Independent Assessment Of Medicaid Beneficiaries Receiving HCBS

Update April 1, 2015

DRA Provision and Initial Guidance

The Deficit Reduction Act, 2006 requires an independent assessment of Medicaid beneficiaries receiving HCBS ONLY for the 1915(i) state option[1]. Dennis Smith, then Medicaid Director, issued subsequent guidance on the definition of independent assessment:

> **Independent Evaluation and Assessment & Conflict of Interest Standards**
> Section 1915(i)(1)(E) of the Act requires an independent evaluation and assessment of each individual who applies for services under this benefit. Additionally, section 1915(i)(1)(H)(ii) of the Act requires States to establish standards for the conduct of the independent evaluation and assessment to safeguard against conflicts of interest. Thus, States should establish standards and procedures to ensure that evaluators and assessors are not:
> - Related by blood or marriage to the individual, or any paid caregiver of the individual;
> - Financially responsible for the individual;
> - Empowered to make financial or health-related decisions on behalf of the individual; and/or
> - Providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS, except when the only willing and qualified provider in a geographic area also provides HCBS, and States devise conflict of interest protections.

In addition, the law sets forth requirements for the independent assessment. Based on these requirements, the assessment should be based on the following:

- An objective face-to-face evaluation by an independent agent trained in assessment of need for HCBS and supports;
- Consultation with the individual and others as appropriate;
- An examination of the individual's relevant history, medical records, care and support needs, and preferences;
- Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986);
- Where applicable, an evaluation of the support needs of the individual (or the

[1] Rep. Nathan Deal, then chair of the House Energy and Commerce Health Subcommittee, now Governor of Georgia, authored the provision.

individual's representative) to participant-direct; and

- A determination of need (and, if applicable, determination that service-specific additional needs-based criteria are met) for at least one State plan HCBS before an individual is enrolled into the State plan HCBS benefit.

Affordable Care Act Amendment and Regulations
The Obama administration issued regulations on January 16, 2014 (the 1915(1) waiver regulations are subpart M) that restated these requirements [The Bush administration issued a proposed rule on April 4, 2008, Federal Register, (73 FR 18676), but it was never finalized and the program was slightly amended in the Affordable Care Act (Section 2402) to liberalize the option with respect to services and eligible beneficiaries.] The new regulations provide the following with respect to an independent assessment and the definition of an independent provider of assessments:

> **§ 441.720 Independent assessment.**
> (a) *Requirements.* For each individual determined to be eligible for the State plan HCBS benefit, the State must provide for an independent assessment of needs, which may include the results of a standardized functional needs assessment, in order to establish a service plan. In applying the requirements of section 1915(i)(1)(F) of the Act, the State must:
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> (1) Perform a face-to-face assessment of the individual by an agent who is independent and qualified as defined in § 441.730, and with a person-centered process that meets the requirements of § 441.725(a) and is guided by best practice and research on effective strategies that result in improved health and quality of life outcomes.
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> (i) For the purposes of this section, a face-to-face assessment may include assessments performed by telemedicine, or other information technology medium, if the following conditions are met:
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> (A) The agent performing the assessment is independent and qualified as defined in § 441.730 and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology.
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> (B) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.
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> (C) The individual provides informed consent for this type of assessment.
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> (ii) [Reserved]
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> (2) Conduct the assessment in consultation with the individual, and if applicable, the individual's authorized representative, and include the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals responsible for the individual's care.
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> (3) Examine the individual's relevant history including the findings from the

independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the person-centered service plan as required in § 441.725.
(4) Include in the assessment the individual's physical, cognitive, and behavioral health care and support needs, strengths and preferences, available service and housing options, and if unpaid caregivers will be relied upon to implement any elements of the person-centered service plan, a caregiver assessment.
(5) For each service, apply the State's additional needs-based criteria (if any) that the individual may require. Individuals are considered enrolled in the State plan HCBS benefit only if they meet the eligibility and needs-based criteria for the benefit, and are also assessed to require and receive at least one home and community-based service offered under the State plan for medical assistance.
(6) Include in the assessment, if the State offers individuals the option to self-direct a State plan home and community-based service or services, any information needed for the self-directed portion of the service plan, as required in § 441.740(b), including the ability of the individual (with and without supports) to exercise budget or employer authority.
(7) Include in the assessment, for individuals receiving habilitation services, documentation that no Medicaid services are provided which would otherwise be available to the individual, specifically including but not limited to services available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973, or the Individuals with Disabilities Education Improvement Act of 2004.
(8) Include in the assessment and subsequent service plan, for individuals receiving Secretary approved services under the authority of § 440.182 of this chapter, documentation that no State plan HCBS are provided which would otherwise be available to the individual through other Medicaid services or other Federally funded programs.
(9) Include in the assessment and subsequent service plan, for individuals receiving HCBS through a waiver approved under § 441.300, documentation that HCBS provided through the State plan and waiver are not duplicative.
(10) Coordinate the assessment and subsequent service plan with any other assessment or service plan required for services through a waiver authorized under section 1115 or section 1915 of the Social Security Act.

(b) *Reassessments.* The independent assessment of need must be conducted at least every 12 months and as needed when the individual's support needs or circumstances change significantly, in order to revise the service plan.

§ 441.730 Provider qualifications.

(a) *Requirements.* The State must provide assurances that necessary safeguards have been taken to protect the health and welfare of enrollees in State plan HCBS, and must define in writing standards for providers (both agencies and individuals) of HCBS and for agents conducting individualized independent evaluation, independent assessment, and service plan development.

(b) *Conflict of interest standards.* The State must define conflict of interest standards that ensure the independence of individual and agency agents who conduct (whether as a service or an administrative activity) the independent evaluation of eligibility for State plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan. The conflict of interest standards apply to all individuals and entities, public or private. At a minimum, these agents must not be any of the following:

(1) Related by blood or marriage to the individual, or to any paid caregiver of the individual.
(2) Financially responsible for the individual.
(3) Empowered to make financial or health-related decisions on behalf of the individual.
(4) Holding financial interest, as defined in § 411.354 of this chapter, in any entity that is paid to provide care for the individual.
(5) Providers of State plan HCBS for the individual, or those who have an interest in or are employed by a provider of State plan HCBS for the individual, except when the State demonstrates that the only willing and qualified agent to perform independent assessments and develop person-centered service plans in a geographic area also provides HCBS, and the State devises conflict of interest protections including separation of agent and provider functions within provider entities, which are described in the State plan for medical assistance and approved by the Secretary, and individuals are provided with a clear and accessible alternative dispute resolution process.

(c) *Training.* Qualifications for agents performing independent assessments and plans of care must include training in assessment of individuals whose physical, cognitive, or mental conditions trigger a potential need for home and community-based services and supports, and current knowledge of available resources, service options, providers, and best practices to improve health and quality of life outcomes.

States Participating in Section 1915(i) Home and Community-Based Services State Plan Option[2]

As of March 2015:

- 17 states are participating (CA, CO, CT, DC, FL, ID, IN, IA, LA, MD, MI, MS, MT, NV, OR, WA, WI); and
- 4 have plans to participate in FY2014 (DE, MN, SC, TX).

Location	Currently Participating	Approved SPA	SPA Submitte	Planned to Participate in	Plans to Participate

[2] Kaiser Family Foundation State Health Facts, Section 1915(i) Home and Community-Based Services State Plan Option, http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/#, accessed October 3, 2014 and April 1. 2015.

	?		d	FY 2014	in FY 2015
United States	17 Yes	15 Yes	2 Yes	4 Yes	4 Yes
Arkansas	No	-		Yes	
California	Yes	Yes		-	
Colorado	Yes	Yes		-	
Connecticut	Yes	Yes		-	
Delaware	No	-		Yes	Yes
District of Columbia	Yes	-	Yes	Yes	
Florida	Yes	Yes		-	
Idaho	Yes	Yes		-	
Indiana	Yes	Yes		-	
Iowa	Yes	Yes		-	
Louisiana	Yes	Yes		-	
Maryland	Yes	Yes		Yes	
Michigan	Yes	Yes			
Minnesota					Yes
Mississippi	Yes	Yes			
Montana	Yes	Yes		-	
Nevada	Yes	Yes		-	
Oregon	Yes	Yes		-	
S. Carolina					Yes
Texas		-		-	Yes
Washington	Yes	-	Yes	-	
Wisconsin	Yes	Yes		-	