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Health and Welfare in Self-Directed Home- and Community-Based Services (HCBS)

Environmental Scan

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Overview

- Background
- Environmental scan
- Next steps

Background

Medicaid Coverage of Self-Direction

- Self-direction is a Medicaid HCBS delivery model that allows individuals to choose their HCBS providers and have control over the amount, duration, and scope of services and supports in their person-centered service plan (PCSP)
- Federal requirements for self-direction models
  - Person-centered planning process and PCSP
  - Quality assurance and continuous improvement system
  - Information and assistance (I&A) supports
  - Financial management services (FMS)
  - Individualized budget

Person-Centered Services

- All HCBS, including self-directed HCBS, must ensure beneficiary health and welfare per federal regulations
- Self-directing beneficiaries have increased choice and autonomy in their service delivery, including the choice to take risks
- An individual's PCSP must reflect choices, goals, and desired outcomes as well as risk factors and measures to minimize them
- This planning can and should include training for workers, quality monitoring and improvement activities, and beneficiary engagement
- Through these person-centered planning processes, federal policies promote beneficiary choice and simultaneously address risks, blending considerations for both beneficiary safety and choice

Federal Health and Welfare Safeguards

- States must provide assurances that they safeguard HCBS users by
  - Establishing standards for HCBS providers
  - Ensuring services are provided in home- and community-based settings
  - Meeting the needs of the populations served
  - Operating an incident management system
- States must meet conflict of interest standards to protect beneficiaries from abuse, neglect, and exploitation
- Specialized safeguards exist for self-direction programs and vary by authority
- The 2024 ensuring access to Medicaid services final rule codified and expanded existing guidance from CMS

Evolution of Self-Direction

- Self-direction enrollment nearly doubled between 2013 and 2023
- Alongside this growth, state and federal stakeholders have observed challenges, some of which have been examined and described by federal oversight bodies
- For example, the Office of the Inspector General in the U.S. Department of Health and Human Services found services that:
  - Were not authorized or supported by documentation
  - Were delivered by a provider who was not registered, screened, employable, or did not meet HCBS worker verification requirements
  - Lacked a signed care plan or were inconsistent with the service plan
- States have updated self-direction program policies based on recommendations from these audits

Environmental Scan

Findings from three state case studies

Reportable Incidents Consistently Include Abuse, Neglect, and Exploitation

- State lists of critical incidents that must be reported generally align with new federal requirements
  - For example, requirements include reporting unexpected deaths, physical or psychological abuse, and serious injury
- Specificity in defining additional critical incidents and reportable events varies by state and delivery system
  - One state established a list of additional critical incidents including environmental and access risks such as utility shutoffs, natural disasters, or an unreachable beneficiary
  - Another state defines triggering events in managed care that may signal potential risk to the beneficiary such as loss of housing or functional decline

Although Mandatory Reporting of Critical Incidents is Universal, Reporting Pathways Differ

- FMS entity and managed care plan staff are mandatory reporters in all states
- Two of our three states define HCBS providers and beneficiaries as mandatory reporters; one does not
- One state has multiple reporting pathways while others are more streamlined
  - In one state, beneficiaries can issue reports to customer service or the supports broker, as well as via email, fax, web portal, or mobile application; supports brokers report directly to the state Medicaid agency and Adult Protective Services (APS)
  - The other two states require incident reporting through an APS hotline or directly to the state Medicaid or operating agency

Responsibility for Managing Corrective Action Differs by Delivery System

Fee-For-Service (FFS)

- Beneficiaries, as the employer, implement corrective action and must report it to the state
  - FMS entity provides support
- Instances when state intervention occurs
  - Immediate risk to beneficiary
  - Corrective action is in response to abuse, neglect, or exploitation
  - Representative must be removed
  - Corrective action is not implemented or reported
  - Issues persist

Managed Care

- Plans are responsible for tracking and trending incidents and risk
  - Evaluate member risk, analyze incident trends, and drive systemic corrective actions
  - HCBS providers implement changes identified through the plan or state monitoring

States Require In-Person Monitoring in Self-Direction

- All states in the study require in-person monitoring in self-direction
  - Federal law does not require in-person monitoring activities in self-direction (except Section 1915(j))
  - Case managers in managed care, supports brokers, and FMS entity staff generally perform monitoring activities
- The cadence of in-person contact and entities involved vary by state
  - Some states require annual meetings while others have quarterly visits
  - In one state, higher-acuity beneficiaries had more required in-person contacts than beneficiaries receiving low- or moderate-intensity care
- Virtual or phone monitoring activities are supplemental

All States Monitor Service and Budget Utilization

Scheduled Monitoring

- Scheduled monitoring activities occur at state-defined intervals
- Frequency of scheduled, in-person monitoring ranges from quarterly to annually
  - Reviews of beneficiary budget management
  - Reassessments of need or level of care reviews
  - Evaluations of health and safety, and risk identification

Triggered Monitoring

- Data systems include
  - Claims adjudication
  - Critical incident management
  - Electronic Visit Verification (EVV)
- Monitoring data for flags that may indicate risk
  - Under or overutilization or anomalous utilization hours
  - Critical incidents
  - Functional decline
  - Missed scheduled monitoring
  - EVV anomalies

States Establish Additional Eligibility Rules and Requirements for Representatives

- Representative availability and accessibility rules
  - One state requires that representatives live within 30 miles or one hour of the beneficiary
  - Another requires that representatives be available to attend visits or trainings, communicate with FMS and counseling entities, and respond to critical incidents
- States prohibit the following individuals from being representatives
  - Anyone with a history of abuse, neglect, or exploitation
  - Subjects of maltreatment investigations
  - Those with disqualifying criminal or abuse registry history
- A representative can be required when a beneficiary cannot safely manage self-direction alone

Disenrollment from Self-Direction is a Last Resort

- Involuntary transitions to agency-directed services only occur when health, safety, or program compliance cannot be maintained
  - Serious health or safety risks
  - Inability to manage employer responsibilities and no representative is available
  - Inability to find or replace a representative
  - Representative is under investigation for abuse, neglect, or exploitation
  - Fraudulent use of funding is suspected or proven
  - Persistent EVV non-compliance
- During care transitions, the state agency or managed care plan must ensure continuity of care

Provider Standards are Multi-Layered

- States have pre-employment qualifications, training, and monitoring standards for HCBS providers
- Pre-employment checks include a criminal background check, a review of state abuse and fraud registries, and a review of federal registries
  - Beneficiaries may request additional background checks
- HCBS providers must receive training on reporting abuse, neglect, and exploitation
- States may also impose requirements for training, qualifications, and certification of supports brokers and FMS entity staff
- All states employ monitoring strategies to enforce provider standards
  - In two states, EVV and monthly fiscal audits confirm HCBS provider credentialing, identify service misuse or performance issues, and ensure compliance with training requirements
  - One state mandates annual provider recredentialling

Oversight and Quality Systems Track Incidents, Monitor Performance, and Drive Corrective Actions

- States generally operate oversight and quality monitoring systems broadly across all service delivery types, including self-direction
  - Critical incident management system: tracks, reviews, and analyzes incidents to detect patterns, trends, and risks
  - Health plan quality assessment and performance improvement strategy: analyzes incident types, service locations, provider involvement, and investigation findings to detect systemic quality concerns
- Systems may span state operating agencies
  - One state designates a cross-agency quality review team to review and collate findings from data systems, quarterly
- Another state has a specific division that monitors quality assurance standards in self-direction
  - Procures and oversees all counseling and FMS entities, enforcing contractual standards
  - Employ continuous data reporting to monitor issues in real time

Integrated Program Integrity Controls are Key to Ensuring Beneficiary Health and Welfare

- Some states integrate EVV data with background checks, credentialing reviews, and payroll systems
  - Prevents fraud and identifies misalignment between services and the PCSP
  - EVV data and payroll system integration prevents payment for ghost visits and indicates whether additional supports are needed to ensure quality service delivery
- State audits of self-directed services verify worker credentials, visit validity, and alignment of EVV data with service authorizations
- Multiple entities support program integrity to ensure health and safety
  - Beneficiary or representative, HCBS provider, FMS entity, managed care plan, Medicaid Fraud Control Unit, and state

Next Steps

- Obtain Commissioner feedback on areas for further investigation through stakeholder and national expert interviews
  - Are any findings from the environmental scan of particular interest to the Commission for further investigation?
- We will return next cycle to discuss findings from our ongoing interviews

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APRIL MEETING

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