DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Disabled & Elderly Health Programs Group

August 23, 2018

Blake T. Fulenwider
Chief of the Medicaid Assistance Plans
State of Georgia, Department of Community Health
2 Peachtree Street, NW, Suite 36450
Atlanta, GA 30303

Dear Mr. Fulenwider:

In follow-up to the 10/25/17 initial approval granted to Georgia's Home & Community Based Services (HCBS) Statewide Transition Plan (STP), CMS provided additional detailed feedback to the state to assist with final approval and implementation of its STP. CMS acknowledges that since this technical assistance was provided, work has continued within the state to bring settings into compliance and further develop the STP; however, a summary of this feedback is attached for reference to assist in the state's efforts as it works towards final approval.

In order to receive final approval, the STP should include:

- A comprehensive summary of completed site-specific assessments of all HCBS settings, validation of those assessment results, and inclusion of the aggregate outcomes of these activities;
- Draft remediation strategies and a corresponding timeline for resolving issues that the site-specific settings assessment process and subsequent validation strategies identified by the end of the HCBS settings transition period (March 17, 2022);
- A detailed plan for identifying settings presumed to have institutional characteristics, as well as the proposed process for evaluating these settings and preparing for submission to CMS for review under heightened scrutiny;
- A process for communicating with beneficiaries currently receiving services in settings that the state has determined cannot or will not come into compliance with the HCBS settings rule by March 17, 2022; and
- A description of ongoing monitoring and quality assurance processes that will ensure all settings providing HCBS continue to remain fully compliant with the federal settings criteria in the future.

Prior to submitting the updated version of the STP for consideration of final approval, the state will need to issue the STP for a minimum 30-day public comment period. I want to personally thank the state for its efforts thus far on the HCBS STP, and look forward to the next iteration of the STP that addresses the feedback in the attachment.

Sincerely,

Ralph F. Lollar, Director
Division of Long Term Services and Supports

ATTACHMENT

Additional CMS feedback on areas where improvement is needed by the State of Georgia in order to receive final approval of the HCBS Statewide Transition Plan

PLEASE NOTE: It is anticipated that the state will need to go out for public comment once these changes are made and prior to resubmitting to CMS for final approval. The state is requested to provide a timeline and anticipated date for resubmission for consideration of final approval as soon as possible.

Site-Specific Settings Assessment

Georgia identified the following settings that must comply with the federal HCBS Settings Criteria:

- Adult Day Health
- Alternative Living Services
- Community Access Group
- Community Residential Alternatives
- Prevocational Services
- Supported Employment Group
- Respite Out-of-Home Care

Based on the state's initial analysis, there were 2,288 unique provider settings. The state attempted to administer a self-assessment survey for 100% of provider settings with validation done by a 5% random sampling of surveys completed by case managers, and a correlating member survey for which there was an over 5% response rate. The state developed a survey that was used interchangeably by providers and case managers, and modified slightly for members.

  - Please provide information about when additional surveys will be completed and whether or not the tool will be modified prior to the next round.
  - Please provide information on how the strategic redesign will achieve greater participation, adequately match provider responses to case manager and consumer survey responses, and resolve other technical issues.

- ***Provider Surveys***: The state distributed an electronic survey in November 2015 to providers of 2,288 settings. Of these, 383 are no longer active providers; 1,795 surveys were returned (by 1,172 unique providers); and 110 are outstanding. 11% self-reported complete compliance with the rule; 76% self-reported non-compliance with at least one requirement; and 13% were considered to be non-compliant because they had not yet submitted the self-assessment survey. CMS requests the following additional information:
  - Please confirm in the STP that providers completed a self-assessment for each individual setting providing Medicaid-funded HCBS.

- Of the 1,172 providers to complete the survey, only 185 provider agency representatives participated in a training webinar. CMS recommends including information in the STP about the training and outreach the state engaged in to educate providers on the survey.
- The number of Community Care Services Program (CCSP) provider surveys submitted (474, page 2 of Appendix G) exceed the total number of CCSP provider settings that need to come into compliance (328, page 37 of STP). Please clarify.

- ***Individual, Private Homes:*** The state may make the presumption that privately-owned or rented homes and apartments of individual HCBS beneficiaries living with family members, friends, or roommates meet the HCBS settings requirements if they are integrated in typical community neighborhoods where people who do not receive HCBS also reside. A state will generally not be required to verify this presumption, but does need to include details within the STP as to how the state will monitor these settings to assure ongoing compliance with the federal HCBS settings criteria in the future. Also note, settings where the beneficiary lives in a private residence owned by an unrelated caregiver (who is paid for providing HCBS to the individual), are considered provider-owned or controlled settings and should be evaluated as such.

Validation of HCBS Settings

Please clarify in the STP the state's validation process for provider self-assessments. The state can use multiple validation processes (including but not limited to state onsite visits; data collection on beneficiary experiences; desk reviews of provider policies, consumer surveys, and feedback from external stakeholders; leveraging of existing case management, licensing & certification, and quality management review processes; partnerships with other federally-funded state entities, including but not limited to DD and aging networks, etc.).

- Please confirm how the state will assure that each setting providing Medicaid-funded HCBS will be assessed and validated, using at least one independent validation strategy, including timelines.
- Please provide more detail in the STP about the state's plan for site visits, including the number or percentage of settings to receive site visits and when and how they will occur.
- ***Case Manager Surveys***: The state validated the provider self-survey results using a 5% sample size of case manager surveys. Page 40 of the STP indicates that, "Case Managers were asked to complete the assessment tool for settings at which members on their case load received services. Case Managers were expected to validate assessments during member visits; however, if the time period of the validation did not coincide with a scheduled visit, they were allowed to complete a desk review based on familiarity with the setting."

- Please clarify whether or not the 5% sample is representative for each category of setting or for the overall number of settings.
- Please confirm that the state's plan is to validate at least 5% of provider assessments in their entirety based on the full survey.

- ***Reporting of Setting Validation Results:*** Please report the findings of all validation activities once they are all completed. In this analysis, make sure to delineate the compliance results across categories of settings for all waivers in a manner that is easy for the public to review and understand. At a minimum, please make sure to confirm the number of settings in each category of HCBS that the state found to be:
  - Fully compliant with the federal HCBS requirements;
  - Could come into full compliance with modifications;
  - Cannot comply with the federal HCBS requirements; or
  - Presumptively institutional in nature.

Remediation Strategies

- ***Site-Specific Remediation:*** The STP indicates that all providers who indicated "No" and "Not Yet" responses will receive some type of remediation ranging from general education, training, solution-focused mapping, technical assistance, and/or follow-up site visits. Providers also had the option of providing a timeline for addressing areas of concern ranging from 1-12 months, and DCH has scheduled follow-up within the designated times indicated on each setting's milestone document. Please provide the following additional information:
  - Describe the process that the state will take to assure that any discrepancies between the consumer and/or case manager responses and provider self-assessments are adequately addressed.
  - Update timelines listed in Appendix A for each of the remedial strategies listed.
  - For those settings that are not able to be brought into compliance, please provide a detailed plan the state will use for communicating and assisting beneficiaries currently receiving services in settings that are determined not to be able to come into compliance prior to the end of the transition period that includes:
    - A description for how participants will be offered informed choice and assistance in locating a new residential or nonresidential setting in which HCBS are provided or accessing alternative funding streams.
    - An estimated number of beneficiaries who are in settings that the state anticipates will not be in compliance by the end of the transition period and may need to access alternative funding streams or receive assistance in locating a compliant setting.
    - Confirmation of the state's timeline for supporting beneficiaries in exploring and securing alternative options should a transition out of a non-compliant setting be necessary.

- An explanation of how the state will ensure that needed services and supports are in place in advance of the individual's transition.

Reverse Integration Strategies: CMS requests additional detail from the state as to how it will assure that non-residential settings comply with the various requirements of the HCBS rule, particularly around integration of HCBS beneficiaries to the broader community. States cannot comply with the rule simply by bringing individuals without disabilities from the community into a setting. Reverse integration, or a model of intentionally inviting individuals not receiving HCBS into a facility-based setting to participate in activities with HCBS beneficiaries, is not considered by CMS by itself to be a sufficient strategy for complying with the community integration requirements outlined in the HCBS settings rule.

Non-Disability Specific Settings: Please provide clarity on the manner in which the state will ensure that beneficiaries have access to services in non-disability specific settings among their service options for both residential and non-residential services. The STP should also indicate the steps the state is taking to build capacity among providers to increase access to non-disability specific setting options across home and community-based services.

Ongoing Monitoring of Settings

The state proposes to create, vet (with the Statewide Task Force), and implement an oversight and monitoring plan, which the Department of Community Health will then implement as part of the state's Medicaid provider re-credentialing/ revalidation process. New providers will be required to complete the assessment for new or expanded applications which will be validated through the Provider Enrollment site-visit prior to approval and enrollment. As part of the every-three-year revalidation process, each provider will be required to sign and attest to ongoing compliance. Please provide the following additional details on the ongoing monitoring process:

- Please add information on the estimated timeframes for implementing each element of the oversight and monitoring plan.
- As part of the oversight and monitoring plan, the state plans to work with its Healthcare Facility Regulation and Provider Enrollment divisions to establish procedures to ensure ongoing compliance, such as potentially modifying a tool that is used on site visits. Please specify whether all settings will receive these site visits or if the state has alternate plans to ensure compliance.

Heightened Scrutiny

As a reminder, the state must clearly lay out its process for identifying settings that are presumed to have the qualities of an institution. These are settings for which the state must submit information for the heightened scrutiny process if the state determines, through its assessments, that these settings do have qualities that are home and community-based in nature and do not

have the qualities of an institution. If the state determines it will not submit information on a presumptively institutional setting, the institutional presumption will stand and the state must describe the process for determining next steps for the individuals involved. Please only submit those settings under heightened scrutiny that the state believes will overcome any institutional characteristics and can comply with the federal settings criteria. Please include further details about the criteria or deciding factors that will be used consistently across reviewers to make a final determination regarding whether or not to move a setting forward to CMS for heightened scrutiny review. There are state examples of heightened scrutiny processes available upon request, as well as several tools and sub-regulatory guidance on this topic available online at http://www.medicaid.gov/HCBS.

Milestones

A milestone template has been completed by CMS with timelines identified in the STP and has been sent to the state for review. CMS requests that the state review the information in the template and send the updated document to CMS. The chart should reflect anticipated milestones for completing systemic remediation, settings assessment and remediation, heightened scrutiny, communications with beneficiaries and ongoing monitoring of compliance.