NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership
Dual Eligible Beneficiaries Workgroup Web Meeting

March 17, 2014

1:00 pm - 2:30 pm ET

Participant Instructions:

- Please log in 15 minutes prior to the scheduled start to allow time for troubleshooting
- Direct your web browser to: http://nqf.commpartners.com for slides and streaming audio
- Under "Enter a Meeting," type in the meeting number **262685** and click "Enter"
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"
- Workgroup members dial (**888) 799-0466**; use conference ID code **4314838** to access the audio platform.
- Public attendees dial **(855) 452-6871**; use conference ID code **4314838** to access the audio platform.

Meeting Objectives:

- Continue exploration of strategies to promote best possible quality of life among dual eligible beneficiaries
- Discuss expectations for shared accountability related to quality of life
- Prepare for upcoming in-person meeting

1:00 pm **Welcome and Introductions**

Alice Lind, Chair of MAP Dual Eligible Beneficiaries Workgroup

- Review meeting objectives
- Roll call

1:10 pm **Recap Themes from Previous Discussions with HCBS Example**

Sarah Lash, Senior Director, NQF

- Key issues in quality of life measurement
- HCBS Final Rule
- Workgroup discussion

1:40 pm **Discuss Shared Accountability for Quality of Life Outcomes**

Alice Lind
All Workgroup Members

- Contributions of stakeholder groups to improving quality of life outcomes
- Live polling questions to facilitate workgroup discussion

2:20 pm **Opportunity for Public Comment**

2:25 pm **Summary and Next Steps**

Alice Lind

- Preview objectives for the April 10-11, 2014 in-person meeting

2:30 pm **Adjourn**

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Dual Eligible Beneficiaries Workgroup Web Meeting

March 17, 2014

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Welcome

Meeting Objectives

- Continue exploration of strategies to promote best possible quality of life among dual eligible beneficiaries
- Discuss expectations for shared accountability related to quality of life
- Prepare for April in-person meeting

Dual Eligible Beneficiaries Workgroup Membership

Workgroup Chair: Alice Lind, MPH, BSN

Organizational Members

American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	Gwendolen Buhr, MD, MHS, MEd, CMD
Center for Medicare Advocacy	Alfred Chiplin Jr., Esq, JD, MDiv
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE
L.A. Care Health Plan	Jennifer Sayles, MD, MPH
America's Essential Hospitals	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

Dual Eligible Beneficiaries Workgroup Membership

Subject Matter Experts

Substance Use	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Care Coordination	Nancy Hanrahan, PhD, RN, FAAN
Medicaid ACO	Ruth Perry, MD
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson Beale, MD
Nursing	Gail Stuart, PhD, RN

Federal Government Members

Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	Jamie Kendall
Substance Abuse and Mental Health Services Administration	Lisa Patton, PhD
Veterans Health Administration	Daniel Kivlahan, PhD

Recap of Themes from Previous Discussions

Major Themes from Previous Workgroup Discussions on Quality of Life

- Workgroup discussed the importance of capturing firsthand experiences of the beneficiary population through patient reported outcomes (PROs)
- Measure gaps related to quality of life outcomes:
  - Goal-directed, person-centered care planning and implementation
  - Shared decisionmaking
  - Community integration

Major Themes from Previous Workgroup Discussions on Quality of Life

- Available tools to measure quality of life:
  - WHOQOL-100, WHOQOL-BREF
  - SF-36
  - PROMIS
  - MFP Participant Experience Survey
- Potential components/domains for measurement based on current tools:
  - Physical Health
  - Mental and Psychological Health
  - Social Relationships
  - Environment

Major Themes from Previous Workgroup Discussions on Quality of Life

- Available tools fall short of being fully person-centered
- Surveys also miss important concepts such as dignity and self-determination
- Need to be aware of potential response burden on consumers as well as providers
- Allow for proxy responses

- Other key themes related to quality of life:
  - Palliation
  - Security
  - Control
  - "Dignity of Risk"

A recent rule from HHS provides guidance to states about the operations of home- and community-based services.

The rule has many aspects intended to support beneficiaries' quality of life.

Medicaid Program for State Plan Home and Community-Based Services Final Rule

- Rule defines and describes state plan home and community-based services (HCBS)
- Provides for 5-year demonstration projects or waivers that provide medical assistance for dual eligible beneficiaries
  - Includes payment reassignment provisions because state Medicaid programs often operate as the primary or only payer for HCBS providers
  - Amends requirements for home and community-based settings

Department of Health and Human Services (HHS). *Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers*. 79 FR 2947. Washington, DC: DHHS; 2014. Last accessed March 2014.

Medicaid Program for State Plan Home and Community-Based Services Final Rule

Quality Requirements for State Plans

- States will be required to develop and implement an HCBS quality improvement strategy that must:
  - Incorporate a continuous quality improvement process
  - Be evidence-based
  - Include outcome measures for program performance, quality of care, and individual experience
  - Measure individual outcomes associated with the receipt of HCBS, related to the implementation of goals included in the individual service plan.

Department of Health and Human Services (HHS). *Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers*. 79 FR 2947. Washington, DC: DHHS; 2014. Last accessed March 2014.

Medicaid Program for State Plan Home and Community-Based Services Final Rule

Person-Centered Planning

- Defines a process of writing a service plan with the individual (and/or that person's representative):
  - Ensures the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions
  - Plan should be created a convenient time and location, with cultural and language supports as needed
  - Process must offer choices in services and supports
  - Determine strategies for solving conflicts and a process for requesting updates to the plan

Department of Health and Human Services (HHS). *Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers*. 79 FR 2947. Washington, DC: DHHS; 2014. Last accessed March 2014.

Medicaid Program for State Plan Home and Community-Based Services Final Rule

Person-Centered Service Plan

- Defines elements of the plan itself:
  - Reflects the services and supports important for the individual to meet identified functional needs
  - Service recipients' preferences for services and supports
    - » choice in residence, strengths, clinical and non-clinical needs, goals and desired outcomes, supports and services to assist in achieving the goals, risk factors and efforts to minimize them
  - Option for self-directing services
  - Plan should prevent unnecessary or inappropriate use of services
  - Plan must be agreed to and shared

Department of Health and Human Services (HHS). *Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers*. 79 FR 2947. Washington, DC: DHHS; 2014. Last accessed March 2014.

Medicaid Program for State Plan Home and Community-Based Services Final Rule

Qualities of Home and Community-Based Settings

- HCBS settings must have certain qualities:
  - Connect to the community and resources, including employment and work, control of personal resources
  - Support an individual's sense of control
    - » Selecting a residential unit and roommates (if applicable)
    - » Control over schedules and activities
    - » Access to food
    - » Visitors of an individual's choosing
- HCBS *does not* include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, hospitals, or other institutional settings

Department of Health and Human Services (HHS). *Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers*. 79 FR 2947. Washington, DC: DHHS; 2014. Last accessed March 2014.

Workgroup Discussion

How does the HCBS rule match the group's thinking about opportunities to support dual eligible beneficiaries in achieving the best possible quality of life?

What additional guidance to states and providers might be necessary to advance person-centeredness?

Discuss Shared Accountability for Quality of Life Outcomes

Shared Accountability for Quality of Life Outcomes

- In the February 2014 Interim Report, MAP emphasized the importance of culturally competent systems that can understand and cope with complex populations
  - Complex populations have different risk factors: e.g., homelessness, access to durable medical equipment, contact with the justice system, substance use disorders
  - Increase focus on person-centeredness and improving quality of life outcomes through a system of health services and supports
  - Health and community systems should recognize and capitalize on their abilities to provide positive influences
- A "collective responsibility"

Contributions to Quality of Life Outcomes

- Countless elements contribute to quality of life outcomes.
- MAP continues efforts to advance person-centered planning, shared decisionmaking, and self-determination as strategies to support quality of life.
  - Beneficiaries can engage in choice
  - Consumers and families must be empowered with information on the risks and benefits of various options
  - Positive correlations between self determination, mental health, physical health, and satisfaction

System Features

What are the features of a system with shared accountability?

"Great health care is the responsibility of all those involved." - Intermountain Health

- Culture and mechanisms to support continual quality improvement
- Coordinated and aligned care and services
- Evidence-based practices
- Tailoring to unique skills and service environments
- Others?

Responsibility for Quality of Life Outcomes

- All parts of the system bear partial responsibility, including:
  - Individuals and their Families/Caregivers
  - Health Professionals and Provider Systems
  - Health Plans
  - Community / Human Services
  - State and Federal Governments

Instructions for Live Polling

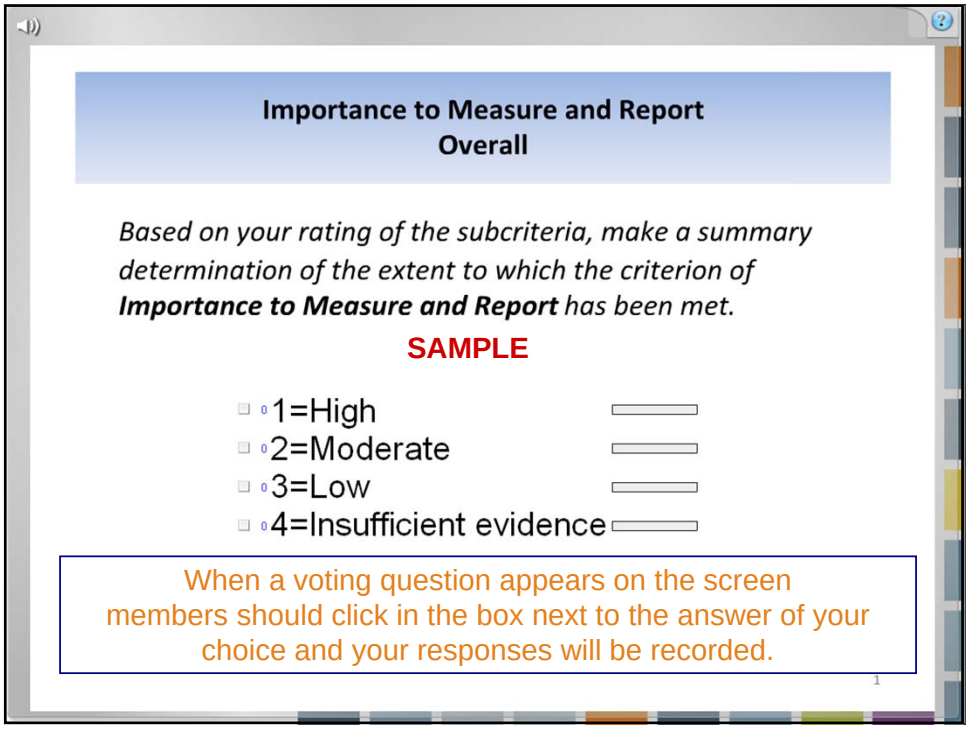
Polling will systematically explore each of the five groups to the right.

1) Consider whether or not the group contributes to the components of quality of life.

2) After each poll, the group will discuss the results and respond to two questions:

   What are the best ways for the group to contribute to improved quality of life outcomes?

   Should the group be measured?


Importance to Measure and Report
Overall
Based on your rating of the subcriteria, make a summary determination of the extent to which the criterion of **Importance to Measure and Report** has been met.
SAMPLE
1=High
2=Moderate
3=Low
4=Insufficient evidence
When a voting question appears on the screen members should click in the box next to the answer of your choice and your responses will be recorded.
1


TEST POLL: Let's get the hang of this…
What is your favorite animal to visit at the zoo?
Penguins
Lions
Pandas
Butterflies
Alligators
Measure Applications Partnership
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Poll #1: Individuals and their Families / Caregivers

- What quality of life components are **Individuals and their Families/Caregivers** primarily responsible for?
  - Physical Health
  - Mental and Psychological Health
  - Social Relationships
  - Environment
  - Other?

Poll #1: Individuals and their Families / Caregivers

- Review poll results.
- Discuss:
  - What are the best ways for individuals and families/caregivers to contribute to improved quality of life outcomes?
  - Should they be measured?

Poll #2: Health Professionals and Provider Systems

- What quality of life components are **Health Professionals and Provider Systems** primarily responsible for?
  - Physical Health
  - Mental and Psychological Health
  - Social Relationships
  - Environment
  - Other?

Poll #2: Health Professionals and Provider Systems

- Review poll results.
- Discuss:
  - What are the best ways for health professionals and provide systems to contribute to improved quality of life outcomes?
  - Should they be measured?

Poll #3: Health Plans

- What quality of life components are **Health Plans** primarily responsible for?
  - Physical Health
  - Mental and Psychological Health
  - Social Relationships
  - Environment
  - Other?

Poll #3: Health Plans

- Review poll results.
- Discuss:
  - What are the best ways for health plans to contribute to improved quality of life outcomes?
  - Should they be measured?

Poll #4: Community / Human Services

- What quality of life components are **Community/Human Services** primarily responsible for?
  - Physical Health
  - Mental and Psychological Health
  - Social Relationships
  - Environment
  - Other?

Poll #4: Community / Human Services

- Review poll results.
- Discuss:
  - What are the best ways for community/human services to contribute to improved quality of life outcomes?
  - Should they be measured?

Poll #5: State and Federal Governments

- What quality of life components are **State and Federal Governments** primarily responsible for?
  - Physical Health
  - Mental and Psychological Health
  - Social Relationships
  - Environment
  - Other?

Poll #5: State and Federal Governments

- Review poll results.
- Discuss:
  - What are the best ways for State and Federal governments to contribute to improved quality of life outcomes?
  - Should they be measured?

Shared Accountability for Quality of Life Outcomes

In summary, who is accountable for quality of life outcomes for dual eligible beneficiaries?

- Individuals and their Families/Caregivers
- Health Professionals and Provider Systems
- Health Plans
- Community and Human Services
- State and Federal Government

Who should be measured on their success?

Opportunity for Public Comment

Summary and Next Steps

"Path Forward" from 2014 Interim Report

- **Fostering measure development to fill gaps**
- **Exploring shared accountability for quality of life outcomes**
- Understanding appropriate risk adjustment for socioeconomic status
- Considering stratification of measure results by dual eligible status

April In-Person Meeting Objectives

- Discuss priority measure gap areas in detail, exploring targeted activities to promote progress
- Update MAP's family of measures for dual eligible beneficiaries based on changes in NQF-endorsed® portfolio
- Develop approach to engaging stakeholders in documentation of measure use and alignment
- Formulate recommendations to HHS about use of performance measurement and other strategies to ensure high-quality care for dual eligible beneficiaries

Important Dates

- April 10-11: **In-Person Meeting** of Dual Eligible Beneficiaries Workgroup
- June: public comment on draft final report
- July: MAP Coordinating Committee review of draft final report
- July: Dual Eligible Beneficiaries Workgroup teleconference to consider public comments and Coordinating Committee feedback
- August: Next final report due to HHS

Thank You for Participating

NATIONAL QUALITY FORUM

Background Information on Recent Home and Community-Based Services Final Rule

Summary

Full text of the final rule published January 16, 2014 is available via the Federal Register.

This final rule amends the Medicaid regulations to define and describe state plan section 1915(i) home and community-based services (HCBS) under the Social Security Act (the Act) amended by the Affordable Care Act. This rule offers states new flexibilities in providing necessary and appropriate services to elderly and disabled populations. This rule describes Medicaid coverage of the optional state plan benefit to furnish home and community based-services and draw federal matching funds.

This rule also provides for a 5-year duration for certain demonstration projects or waivers at the discretion of the Secretary, when they provide medical assistance for individuals dually eligible for Medicaid and Medicare benefits, includes payment reassignment provisions because state Medicaid programs often operate as the primary or only payer for the class of practitioners that includes HCBS providers, and amends Medicaid regulations to provide home and community-based setting requirements related to the Affordable Care Act for Community First Choice State plan option. This final rule also makes several important changes to the regulations implementing Medicaid 1915(c) HCBS waivers.

Quality Requirements for State Plan 1915(i)

§441.745 State plan HCBS administration: State responsibilities and quality improvement.

(b) Quality improvement strategy: Program performance and quality of care.
States must develop and implement an HCBS quality improvement strategy that includes a continuous improvement process and measures of program performance and experience of care. The strategy must be proportionate to the scope of services in the State plan HCBS benefit and the number of individuals to be served. The State will make this information available to CMS at a frequency determined by the Secretary or upon request.

(1) Quality Improvement Strategy. The quality improvement strategy must include all of the following:

(i) Incorporate a continuous quality improvement process that includes monitoring, remediation, and quality improvement.

(ii) Be evidence-based, and include outcome measures for program performance, quality of care, and individual experience as determined by the Secretary.

(iii) Provide evidence of the establishment of sufficient infrastructure to implement the program effectively.

(iv) Measure individual outcomes associated with the receipt of HCBS, related to the implementation of goals included in the individual service plan.

Person Centered Planning for 1915(c), 1915(i)

§441.725 Person-centered service plan.

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

The person-centered planning process is driven by the individual. The process:

(1) Includes people chosen by the individual.

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

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

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

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

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

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

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

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

Commensurate with the level of need of the individual, and the scope of services and supports available under the State plan HCBS benefit, the written plan must:

(1) Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

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

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

(4) Include individually identified goals and desired outcomes.

(5) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS.

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

(7) Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it

must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.
(8) Identify the individual and/or entity responsible for monitoring the plan.
(9) Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
(10) Be distributed to the individual and other people involved in the plan.
(11) Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of §441.740.
(12) Prevent the provision of unnecessary or inappropriate services and supports.
(13) Document that any modification of the additional conditions, under §441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

(i) Identify a specific and individualized assessed need.
(ii) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(iii) Document less intrusive methods of meeting the need that have been tried but did not work.
(iv) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
(vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(vii) Include informed consent of the individual; and
(viii) Include an assurance that the interventions and supports will cause no harm to the individual.
(c) Reviewing the person-centered service plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required in §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

§441.740 Self-directed services 1915(i), 1915(c), 1915(k)

(a) State option. The State may choose to offer an election for self-directing HCBS. The term "self-directed" means, with respect to State plan HCBS listed in §440.182 of this chapter, services that are planned and purchased under the direction and control of the individual, including the amount, duration, scope, provider, and location of the HCBS. For purposes of this paragraph, individual means the individual and, if applicable, the individual's representative as defined in §441.735.
(b) Service plan requirement. Based on the independent assessment required in §441.720, the State develops a service plan jointly with the individual as required in §441.725. If the individual chooses to direct some or all HCBS, the service plan must meet the following additional requirements:

(1) Specify the State plan HCBS that the individual will be responsible for directing.

(2) Identify the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget.

(3) Include appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

(4) Describe the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods.

(5) Specify the financial management supports, as required in paragraph (e) of this section, to be provided.

(c) Employer authority. If the person-centered service plan includes authority to select, manage, or dismiss providers of the State plan HCBS, the person-centered service plan must specify the authority to be exercised by the individual, any limits to the authority, and specify parties responsible for functions outside the authority the individual exercises.

(d) Budget authority. If the person-centered service plan includes an individualized budget (which identifies the dollar value of the services and supports under the control and direction of the individual), the person-centered service plan must meet the following requirements:

(1) Describe the method for calculating the dollar values in the budget, based on reliable costs and service utilization.

(2) Define a process for making adjustments in dollar values to reflect changes in an individual's assessment and service plan.

(3) Provide a procedure to evaluate expenditures under the budget.

(4) Not result in payment for medical assistance to the individual.

(e) Functions in support of self-direction. When the State elects to offer self-directed State plan HCBS, it must offer the following individualized supports to individuals receiving the services and their representatives:

(1) Information and assistance consistent with sound principles and practice of self-direction.

(2) Financial management supports to meet the following requirements:

(i) Manage Federal, State, and local employment tax, labor, worker's compensation, insurance, and other requirements that apply when the individual functions as the employer of service providers.

(ii) Make financial transactions on behalf of the individual when the individual has personal budget authority.

(iii) Maintain separate accounts for each individual's budget and provide periodic reports of expenditures against budget in a manner understandable to the individual.

(3) Voluntary training on how to select, manage, and dismiss providers of State plan HCBS.

HCBS Settings Requirements 1915(k), 1915(c), 1915(i)

(4) Home and Community-Based Settings.

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

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

Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(ii) The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Identify a specific and individualized assessed need.

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

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

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(7) Include the informed consent of the individual.
(8) Include an assurance that interventions and supports will cause no harm to the individual.

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

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

Information in settings rule on Privacy:

Home and community based settings are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

Home and community based settings ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint. They also optimize, but do not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact. Home and community based settings facilitate individual choice regarding services and supports, and who provides them.

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

For provider owned settings each person has privacy in their sleeping or living unit. Privacy in this context means:

- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
- Individuals sharing units have a choice of roommates in that setting.
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- Individuals are able to have visitors of their choosing at any time.
- The setting is physically accessible to the individual.

Home and community based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital, or any other location that have qualities of an institutional setting. For instance, any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS is presumed to be a setting that has the qualities of an institution.

CMS guidance applicable to employment related services and supports:

Cross-walk of HCBS final rule on settings with 1915(c) information bulletin regarding employment and employment related services:

HCBS final rule – settings	1915c Information Bulletin regarding employment and employment related services
The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. Settings not considered home and community based: Nursing facility, IMD, ICF-IDD, hospital or any locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the	Supported employment and prevocational services may be furnished as expanded habilitation services under the provisions of §1915(c)(5)(C) of the Act. They may be offered to any target group for whom the provision of these services would be beneficial in helping them to realize their goals of obtaining and maintaining community employment in the most integrated setting. As provided in Olmstead Letter #3 (included in Attachment D), the provision of these services is not limited to participants with intellectual or developmental disabilities, and can be a meaningful addition to the service array for any of the regulatorily identified target groups. Waiver (*Medicaid) funding is not available for the provision of vocational services delivered in facility based or sheltered work settings, where individuals are supervised for the primary purpose

effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.	of producing goods or performing services. The distinction between vocational and pre-vocational services is that pre-vocational services, regardless of setting, are delivered for the purpose of furthering habilitation goals *such as attendance, task completion, problem solving, interpersonal relations and safety,* as outlined in the individual's person-centered services and supports plan. Prevocational services should be designed to create a path to integrated community based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment individual employment supports does not include facility based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. **Supported Employment - Small Group Employment Support Core Service Definition** Supported Employment Small Group employment support are services and training activities provided in regular business, industry and community settings for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group

	employment support does not include vocational services provided in facility based work settings. Supported employment small group employment supports may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits support, training and planning transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the beneficiary to be successful in integrating into the job setting. **Guidance** • Supported employment small group employment support does not include vocational services provided in facility based work settings or other similar types of vocational services furnished in specialized facilities that are not a part of general community workplaces. • Supported employment small group employment supports do not include volunteer work. Such volunteer learning and training activities that prepare a person for entry into the paid workforce are more appropriately addressed through pre-vocational services. • Supported employment small group employment support does not include payment for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business. • Supported employment small group employment support services may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker, supervisor or other personnel and these individuals meet the pertinent qualifications for the providers of service. • Personal care/assistance may be a component part of supported employment small group employment support services, but may not

	comprise the entirety of the service. • All prevocational and supported employment service options should be reviewed and considered as a component of an individual's person-centered services and supports plan no less than annually, more frequently as necessary or as requested by the individual. These services and supports should be designed to support successful employment outcomes consistent with the individual's goals. • Individuals receiving supported employment small group employment support services may also receive educational, prevocational and/or day habilitation services and career planning services. A participant's person-centered services and supports plan may include two or more types of non-residential habilitation services. However, different types of non-residential habilitation services may not be billed during the same period of time. If States wish to cover "career planning" they may choose to include it as a component part of supported employment small group employment support services or it may be broken out as a separate stand alone service definition. • Supported employment small group employment support services may be furnished to any individual who requires and chooses them. If a state offers both supported employment-individual and small group employment support services, individuals should be provided information to make an informed decision in choosing between these services. Supported employment small group employment support services are not limited to persons with intellectual or developmental disabilities.