NATIONAL RESOURCE CENTER *for*
PARTICIPANT-DIRECTED SERVICES

PARTICIPANT DIRECTION 201:

CMS Final Rule and its Impact on Participant Direction

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History and Background

- More than 2000 public comments received to the proposed rules which were published on April 15, 2011, and May 3, 2012
- Final rule: CMS 2249-F and CMS 2296-F
- Published in the Federal Register on January 16, 2014
- Affects §1915(c), §1915(k) and §1915(i) programs
- Helps states meet their Olmstead obligation to offer individuals services in the least restrictive setting

Highlights

- Person-Center Planning Required in §1915(c) and § 1915(i) Programs
  - Minimum requirements of the process defined
- Combining Waiver Populations
  - States may combine multiple target populations into one waiver
- Home and Community-Based Settings Defined
  - More detailed rules on which settings qualify
  - Rule aligns requirements across §1915(c), §1915(k) and §1915(i) programs
- Final Regulations for 1915(i) Implemented
- New Exception to the Rule Against Provider Claim Reassignment

Prohibition on Provider Claim Reassignment

- General rule: payments for Medicaid services must be made to the provider or beneficiary
  - No reassignment of claims
- Existing exception for payment of training costs and other benefits that are part of the cost of doing business for providers
  - Costs could be taken into account when determining the **service rate paid to providers**, but not claimed as a separate administrative expense by the Medicaid agency (under old rules)
    - See *CMCS Informational Bulletin, July 13, 2011*

New Exception to Allow Direct Payments for Employee Benefits

- New exception to prohibition on provider claim reassignment:
  - "In the case of a class of practitioners for which the Medicaid program is the primary source of service revenue, payment may be made to a **third party** on behalf of the individual practitioner for benefits such as **health insurance, skills training and other benefits customary for employees**." – 42 CFR Section 447.10(g)(4)

Two Ways to Pay for Employee Benefits

- Option 1 (old way): state pays providers, providers pay for benefits
  - Cost of benefits is factored into the **provider rate** as a cost of doing business
- Option 2 (new way): state pays a third party directly for benefits, and pays providers separately for providing services
  - Possible advantages:
    - Uniform access to benefits and skills training
    - Cost savings from the collective purchase of benefits
    - Greater workforce stability

Overarching Impact of the Changes

- Greater support and opportunities for choice and control
- More emphasis community inclusion
- Emphasis on attaining personal goals based on individual preferences
- Reduction of state administrative burden
- Supports direct services workers through training and benefits

Person-Centered Planning Implications

- Requirments for §1915 (c), §1915(i), §1915(j) & §1915(k) but not traditional state plan services
- PcP manifests itself differently for various populations – one size does not fit all
  - IDD
  - Adults with disabilities
  - Elders with disabilities
- Training staff is key
- Since a requirement, quality strategies should be adopted

Combing Populations Implications

- Past requirements – separation of IDD, D/E, and other diagnoses
- Now can combine – now look at functional needs rather than diagnoses
- Reduces duplicate administrative activity, reduces reporting & renewal work, and centralizes administrative oversight
- In the past, §1115 Demonstrations used to combine populations
- Concerns – bring parity across populations

HCBS Setting Implications

- Advocates have taken exception to past definition
- New definition based on degree of choice and control
  - More outcome based
  - Maximizes access to community living
- Existing group homes, shared living, residential facilities and assisted living providers must adjust to new definition
- May be challenging for some programs
- CMS supports through toolkit and transition period
- May impact state rebalancing efforts

Implications of §1915(i)

- Significant support for participant direction
- Expansion opportunities for state plan participant direction
- Defines essential elements
  - Participant direction
  - Employer/budget authority
  - Supports
- Voluntary training requirement
- Target populations with unique service package
- Statewide requirement with no caps/limits
- Anticipated increase submissions for §1915(i)

Implications of Reassignment

- States may now arrange for health benefits, extended training opportunities, or other benefits customary for employees for direct service workers through FMS or directly with a third party provider
- Represents a significant impact to improve the workforce to function as a health care provider and advances knowledge through skills building
- Challenges:
  - State must dedicate additional funding to support benefits and training

Conclusions

- Training on PcP
- Could see FMS centralized
- Unique service package for groups with less than Level of Care admissions
- Groups homes, shared living, residential settings and assisted living will remove barriers to inclusion
- Potential avenue for health care coverage for direct service workers

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OPEN DISCUSSION AND QUESTIONS

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