

As part of its HCBS waiver application, a state must describe the reimbursement method that will be used to determine payments to providers. States must follow these reimbursement methods when they pay providers.

Payments

States must describe the process by which providers will be paid.

Unallowable Costs

Medicaid cannot pay for room and board costs (that is, housing, meals), except in certain circumstances. These costs are allowed only if a person is receiving institutional respite or when the person needs a live-in caregiver.

Cost Neutrality

The cost of services provided under the HCBS waiver cannot exceed the cost of services provided in a nursing home or in an institution for persons with intellectual disabilities. This is usually referred to as "cost neutrality".

Medicaid is a state/federal program. If the state does not comply with these requirements, it will not receive the federal portion of the Medicaid payments.

ASSURANCE 6 - ADMINISTRATIVE AUTHORITY

The state Medicaid Agency is fully accountable for HCBS waiver design, operations and performance.

Delaware must structure its HCBS waiver so that the state Medicaid Agency retains authority over HCBS waiver decisions and oversight, even if the administration and operation of the HCBS waiver is decentralized to other state agencies or non-state entities.

A state Medicaid Agency may delegate the day-to-day operations of an HCBS waiver to another state agency (known as the “operating agency”). In these cases, a written agreement must be in place specifying the activities and functions to be performed and the methods by which the state Medicaid Agency will provide supervision and oversight.

If the state Medicaid Agency or operating agency is going to delegate any administrative or operational functions to a local/regional non-state entity, they must develop a written agreement/contract to clearly specify the activities that they are authorized to perform, the policies governing those activities, and the methods by which the state Medicaid Agency will monitor performance.

A state must assure that there is consistent, uniform administration and operation of the HCBS waiver across all geographic areas.

ASSURANCE 6 - ADMINISTRATIVE AUTHORITY

An HCBS waiver may be operated by a division/unit/department outside of the state Medicaid agency. In these cases, there must be a formal, written agreement between the state Medicaid agency and the operating agency. These agreements usually specify:

The functions and activities that will be performed by the operating agency.

Oversight and policy setting responsibilities of each entity.

Authority and conditions related to sub-contracts between the operating agency and regional or sub-state entities.

Methods by which the state Medicaid Agency assumes full responsibility for waiver operations and performance. These may include reporting requirements, periodic audits, development of performance goals and strategies.

Regardless of structure, a state Medicaid Agency must show that it has final authority and responsibility for the HCBS waiver. It must also demonstrate that it has the systems and procedures in place to monitor and improve performance.

FIN

Thank-you!

Upon completion of this curriculum, please send your name and that of your supervisor to the e-mail box: dsamhpromise@state.de.us as proof of your task completion.

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