SOUTH CAROLINA COMMISSION ON DISABILITIES AND SPECIAL NEEDS

MINUTES

January 16, 2014

The South Carolina Commission on Disabilities and Special Needs met on Thursday, January 16, 2014, at 10:30 a.m. at the Department of Disabilities and Special Needs Central Office, 3440 Harden Street Extension, Columbia, South Carolina.

The following were in attendance:

COMMISSION

Present:
Fred Lynn, Chairman
Christine Sharp, Vice Chairman
Harvey Shiver, Secretary
Katherine Davis
Katherine Finley (Via Teleconference)
Deborah McPherson
Eva Ravenel

DDSN Administrative Staff
Dr. Buscemi, State Director; Mrs. Susan Beck, Associate State Director, Policy; Mr. David Goodell, Associate State Director, Operations; Mr. Tom Waring, Associate State Director, Administration; Mrs. Tana Vanderbilt, General Counsel (For other Administrative Staff see Attachment 1 – Sign In Sheet).

Guests

(See Attachment 1 Sign-In Sheet)

Coastal Regional Center (via videoconference)

(See Attachment 2 Coastal Center Regional Center Sign-In Sheet)

Pee Dee Regional Center (via videoconference)

(No Attendees)

Whitten Regional Center (via videoconference)

(See Attachment 3 Whitten Center Regional Center Sign-In Sheet)

York County DSN Board (via videoconference)

(See Attachment 4 York County Sign-In Sheet

News Release of Meeting

Chairman Fred Lynn called the meeting to order and Commissioner Harvey Shiver read a statement of announcement about the meeting that had been mailed to the appropriate media, interested persons, and posted at the Central Office and on the website in accordance with the Freedom of Information Act.

Invocation

Commissioner Deborah McPherson gave the invocation.

Adoption of the Agenda

The Commission adopted the January 16, 2014 Meeting Agenda by unanimous consent. (Attachment A)

Approval of the Minutes of the December 19, 2013 Commission Meetings

The Commission approved the minutes of the December 19, 2013 Commission Meeting by unanimous consent.

Public Input

There was no participation in Public Input.

Report from DSN Boards

Dr. Jerry Bernard spoke on behalf of the SC Human Service Providers Association.

Commissioners' Update

Commissioners Christine Sharp and Deborah McPherson spoke of events in their districts.

Silver Palmetto Award

Ms. Lois Park Mole presented information on the 2013 Silver Palmetto Award that is given annually to a city or town in South Carolina that has best demonstrated exceptional support and commitment to the people we serve during the previous year. It was recommended that the town of Kingstree be awarded the 2013 Silver Palmetto Award for their strong advocacy and support for the disability population. On motion of Commissioner Katherine Davis, seconded and passed, the Commission approved that the town of Kingstree receive the 2013 Palmetto Award. Commissioner Katherine Davis will present the award at the Municipal Association of SC in Columbia, SC on February 5, 2013.

Waiting List Report Update

Mrs. Susan Beck provided a handout which included a layout of the rotation of the waiting list reports. She gave a mid-year report of the movement of Medicaid Waiver Waiting Lists stating 898 individuals were removed from the Waiver Waiting Lists with 645 new individuals allocated a slot. She gave a report of the HASCI Waiting List movement stating that 33 new waiver slots were awarded from July 1, 2013 to December 31, 2013; 53 new consumers were served in FY 2012 and 32 consumers were served in FY 2013, with a total of 85 served for the last two-year timeframe. Mrs. Beck also reported on the ID/RD Waiting List movement stating that 90 new waiver slots were awarded from July 1, 3013 to December 31, 2013; 94 new consumers were served in FY 2012, with a total of 158 for the last two-year timeframe. The year-to-date update was also provided for the other waiting lists. (Attachment B)

Mid-Year Spending Report

Mr. Tom Waring summarized the Mid-Year Spending Report that was presented at the Work Session prior to the Commission Meeting. Mr. Waring stated that DDSN is on target to meet its financial obligations and is staying in line with the spending plan the Commission previously approved. (Attachment C)

Budget Update

Mr. Waring went over the budget chart in detail that outlines the Governor's Executive Budget. In the Executive Budget, DDSN received an increase in other funds of $31 million that is matched with $13.3 million in state funds, appropriated to DHHS. The appropriation in DHHS' budget is a new model. Eight hundred thousand ($800,000) in permanent funds was appropriated in DDSN's budget for improvements in data security. Mr. Waring explained the $9 million in excess debt services funds that the Governor mentioned in her Executive Budget had occurred at the request of legal staff from the Budget and Control Board in regards to a pending lawsuit. As a result, approved capital projects have been put on hold for about a year which generated the $9 million balance. These projects have now been released and once the approved projects are authorized, the balance will be around $1.5 million which will be used for emergencies. (Attachment D)

Consideration of Bid

Mr. Tom Waring presented information for Commission approval on the bid for general repairs to two community residences in Bamberg County. On motion of Commissioner Deborah McPherson, seconded and passed, the Commission approved to accept staff recommendation to award the contract to CF Evans, Inc. of Orangeburg, South Carolina in the amount of $127,460.00. (Attachment E)

CMS Final Rule on the Definition of Community for Home Community Based Services

Dr. Buscemi spoke of the CMS Final Rule on the Definition of Community for Home Community Base Services and how it could be very significant to our system. This ruling does not just affect our population but other disabilities. The ruling goes into effect March 16, 2014. CMS is giving states up to five years to be in compliance. The ruling does not just affect where the individuals live but how do they spend their day which would affect our Day Programs. DHHS will be the lead agency implementing this system change. (Attachment E)

State Director's Report

Dr. Buscemi stated that DHHS is planning to add dental back into the state plan for adults. Currently only emergency dental is covered. The plan will include sedation services but may require prior authorization. This is very good news and is crucial to our population.

Dr. Buscemi reported that DHHS is exploring expanding Medicaid transportation options to include non-medical services, possibly to and from employment for our population. DHHS is currently examining a RFP for transportation and examining what services include transportation and if the rates are current.

Dr. Buscemi reported that a memo went out yesterday concerning ongoing MTCM for people currently on a CLTC Waiver. Per Medicaid this is not allowable. DDSN service coordination will no longer be able to provide this service effective March 15, 2014. There have been ongoing conversations about how to handle case management for transitional purposes. More information will be provided regarding this issue.

Dr. Buscemi stated the comprehensive review of DDSN planned by DHHS has begun. DHHS has contracted with Myers and Stauffer LC to conduct the review. An entrance conference took place last week. Their goal is to be done with the review by the end of March or early April and a final report by the end of the fiscal year.

Dr. Buscemi stated that the SCHSPA Conference is scheduled for February 10 – 12, 2014 with several DDSN staff members attending and presenting.

Dr. Buscemi reported that DDSN's Healthcare Subcommittee budget presentation is scheduled for the afternoon of Tuesday, January 28, 2014.

Next Regular Meeting Date

Chairman Fred Lynn announced the next regular Commission Meeting is scheduled for Thursday, February 20, 2014 with the starting time to be determined.

Executive Session

On motion of Commissioner Eva Ravenel, seconded and passed, the Commission entered into Executive Session to discuss a contractual matter.

Enter into Public Session

The Commission entered into Public Session. It was noted that no action was taken in the Executive Session.

Adjournment

With no further business, Chairman Fred Lynn adjourned the meeting.

Submitted by,

Sandra J. Delaney

Sandra J. Delaney

Approved:

Harvey A. Shiver

Commissioner Harvey Shiver
Secretary

SC COMMISSION ON DISABILITIES AND S

Attachment 1

Commission Meeting

January 15, 2014

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1.	Bill & Peggy Farmer	Com Mtg
2.	Phil Clarkson	BIASC
3.	DAVID MCMAHON	MYERS & STAUFFER
4.	Mildred Lilley	Parent
5.		Babcock Center
6.	P. Hutson	advocate
7.	KATHLEEN ROBERTS	WHITTEN CENTER - PADD
8.	Kathleen Martin	P + A
9.	Gerald Bernal	Charles Lea Center
10.	Linda Bodiford	PGA Coastal
11.	Suzanne Johnson	PGA Coastal Center
12.	R.C. Hoyle	Family Connection
13.	Mary B. Rushlofski	Midlands Center FC
14.	Gloria M. James	Bamberg Co. DSN Bd.
15.	JENNIFER PARKER	WHITTEN CENTER
16.	Linda Lee	Whitten Center
17.	LINDA Veldheer	DDSN
18.	Joyce Davis	BIASC
19.	Lisa Weeks	DDSN
20.	Amara Ransom	UAC

SC COMMISSION ON DISABILITIES AND SPECIAL NEEDS
Commission Meeting
January 15, 2014

Guest Registration Sheet

(PLEASE PRINT) **Name and Organization**

21. Margie Williamson — The Arc of SC
22. Chris Mullen — Midlands Cntr Fam Council / BLDSNB
23. GEORGE MAKIN — SCDHHS
24. Mary F. Boykin — MC Family Council
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SC COMMISSION ON DISABILITIES AND Commission Meeting

Attachment 2

January 15, 2014

Guest Registration Sheet

(PLEASE PRINT) Name and Organization

1. Rufus Britt, III — SCDDSN
2. Harriet Capps — VOR (VOR STATE Rep.)
3. Mitzi W. Wagner — Beaufort DSN
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SC COMMISSION ON DISABILITIES AN
Commission Meetin
January 15, 2014

Guest Registration Sheet

(PLEASE PRINT) **Name and Organization**

1. John Kinig — DDSN
2. PAT FAGAN — DDSN
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Attachment 4

SC COMMISSION ON DISABILITIES AND
Commission Meetinç

January 15, 2014

Guest Registration Sheet

(PLEASE PRINT) **Name and Organization**

1. Michelle Shaffer YCBDSN
2. Janice Fowler YCBDSN
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SOUTH CAROLINA COMMISSION ON DISABILITIES AN

A G E N D A

South Carolina Department of Disabilities and Special Needs
3440 Harden Street Extension
Conference Room 251
Columbia, South Carolina

January 16, 2014 **10:30 A.M.**

1. Call to Order — *Chairman Fred Lynn*
2. Welcome - Notice of Meeting Statement — *Commissioner Harvey Shiver*
3. Invocation — *Commissioner Deborah McPherson*
4. Introduction of Guests
5. Adoption of Agenda
6. Approval of the Minutes of the December 19, 2013 Commission Meeting
7. Public Input
8. Report from DSN Boards — *Dr. Jerry Bernard*
9. Commissioners' Update — *Commissioners*
10. Business:
    - A. Silver Palmetto Award — *Mrs. Lois Park Mole*
    - B. Waiting List Report Update — *Mrs. Susan Beck*
    - C. Mid-Year Spending Report — *Mr. Tom Waring*
    - D. Budget Update — *Mr. Tom Waring*
    - E. Consideration of Bid — *Mr. Tom Waring*
      Bamberg County DSN Residential Renovations
    - F. CMS Final Rule on the Definition of Community — *Dr. Beverly Buscemi*
      for Home Community Based Services
11. State Director's Report — *Dr. Beverly Buscemi*
12. Executive Session
13. Next Regular Meeting Date (February 20, 2014)
14. Adjournment

PLEASE SILENCE CELL PHONES DURING THE MEETING. THANK YOU.

Attachment B

Movement of Medicaid Waiver Waiting Lists

Mid-Year Report

July 1, 2013 through December 31, 2013

Medicaid Waiver	Total # of Individuals Removed From the Waiver Waiting List	Total # New Individuals Allocated a Slot
Head and Spinal Cord Injury	77	33
Intellectual Disability/Related Disability	166	90
Community Supports	433	369
Pervasive Developmental Disorder	222	153
Total for 6-month period FY 2014	**898**	**645* ******

*The total of 645 individuals reflects 141 expansion slots appropriated for FY 2014.

**For each fiscal year, 2012 and 2013, approximately 1,000 new individuals were allocated a waiver slot through attrition. During the first 6 months of FY 2014, 645 (504 Attrition + 141 Expansion = 645) new individuals moved off of the waiting lists. DDSN projects the total number of individuals moving off of a waiting list will reach about 1,150 (645 for first 6 months of FY 2014 + 504 from the 6 month average from FY 2013 = 1,149) by June 30, 2014.

Planned Rotation of Monthly Commission Reports on Quarterly Waiting List Progress

FY 2014	Community Supports	PDD	HASCI	ID/RD
July (Annual Report)	X	X	X	X
August	X			
September		X		
October			X	X
November	X			
December		X		
January			X	X
February	X			
March		X		
April			X	X
May	X			
June		X		

*Critical List updates will be provided monthly

South Carolina Department of Disabilities and Special Needs

Waiting List Updates

Movement of Waiver Waiting Lists Interpretation Guide

1. Column 2: For the given time period, # of slots were awarded to new consumers.
2. Column 3: As of the earliest date of this period, the next person awarded was # on the waiting list.
3. In general, some individuals on the waiting list were not able to be located, no longer wanted the slot or have been served some other way and so the list has moved more than the designated # of slots awarded when these individuals were removed from the list.

MOVEMENT OF WAIVER WAITING LISTS:
HASCI Waiver Waiting List Quarterly Report
(July 1, 2013 TO December 31, 2013)

WAIVER WAITING LIST	NEW CONSUMERS SERVED (slot movement)	NEXT PERSON TO BE AWARDED A SLOT ON THE WAITING LIST WAS THIS NUMBER ON JULY 1, 2013
Head and Spinal Cord Injury	33	9

PREVIOUS FISCAL YEAR TOTALS:

HASCI WAIVER WAITING LIST	NEW CONSUMERS SERVED (slot movement)
TOTAL FISCAL YEAR 2012 (July 1, 2011 to June 30, 2012)	53
TOTAL FISCAL YEAR 2013 (July 1, 2012 to June 30, 2013)	32
TOTAL FISCAL YEAR 2012 and 2013 (2-YEAR TOTAL)	85

MOVEMENT OF WAIVER WAITING LISTS:
ID/RD Waiver Waiting List Quarterly Report
(July 1, 2013 TO December 31, 2013)

WAIVER WAITING LIST	NEW CONSUMERS SERVED (slot movement)	NEXT PERSON TO BE AWARDED A SLOT ON THE WAITING LIST WAS THIS NUMBER ON JULY 1, 2013
Intellectual Disability/Related Disability	90	88

PREVIOUS FISCAL YEAR TOTALS:

ID/RD WAIVER WAITING LIST	NEW CONSUMERS SERVED (slot movement)
TOTAL FISCAL YEAR 2012 (July 1, 2011 to June 30, 2012)	94
TOTAL FISCAL YEAR 2013 (July 1, 2012 to June 30, 2013)	64
TOTAL FISCAL YEAR 2012 and 2013 (2-YEAR TOTAL)	158

South Carolina Department Of Disabilities & Special Needs

Community Waiting List			
	6/30/12	6/30/13	12/31/13
Critical	50	45	39
Priority One	321	297	288
Other	1677	1679	1661
Total	1998	1976	1949
Day Supports Waiting List			
	6/30/12	6/30/13	12/31/13
Day Program (Center Based)	987	968	957
Job Coach	183	175	173
Other	182	175	180
Total - Unduplicated	1288	1259	1252
Regional Centers Waiting List			
	6/30/12	6/30/13	12/31/13
Priority One	1	1	0
Other	23	21	20
Total	24	22	0
Intellectual Disability/Related Disabilities (ID/RD) Waiver Waiting List			
	6/30/12	6/30/13	12/31/13
ID/RD – Critical	0	0	0
Autism - Critical	0	0	0
Total – Critical	0	0	0
ID/RD – Regular	2726	3399	3776
Autism – Regular	614	856	981
Total - Regular	3340	4255	4757
Total	3340	4255	4757
Head & Spinal Cord Injury (HASCI) Waiver Waiting List			
	6/30/12	6/30/13	12/31/13
HASCI - Critical	0	0	0
HASCI - Regular	393	385	362
Total	393	385	362
Pervasive Developmental Disorder (PDD) Waiver Waiting List			
	6/30/12	6/30/13	12/31/13
Total	812	1009	1208
Community Supports Waiver Waiting List			
	6/30/12	6/30/13	12/31/13
Total	3233	3787	4012

South Carolina Department Of Disabilities Special Needs
Critical List Activity For 11/30/2013 Through 12/31/2013

	As Of 11/30/2013	Added During The Period	Removed During The Period	As Of 12/31/2013
Coastal	8	6	7	7
Midlands	12	5	5	12
Pee Dee	2	2	0	4
Piedmont	12	9	5	16
Total:	34	22	17	39

South Carolina Department of Disabilities and Special Needs

FY 2013-2014 Spending Plan - Approved by DDSN Commission 9/19/13

Attachment C

Financial Outlay for Fiscal Year 2014	Description	Base Expenditures as of July 1, 2013 (Total Funds)	Commitments after July 1, 2013	Committed or Expended as of 12/31/13	Balance to be Completed by 6/30/14
Base Expenditures:					
Administration		$7,371,805		$3,497,758	$3,874,047
Residential Services		$216,596,424		$216,596,424	$0
Day Supports		$56,263,862		$56,263,862	$0
Individual/Family Support Services		$48,606,529		$48,606,529	$0
Service Coordination		$16,433,623		$16,433,623	$0
Early Intervention		$18,820,280		$18,820,280	$0
Prevention		$9,049,176		$9,049,176	$0
Interagency Service Contracts		$1,336,440		$1,336,440	$0
Special Service Contracts (RFP)		$235,000		$235,000	$0
Regional Centers/Community Program Services		$94,650,065		$46,657,910	$47,992,155
Subtotal		$469,363,204		$417,497,002	$51,866,202
Service Development					
Residential Services:					
1. Movement of Individuals from Regional Centers	32 Placements				
2. Critical /Crisis Response					
a. Autism: Beds Vacated	23 Placements Due to Turnover - from base	$1,517,770		$791,880	$725,890
b. ID: Beds Vacated	234 Placements Due to Turnover - from base	$15,441,660		$8,710,680	$6,730,980
c. HASCI: Beds Vacated	1 Placements Due to Turnover - from base	$65,990		$0	$65,990
3. Alternative Residential Placements					
a. Bed Attrition to serve dually diagnosed	34 Placements for MH/ID Dually Diagnosed - from base	$2,550,000		$2,325,000	$225,000
b. ID Development	8 Placements Least Restrictive Residential - from base	$204,000		$204,000	$0
At Home Services:					
Head & Spinal Cord Injury					
1. HASCI Waiver Attrition	31 Waiver Slots through Attrition - from base	$955,240		$431,399	$523,841
2. HASCI Waiver - Expansion	15 Waiver Slots Expansion from FY 14 New Funding		$462,213	$462,213	$0
Autism					
1. ID/RD and CS Waiver Attrition	6 Waiver Slots through Attrition - from base	$61,110		$30,555	$30,555
2. ID/RD and CS Waiver - Expansion	11 Waiver Slots Expansion from FY 14 New Funding		$112,035	$112,035	$0
3. PDD Program					
a. Attrition Slots	216 Slots through Attrition - from base	$6,739,200		$4,773,600	$1,965,600
b. Rate Increase	$2 per hour Rate Increase for Line Therapists		$1,976,000	$1,976,000	$0
Intellectual Disability					
1. Family Support					
a. ID/RD Waiver - Attrition	58 Waiver Slots through Attrition - from base	$926,835		$305,550	$621,285
b. ID/RD Waiver - Expansion	35 Waiver Slots Expansion from FY 14 New Funding		$356,475	$356,475	$0
c. Respite Rate Increase - Expansion	$1 per hour Increase in Rate from FY 14 New Funding		$803,600	$803,600	$0
d. Individual Family Support and Respite (IFSR) - Expansion	Additional Funding for State Funded IFSR from FY 14 New Funding		$150,000	$150,000	$0
e. Service Coordination	321 New Individuals Determined Eligible for DDSN		$105,529	$53,915	$51,614
2. Community Support Waiver					
a. CS Waiver - Attrition	422 Waiver Slots through Attrition - from base	$4,337,316		$2,970,342	$1,366,974
b. CS Waiver - Expansion	80 Waiver Slots Expansion from FY 14 New Funding		$822,240	$822,240	$0
c. CS Waiver Band A Attrition (5 Rotate off)	10 Waiting List Consumers related to Attrition - from base	$102,780		$0	$102,780
3. Consumer Needs Assessment	Additional Band Changes and Outliers - from base	$300,000	$300,000	$551,000	$49,000

South Carolina Department of Disabilities and Special Needs
FY 2013-2014 Spending Plan - Approved by DDSN Commission 9/19/13

Financial Outlay for Fiscal Year 2014	Description	Base Expenditures as of July 1, 2013 (Total Funds)	Commitments after July 1, 2013	Committed or Expended as of 12/31/13	Balance to be Completed by 6/30/14
Statewide Service Initiatives:					
Employer Fringe Benefit Increase					
System Wide Employer Increase	Employer Health Insurance Rate Increase		$3,035,352	$3,035,352	$0
Other Initiatives					
1. Workforce Recruitment and Retention - Compression Adjustment	Workforce Recruitment and Retention - Direct Care and Nurses (Hands-on staff) from FY 14 New Funding		$1,500,000	$1,500,000	$0
2. Community Providers Funding	To Maintain Band Rates at 2012 Levels - from base	$500,000		$500,000	$0
3. Employment Services Pilot	Employment Services (Individual Model) Pilot Year One - ID and Autism Consumers		$246,000	$0	$246,000
One-Time Capital					
1. Capital Development/Infrastructure	Required Maintenance, Health/Safety Upgrades, Technology Needs	$2,488,300		$1,631,750	$856,550
2. Regional Centers	Capital Projects from CPIP - Debt Service Funding	$2,980,400		$2,635,400	$345,000
Other One-Time Funds Utilization					
1. Greenwood Genetic Center - Proviso	Funding for Autism Research		$500,000	$500,000	$0
2. TBI/SCI Post-Acute Rehabilitation Program	Traumatic Brain Injury or Spinal Cord Injury Post-Acute Rehabilitation		$583,000	$225,000	$358,000
Total Projected Expenditures for Funding		$508,533,805	$10,952,444	$453,354,988	$66,131,261
			$519,486,249		$519,486,249

South Carolina Department of Disabilities & Special Needs

Utilization of Debt Service/Capital Funds FY 2013-14

	Authorized 9/19/13	Commitments as of 12/31/13	Remaining to be Completed by 6/30/14
Debt Service Funds Available	$5,500,000	$4,267,150	$1,232,850
Total Funds Available:	**$5,500,000**	**$4,267,150**	**$1,232,850**
Utilization of Funds:			
CPIP Project Needs for FY 2014:			
DHEC Health/Safety/Licensure Requirements, Demolition, Required Maintenance, Roofing Replacements, Energy Management System Replacement, Fire Alarm Replacements	$2,980,400	$2,635,400	$345,000
Subtotal Debt Service	**$2,980,400**	**$2,635,400**	**$345,000**
Additional Statewide Needs for FY 2014:			
Capital Development and Infrastructure Needs	$2,488,300	$1,631,750	$856,550
Net Available	**$31,300**	**$0**	**$31,300**

FINANCIAL POSITION ANALYSIS - OPERATING FUNDS
FYE 2014 AS OF 12/31/2013

	State Fund Revenue (Appropriations)	Earned Medicaid Revenue	Other Revenue & One-Time Carryforward	Federal and Restricted Funds	Total
Activity through 12/31/2013					
Revenue	$187,653,209.00	$159,154,868.00	$2,334,366.00	$488,817.00	$349,631,260.00
Carryforward	$2,232,951.00 (1)	$1,530,706.00	$0.00	$130,687.00 (2)	$3,894,341.00
Personal Services Expense	($22,206,482.00)	($7,072,888.00)		($102,108.00)	($29,381,478.00)
Fringe & Benefit Expense	($9,008,645.00)	($3,046,724.00)		($36,517.00)	($12,091,886.00)
Other Operating Expense	($51,144,411.00)	($146,186,574.00)	($145,240.00)	($21,273.00)	($197,497,498.00)
Balance as of 12/31/2013 per Financial System	**$107,526,622.00**	**$4,379,388.00**	**$2,189,126.00**	**$459,606.00**	**$114,554,742.00**
Projected activity 01/01/2014 through 06/30/2014					
Revenue		$146,624,270.00	$2,250,000.00	$306,827.00	$149,181,097.00
Salary Expense	(22,206,482.00)	(7,072,888.00)		(102,108.00)	($29,381,478.00)
Fringe & Benefit Expense	(9,008,645.00)	(3,046,724.00)		(36,517.00)	($12,091,886.00)
Other Operating Expense	(74,811,495.00)	(140,884,046.00)	(4,439,126.00)	(320,808.00)	($220,455,475.00)
Estimated Position as of 06/30/2014	**$1,500,000.00 (1)**	**$0.00**	**$0.00**	**$307,000.00 (2)**	**$1,806,999.00**

(1) PDD $ carried forward
(2) any EIA unusable to be returned to SC DOE

South Carolina Department of Disabilities and Special Needs
FY 2014 – 2015 Budget Request In Priority Order

	Program Need	Budget Request for FY 2014-2015	New Services By Individual Based on FY 2015 Request	Governor's Executive Budget
1	Boost the continued transition of individuals with very complex needs from institutional (ICF/ID) settings to less restrictive community settings, while maintaining quality care. DDSN has managed this movement within its own resources for the past 19 years. With increasing cost of care for those individuals leaving the regional centers, new state funds are necessary to allow individuals with the most complex medical and behavioral challenging needs to move without jeopardizing their health and safety. This request also maintains the provision of quality care at the regional centers as required. Funds requested will allow 50 individuals to move to community settings.	**$1,500,000**	**50**	
2	Provide individuals with severe disabilities on waiting lists with in-home supports and services necessary to keep them at home with family and prevent unnecessary and expensive out-of-home placements. This request will provide approximately 1,400 individuals with severe disabilities on waiting lists with in-home supports and services necessary to keep them at home with family and prevent unnecessary and expensive out-of-home placements. On average individual and family support services cost less than one-half the least expensive out-of-home placement option. Often these services are the difference between helping the family with supports versus replacing the family. Supports strengthen the family and allow family caregivers to remain employed. Supports also allow people with disabilities to earn money and often persons with physical disabilities can live independently or with limited assistance.	**$5,400,000**	**1,400**	**$13,293,825** **Appropriated to DHHS for this purpose.**
3	Service funding rates must be sufficient to cover the actual cost of care as a maintenance of effort to the providers of services. If not funded, local community providers will not be able to continue to provide the same level of service or maintain quality as there are no automatic increases to cover increased operational expenses. Over the past 5 years the costs of gasoline, food, electricity, medical professionals and other goods and services have increased significantly.	**$2,900,000**	**Statewide**	
4	Increase and improve access to respite services critical to helping parents and other family caregivers cope with the stress of providing daily care and supervision to their loved one. DDSN needs to increase the hourly rate that is paid to respite caregivers. The hourly rate that DDSN pays for this service has not been increased during the last ten years until last year's increase of $1.00. DDSN is requesting new state funds to further increase the hourly rate by an additional $1.00, for a total hourly rate of $10.30. This increase will provide better access to this valuable service by identifying more caregivers as well as attracting more providers on a statewide basis who will qualify to provide this important service.	**$500,000**	**Statewide**	

South Carolina Department of Disabilities and Special Needs
FY 2014 – 2015 Budget Request In Priority Order

	Program Need	Budget Request for FY 2014-2015	New Services By Individual Based on FY 2015 Request	Governor's Executive Budget
5	Provide for the increased cost of providing care and addressing nursing and supervision needs of consumers. Address workforce issues to recruit and retain quality staff that provide essential 24/7 nursing care and direct supervision and care of consumers. Quality cannot be reduced and staffing ratios must meet compliance standards and be maintained. Wage compression exists where longtime quality employees make the same wage as new hires. Loss of longtime quality employees due to wage levels not keeping up with industry benchmarks increases turnover, affects the quality of consumer care, results in higher contract cost and increases the cost of training new staff to perform these vital services.	**$1,000,000**	**Statewide**	
6	Improve IT/Data Security statewide, replace obsolete systems, create a bridge to address BabyNet requirements and make system modifications related to MTCM requirements to include data security and HIPAA compliance. The intended impact is to protect personal and healthcare data, to create efficiencies in DDSN's statewide network and to meet new demands required by external entities.	**$800,000**	**Statewide**	**$800,000**
7	Employment initiative that represents the state's need to develop school to work transition for individuals aging out of the public school system and the need to establish job recruitment, job coach and job retention for adults with disabilities currently receiving day supports or on the waiting list. A two-prong approach, $600,000 of this new funding will provide employment services for approximately 75 adults with an intellectual disability, autism, traumatic brain injury or spinal cord injury and $500,000 of this funding will allow approximately 50 younger individuals to transition from public school to employment.	**$1,100,000**	**125**	
8	Provide necessary residential supports and services for individuals living with caregivers age 70 years old or older. As of June 30, 2013, there were over 1,100 individuals with severe disabilities living with parents/caregivers age 70 and over. More than 450 of these caregivers are at least 80 years old. The requested funds will provide residential and day supports and services for 100 individuals.	**$1,800,000**	**100**	
9	Increase access to post-acute rehabilitation that is specialized for traumatic brain or spinal cord injuries. This request will fund specialized rehabilitation for 8 to 10 individuals who are uninsured or underinsured.	**$500,000**	**8 – 10**	
TOTAL		**$15,500,000**		**$800,000**

Pending Issues with Fiscal Impact for FY 2014 – 2015:

- Change to Administrative Cost - $4.8 million in one-time funds to comply with the OIG's required payback with regard to consumers bearing a higher percentage of administrative costs.
- Changes and Implementation of MTCM
- Changes and Implementation of WCM
- Change in Interpretation of DDSN Eligibility for Individuals Determined Incompetent to Stand Trial

CONSIDERATION OF BID

HAMPTON STREET & ZEIGLER STREET

COMMUNITY RESIDENCES – RENOVATION

COASTAL REGION

J16-9872

This project scope includes general repairs to two community residences in Bamberg County, including bathroom renovations to improve accessibility, flooring replacement, kitchen cabinet refurbishment, kitchen countertop replacement, replacement of old lighting with new more energy efficient fluorescent lighting, and other miscellaneous work.

It is recommended that a contract be awarded for the Base Bid to **CF Evans, Inc. of Orangeburg, South Carolina** in the amount **of $127,460.00.** The agency has worked with this contractor on past projects with responsible performance.

Acceptance of **Alternate No. One** to substitute LED light fixtures is not recommended.

BASE BID:	**$127,460.00**
CONTRACT AMOUNT:	**$127,460.00**

Attachment: Bid Tabulation

Funds: Debt Service

Bid Date: January 7, 2014
Date: January 7, 2014

PROJECT NO.: J16-9872
PROJECT NAME: Hampton St. & Zeigler St. Community Residences - Renov.
PROJECT DESCRIPTION: Renovations - Coastal Region

ARCHITECT/ENGINEER: SCDDSN

SCDDSN Engineering and Planning
3440 Harden St. Extension
Columbia, SC 29203
Phone: (803) 898-9796
Fax: (803) 832-8188

BID DATE: Tues., 1/7/14
TIME: 2:00 p.m.
LOCATION: SCDDSN, Central Office, Rm. 247

BID TABULATION

	CONTRACTOR NAME	BID SEC	Addendum No. 1	BASE BID	ALTERNATE #1	SUBCONTRACTORS
1	CFE Construction Services, LLC Orangeburg, SC	✓	✓	$127,460.00	$2,086.00	Base Bid Electrical: C.F. Evans & Co., Inc.
						Base Bid Plumbing: Barwick Plumbing Co., LLC
2	Skip Welch Construction, Inc. Orangeburg, SC	✓	✓	$128,607.00	<$585.00>	Base Bid Electrical: Goolsby & Son
						Base Bid Plumbing: Quality Plumbing
3	M.A.R. Construction Co., Inc. Lexington, SC	✓	✓	$145,754.00	$18,750.00	Base Bid Electrical: Johnny's Electric
						Base Bid Plumbing: Crumpton Plumbing

Joan Cooper, Director of Engineering & Planning

Witness

CMS Releases HCBS Final Rule Defining Community Settings

The Centers for Medicare and Medicaid Services (CMS) today issued the final rule on Home and Community Based Services (HCBS) that includes the definition of community settings. The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS. In materials accompanying the rule, CMS stated its "intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting."

The broad-ranging rule finalizes several proposed rules and addresses several areas of HCBS policy. Among its provisions, the rule:

- Defines and describes the requirements for home and community-based settings appropriate for the provision of HCBS under section 1915(c) HCBS waivers, section 1915(i) State Plan HCBS and section 1915(k) (Community First Choice) authorities;
- Defines person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities;
- Provides states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses on functional needs.
- Provides new implementing regulations for section 1915(i) State Plan HCBS, revised to include new flexibilities enacted under the Affordable Care Act (ACA) to offer expanded HCBS and to target services to specific populations;
- Allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c);

- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs;
- Clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates.

HCBS Settings The final rule requires that all home and community-based settings meet certain qualifications. These include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

In addition to excluding statutorily-defined institutional settings, the final rule identifies other settings that are presumed to have

institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings, according to a CMS fact sheet, "include those in a publicly or privately-owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS." If states seek to include such settings in Medicaid HCBS programs, the fact sheet indicates "a determination will be made through heightened scrutiny, based on information presented by the state demonstrating that the setting is home and community-based and does not have the qualities of an institution."

The fact sheet also points out that the final rule "clarifies that when an individual chooses to receive home and community-based services in a provider owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate." For any services that are not included in the bundled rate, however, "the individual may choose any qualified provider, including the provider who controls or owns the setting if the provider offers the service separate from the bundle."

The final rule also clarifies that, according to the fact sheet, "states, as opposed to individual providers, have the responsibility for ensuring that individuals have options available for both private and shared residential units within HCBS programs." Provider owned or operated residential settings "will be responsible to facilitate individuals having choice regarding roommate selection within a residential setting."

The same fact sheet offers the important note that "CMS has clarified that the rule applies to all settings where HCBS are delivered, not just to residential settings," and indicates that CMS "will be providing additional information about how states should apply the standards to

non-residential settings, such as day program and pre-vocational training settings."

The final rule includes a provision requiring states offering HCBS under existing state plans or waivers to develop transition plans to ensure that HCBS settings will meet final rule's requirements. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. CMS will afford states a maximum of a one year period to submit a transition plan, and CMS may approve plans for a period of up to five years, as supported by an individual state's circumstances, although material accompanying the rule emphasizes that "CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress toward compliance during any transition period." States submitting a 1915(c) waiver renewal or waiver amendment within the first year after the effective date of the rule need to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs within 120 days of the submission of the renewal or amendment. New waivers or state plans must meet the new requirements to be approved. CMS indicates it will be issuing future guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning In the final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed "through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals." The rules require that the person-centered planning process is

directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process.

The rule is expected to be officially published next week, and has an effective date of 60 days from publication, meaning the one year states have to develop a transition plan is expected to begin in March. In conference calls held today with various stakeholders, CMS has indicated that they plan an extensive education and outreach process to help states with implementation of the new rule. This will include Webinars open to the general public (January 23, 2014: 1:00pm - 3:00pm and January 30, 2014: 1:00pm - 3:00pm) as well as Webinars and conference calls beginning with high level overviews and eventually moving into more specific examinations of individual aspects of the rule.

FMI: CMS has placed links to several important items regarding the new rule defining HCBS settings at http://www.medicaid.gov/hcbs, including:

- The text of the Final Rule
- An Information Bulletin on the Final Rule
- A press release announcing the Final Rule
- Four factsheets:
    - An overview of the regulation
    - Changes to 1915 (c)
    - Changes to 1915 (i)
    - Summary of Key Provisions

Taken from NASDDDS Federal News Briefs, January 10, 2014

CMS.gov
Centers for Medicare & Medicaid Services

Details for Title: HHS strengthens community living options for older Americans and people with disabilities

Title	HHS strengthens community living options for older Americans and people with disabilities
For Immediate Release	Friday, January 10, 2014
Contact	press@cms.hhs.gov

HHS strengthens community living options for older Americans and people with disabilities

The Centers for Medicare & Medicaid Services (CMS) issued a final rule today to ensure that Medicaid's home and community-based services programs provide full access to the benefits of community living and offer services in the most integrated settings. The rule, as part of the Affordable Care Act, supports the Department of Health and Human Services' Community Living Initiative. The initiative was launched in 2009 to develop and implement innovative strategies to increase opportunities for Americans with disabilities and older adults to enjoy meaningful community living.

Under the final rule, Medicaid programs will support home and community-based settings that serve as an alternative to institutional care and that take into account the quality of individuals' experiences. The final rule includes a transitional period for states to ensure that their programs meet the home and community-based services settings requirements. Technical assistance will also be available for states.

"People with disabilities and older adults have a right to live, work, and participate in the greater community. HHS, through its Community Living Initiative, has been expanding and improving the community services necessary to make this a reality," said HHS Secretary Kathleen Sebelius. "Today's announcement will help ensure that all people participating in Medicaid home and community-based services programs have full access to the benefits of community living."

In addition to defining home and community-based settings, the final rule implements the Section 1915(i) home and community-based services State Plan option. This includes new flexibility provided by the Affordable Care Act that gives states additional options for expanding home and community-based services and to target services to specific populations. It also amends the 1915(c) home and community-based services waiver program to add new person-centered planning requirements, allow states to combine multiple target populations in one waiver, and streamlines waiver administration.

For more information about the final rule, please visit: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-10-2.html

For more information regarding the Home and Community-Based Services available under Medicaid, please visit: http://www.medicaid.gov/HCBS

For more information regarding the Community Living Initiative, please visit: http://www.hhs.gov/od/community/index.html

The final rule can be found here: http://ofr.gov/OFRUpload/OFRData/2014-00487_PI.pdf

Medicaid.gov
Keeping America Healthy (/)

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Home (/) > Medicaid (/Medicaid-CHIP-Program-Information/Medicaid-and-CHIP-Program-Information.html) > By-Topic (/Medicaid-CHIP-Topics/By-Topic.html) > Long Term Services and Support (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-and-Support.html) > Home and Community-Based Service

Home & Community Based Services

Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community. These programs serve a variety of targeted populations groups, such as people with mental illnesses, intellectual or developmental disabilities, and/or physical disabilities.

Recent Guidance **History and Authorities**

The final Home and Community-Based Services regulations set forth new requirements for several Medicaid authorities under which states may provide home and community-based long-term services and supports. The regulations enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities.

- **Final Regulation:** 1915(i) State Plan HCBS, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) HCBS Waivers - CMS-2249-F/CMS-2296-F (https://www.federalregister.gov/articles/2014/01/16/2014-00487/state-plan-home-and-community-based-services-5-year-period-for-waivers-provider-payment-reassignment)
  - **Informational Bulletin** - Final regulations for HCBS provided under Medicaid's 1915(c), 1915(i) and 1915(k) authorities (/Federal-Policy-Guidance/Downloads/CIB-01-10-14.pdf)
  - **Press Release** - Final regulations for HCBS provided under Medicaid's 1915(c), 1915(i) and 1915(k) authorities (http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-10-2.html)

Featured Resources:

- Balancing (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Long-Term-Services-and-Supports.html)
- Managed Long Term Services & Supports (MLTSS) (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Medicaid-Managed-Long-Term-Services-and-Supports-MLTSS.html)
- Self Direction (/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Self-Directed-Services.html)
- Integrating Care (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Integrating-Care.html)

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- Overview of Regulation (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Downloads/final-rule-fact-sheet.pdf)
- 1915(c): Changes to HCBS Waiver Program (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Downloads/1915c-Fact-Sheet.pdf)
- 1915(i): Key Provisions for HCBS State Plan Option (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Downloads/1915i-fact-sheet.pdf)
- Summary of Key Provisions of the HCBS Settings Final Rule (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Home-and-Community-Based-Services/Downloads/HCBS-setting-fact-sheet.pdf)

HCBS Final Rule Webinars

Registration information will be posted soon.

- January 23, 2014: 1:00pm - 3:00pm Public Webinar on HCBS Final Rule
- January 30, 2014: 1:00pm - 3:00pm (repeat) Public Webinar on HCBS Final Rule

Additional Resources

Person (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html)

- Real Choice System Change (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Real-Choice-Systems-Change-Grant-Program-RCSC/Real-Choice-Systems-Change-Grant-Program-RCSC.html)
- Health Homes (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html)
- PACE (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Program-of-All-Inclusive-Care-for-the-Elderly-PACE/Program-of-All-Inclusive-Care-for-the-Elderly-PACE.html)
- Community Living (/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Community-Living/Community-Living-Initiative.html)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: January 10, 2014

FROM: Cindy Mann
Director

SUBJECT: **Final Rule - CMS 2249-F – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and CMS 2296-F 1915(c) Home and Community-Based Services Waivers**

Today the Centers for Medicare & Medicaid Services (CMS) is pleased to announce the publication of an important final rule about home and community-based services (HCBS) provided through Medicaid's 1915(c) HCBS Waiver program, 1915(i) HCBS State Plan Option, and 1915(k) Community First Choice. The rule enhances the quality of HCBS, provides additional protections to HCBS program participants, and ensures that individuals receiving services through HCBS programs have full access to the benefits of community living. The rule is available at http://www.medicaid.gov/HCBS.

The final rule is a result of multiple rulemaking efforts over the last five years and consideration by CMS of input from thousands of stakeholders. This robust process helped CMS ensure that the regulation takes into account a wide range of stakeholder perspectives and the varying experiences across the states. There will be continued opportunities for stakeholder input as CMS works with states to implement this final rule.

CMS will offer opportunities for additional information, issuing additional guidance, and providing assistance as states begin implementing this final rule. We recognize that implementing this final rule may require states to evaluate and make adjustments in their current systems and that this process will take time. The final rule provides for a process that will allow states to implement this rule in a manner that will support continuity of services for Medicaid participants and minimize disruptions in service systems during implementation. This Informational Bulletin contains a brief overview of this transition process and the assistance available from CMS to assist states with the process.

Additional Information and Forthcoming Guidance

CMS is committed to ensuring that stakeholders have immediate access to information to help them understand the final rule. CMS has developed a website dedicated to providing information about the rule, available at http://www.medicaid.gov/HCBS. On this website, stakeholders can find links to fact sheets, questions and answers and other related resources. In addition, CMS will be holding a series of informational webinars over the next several weeks. The dates for these webinars can be

found on the website. CMS has also established a mailbox at HCBS@cms.hhs.gov and encourages you to submit questions to the mailbox.

As states begin implementation, CMS will provide additional information on a number of topics over the next several weeks and months. The information will be provided through additional Informational Bulletins and through revisions to the 1915(c) Waiver Technical Guide for regulatory changes for the 1915(c) HCBS Waivers, CMS will also be creating additional fact sheets and frequently asked questions (FAQs) to address questions from the public after they have had a chance to review the final rule.

Transition for Implementing Home and Community-Based Settings Requirements

CMS recognizes that states and providers may need time to implement the clarifying requirements about the characteristics of home and community-based settings. The final regulation provides for a transition process that will allow states to implement this rule in a manner that supports continuity of services for Medicaid participants and minimizes disruptions in service systems during implementation. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress towards compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing sub-regulatory guidance to provide the details regarding requirements for transition plans.

Assistance from CMS

CMS is committed to assisting states in implementing these rules and is available to work closely with individual states at the beginning and throughout the development of their transition plans. In addition, CMS is working to provide additional technical assistance resources to states and will provide information about these resources as soon as possible.

Many states have made significant progress in recent years to increase the availability and quality of home and community-based services. We believe the implementation of these rules will contribute

significantly to the quality and experience of participants in Medicaid HCBS programs and will further expand their opportunities for meaningful community integration in support of the goals of the Americans with Disabilities Act and the Supreme Court's decision in *Olmstead v. L.C.*

We thank the many individuals and organizations who contributed input to these rules and look forward to the continuing dialogue with stakeholders as we work together to make them a reality.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
200 Independence Avenue, SW
Washington, DC 20201

FACT SHEET

FOR IMMEDIATE RELEASE
January 10, 2014

Contact: CMS Media Relations
(202) 690-6145

Home and Community Based Services

Overview

The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for home and community-based services (HCBS). The rule supports enhanced quality in HCBS programs, adds protections for individuals receiving services. In addition, this rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. Highlights of this final rule include:

- Provides implementing regulations for section 1915(i) State Plan HCBS, including new flexibilities enacted under the Affordable Care Act to offer expanded HCBS and to target services to specific populations;
- Defines and describes the requirements for home and community-based settings appropriate for the provision of HCBS under section 1915(c) HCBS waivers, section 1915(i) State Plan HCBS and section 1915(k) (Community First Choice) authorities;
- Defines person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities;
- Provides states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses on functional needs.
- Allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).
- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs.

Key Provisions of the Final Rule

1915(c) Home and Community-Based Waivers

The final rule amends the regulations for the 1915(c) HCBS waiver program, authorized under section 1915(c) of the Social Security Act (the Act), in several important ways designed to improve the quality of services for individuals receiving HCBS. Specifically, it establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act, defines person-centered planning requirements, provides states with the option to combine multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and provides CMS with additional compliance options for HCBS programs. For more detail, please refer to the 1915(c) fact sheet at http://www.medicaid.gov/HCBS.

Section 1915(i) Home and Community-Based State Plan Option

The final rule implements the section 1915(i) HCBS state plan option, including new flexibilities enacted under the Affordable Care Act that offer states the option to provide expanded home and community-based services and to target services to specific populations. In addition, the final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. For more detail, please refer to the 1915(i) fact sheet at http://www.medicaid.gov/HCBS.

Section 2601 of the Affordable Care Act: Five Year Period for Certain Demonstration Projects and Waivers

To simplify administration of the program for states, this final rule provides a five-year approval or renewal period for demonstration and waiver programs in which a state serves individuals who are dually eligible for Medicare and Medicaid benefits. This provision allows states to use a five year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).

Home and Community-Based Settings Requirements

The final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. The rule creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The regulatory changes will maximize the opportunities for HCBS program participants to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid home and community-based services to provide alternatives to services provided in institutions. For more detail, please refer to the HCBS Settings fact sheet at http://www.medicaid.gov/HCBS.

The final rule includes a provision requiring states offering HCBS under existing state plans or waivers to develop transition plans to ensure that HCBS settings will meet final rule's requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress toward compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan that provides for the delivery of HCBS services within settings meeting the final rule's requirements, and CMS may approve transition plans for a period of up to five years, as supported by an individual state's circumstances.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year after the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will be issuing future guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

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January 10, 2014

Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule
(CMS 2249-F/2296-F)

This final rule establishes requirements for the qualities of settings that are eligible for reimbursement for the Medicaid home and community-based services (HCBS) provided under sections 1915(c), 1915(i) and 1915(k) of the Medicaid statute. Over the past five years, CMS has engaged in ongoing discussions with stakeholders, states and federal partners about the qualities of community-based settings that distinguish them from institutional settings. As part of this stakeholder engagement, CMS issued an Advanced Notice of Proposed Rule Making (ANPRM) and various proposed rules relating to home and community-based services authorized by different sections of the Medicaid law, including 1915(c) HCBS waivers, 1915(i) State Plan HCBS and 1915(k) Community First Choice State Plans. CMS' definition of home and community-based settings has benefited from and evolved as a result of this stakeholder engagement.

In this final rule, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of individuals' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions.

Overview of the Settings Provision

The final rule requires that all home and community-based settings meet certain qualifications. These include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections;

- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Any modification to these additional requirements for provider-owned home and community-based residential settings must be supported by a specific assessed need and justified in the person-centered service plan.

The final rule excludes certain settings as permissible settings for the provision of Medicaid home and community-based services. These excluded settings include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. Other Medicaid funding authorities support services provided in these institutional settings.

The final rule identifies other settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings include those in a publicly or privately-owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. If states seek to include such settings in Medicaid HCBS programs, a determination will be made through heightened scrutiny, based on information presented by the state demonstrating that the setting is home and community-based and does not have the qualities of an institution. This process is intended to be transparent and includes input and information from the public. CMS will be issuing future guidance describing the process for the review of settings subject to heightened scrutiny through either the transition plan process (for settings already in states' HCBS programs) or the HCBS waiver review processes (for settings states seek to add to their HCBS programs).

The final rule includes a transitional process for states to ensure that their waivers and state plans meet the HCBS settings requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states must evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual states' circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing future guidance on requirements for transition plans.

Changes in the Final Rule

The final rule clarifies several major areas of confusion and concern expressed by some commenters and stakeholders engaged throughout the processes of rulemaking regarding the requirements for home and community-based settings. While CMS' responses to the specific comments are contained in the preamble to the final rule, below is a summary of the areas of the rule that received the most feedback and the changes in the final rule that address those comments:

- **Disability specific complex**. The proposed rule included "disability specific complex" in the list of settings presumed not to be home and community-based settings. Comments on the proposed rules suggested that the phrase "disability specific complex" had multiple meanings, and the continued use of the phrase could have unintended adverse impacts on affordable housing options. To avoid those consequences, CMS eliminated the use of the phrase from the final rule. The final rule includes the following language on other settings: "any other setting that has the effect of discouraging integration of individuals from the broader community..."

- **Rebuttable presumption**. The proposed rule indicated that CMS would exercise a "rebuttable presumption" that certain settings are not home and community-based. CMS has removed this phrase from the final rule and clarified in the final rule that certain settings are presumed to have institutional characteristics and will be subjected to heightened scrutiny if states seek to include these settings in their HCBS programs. The rule allows the state to present evidence to CMS that the setting is actually home and community-based in nature and does not have the qualities of an institution. CMS will consider input from stakeholders, as well as its own reviews, in applying heightened scrutiny. This process will require the state to solicit public input.

- **Choice of provider in provider owned or controlled settings.** The final rule clarifies that when an individual chooses to receive home and community-based services in a provider owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate. For any services that are not included in the bundled rate, the individual may choose any qualified provider, including the provider who controls or owns the setting if the provider offers the service separate from the bundle. For example, if a residential program provides habilitation connected with daily living and on-site supervision under a bundled rate, an individual is choosing the residential provider for those two services when he or she chooses the residence. The individual has free choice of providers for any other services in his or her service plan, such as employment services and other community supports.

- **Private rooms and roommate choice.** The final rule clarifies that states, as opposed to individual providers, have the responsibility for ensuring that individuals have options available for both private and shared residential units within HCBS programs. The rule further clarifies that an individual's needs, preferences and resources are relevant to his/her options for shared versus private residential units. Provider owned or operated residential settings will be responsible to facilitate individuals having choice regarding roommate selection within a residential setting.

- **Application of home and community-based settings requirements to non-residential settings.** CMS has clarified that the rule applies to all settings where HCBS are delivered, not just to residential settings. CMS will be providing additional information about how states should apply the standards to non-residential settings, such as day program and pre-vocational training settings.

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Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule
(CMS 2249-F/2296-F)

Background

Section 1915(c) of the Social Security Act (the Act) authorizes the Secretary of Health and Human Services to waive certain requirements in Medicaid law in order for states to provide home and community-based services (HCBS) to meet the needs of individuals who choose to receive their long-term care services and supports in their home or community, rather than in institutional settings. Final rules were published to implement this law on July 25, 1994.

On June 22, 2009, CMS published an advance notice of proposed rulemaking (ANPRM) that indicated CMS' intention to initiate rulemaking on a number of areas within the section 1915(c) program. On April 15, 2011, CMS published the Notice of Proposed Rule Making (NPRM) that addressed many of the same issues raised in the ANPRM. The final rule published today reflects the significant public comment received over the extensive rulemaking process related to these issues.

This final rule makes several important changes to the 1915(c) HCBS waiver program. It provides states the option to combine existing waiver targeting groups. The rule also establishes requirements for home and community-based settings under the 1915(c), 1915(i) and 1915(k) Medicaid authorities, and person-centered planning requirements for Medicaid HCBS participants under 1915(c) and 1915(i). In addition, it clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates. Finally, it describes the additional strategies available to CMS to ensure state compliance with the statutory provisions of section 1915(c) of the Act. Below is a summary of each of these provisions.

Flexibility to Combine Target Groups Under One Waiver

The final rule permits, but does not require, states to combine target groups within one HCBS waiver. Prior to that change, a single section 1915(c) HCBS waiver could only serve one of the following three target groups: older adults, individuals with disabilities, or both; individuals with intellectual disabilities, developmental disabilities, or both; or individuals with mental illness. This change will remove a barrier for states that wish to design a waiver that meets the needs of more than one target population. The rule includes a provision specifying that if a state chooses the option of more than one target group under a single waiver, the state must assure CMS that it is able to meet the unique service needs of individuals in each target group, and that each individual in the waiver has equal access to all needed services.

Home and Community-Based Settings

CMS' definition of home and community-based settings has evolved over the past five years, based on experience throughout the country and extensive public feedback about the best way to differentiate between institutional and home and community-based settings. Based on the comments received on the ANPRM and the proposed 1915(c) rules, and the comments received on the 1915(i) and 1915(k) proposed rules, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions and maximize the opportunities for waiver participants to have access to the benefits of community living, including receiving services in the most integrated setting. For more detail, please refer to the HCBS Settings Fact Sheet, available at http://www.medicaid.gov/HCBS.

The final rule includes a transition period for states to ensure that their waivers and Medicaid state plans meet the HCBS settings definition. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final rule home and community-based settings definition, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plans meet the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing future guidance regarding transition plans.

Person-Centered Planning

The final rule specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative that the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related community participation, employment, income and savings, health care and wellness, education and others. The plan should reflect the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services. This planning process, and

the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

Duration, Extension and Amendment of Waivers

In this final rule, CMS added a new provision to clarify guidance regarding the effective dates of HCBS waiver amendments with substantive changes. Substantive changes include, but are not limited to, changes in eligible populations; constriction of service, amount, duration, or scope; and other modifications as determined by the Secretary. The rule also adds regulatory language that waiver amendments with substantive changes may only take effect on or after the date when the amendment is approved by CMS. Substantive changes also must be accompanied by information on how the state has assured smooth transitions and minimal adverse impact on individuals impacted by the change.

In addition, the final rule includes a new provision to ensure that states provide public notice when they propose substantive changes to their methods and standards for setting payment rates for services. The final rule also includes a provision directing that states establish public input processes specifically for waiver changes.

Strategies to Ensure Compliance with Statutory Assurances

A primary concern in the oversight of 1915(c) HCBS waivers is the health and welfare of the individuals served within the programs. Section 1915(f) of the Act requires the Secretary to monitor implementation of waivers to assure compliance with all requirements and provides for termination of waivers where the Secretary has found noncompliance. This authority and the process for termination of waivers are addressed in this final rule. CMS has included provisions that describe additional strategies that CMS may employ to ensure state compliance with the requirements for a waiver.

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Fact Sheet: Summary of Key Provisions of the Final Rule for 1915(i) Home and Community-Based Services (HCBS) State Plan Option
(CMS 2249-F/2296-F)

Background

Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(i) to the Social Security Act (the Act) providing states the option to offer home and community-based services, previously available only through a 1915(c) HCBS waiver, through the state's Medicaid state plan. As originally enacted, states could only serve individuals eligible under the State plan with incomes at or below 150 percent of the Federal poverty level (FPL) or below and could offer some, but not all, HCBS services and supports available through 1915(c) HCBS waivers. In addition, states were not able to target 1915(i) state slan HCBS to particular populations within the state.

The Affordable Care Act expanded coverable services under 1915(i) to include any of the HCBS permitted under section 1915(c) HCBS waivers, certain services for individuals with mental health and substance use disorders and other services requested by a state and approved by the Secretary of Health and Human Services. In addition, the changes support ensuring the quality of HCBS, require states to offer the benefit statewide and enable states to target 1915(i) State Plan HCBS to particular groups of participants but not limit the number of participants who may receive the benefit. CMS published a proposed rule on May 4, 2012 for these 1915(i) provisions. This final rule responds to the public comments received on those proposed rules.

In addition to the above provisions, the final rule also establishes a set of requirements for home and community-based settings under the 1915(i), 1915(c) and 1915(k) Medicaid authorities, and a set of person-centered planning requirements for Medicaid HCBS participants under 1915(c) and 1915(i).

Home and Community-Based Settings

CMS' definition of home and community-based settings has evolved over the past five years, based on experience throughout the country and extensive public feedback about the best way to differentiate between institutional and home and community-based settings. Based on the comments received on the 1915(c) advance notice of proposed rulemaking (ANPRM), the proposed 1915(c) rule, and the comments received on the 1915(i) and 1915(k) proposed rules, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions and maximize the opportunities for waiver participants to have access to the benefits of

community living, including receiving services in the most integrated setting. For more detail, please refer to the HCBS Settings Fact Sheet available at http://www.medicaid.gov/HCBS.

The final rule includes a transition period for states to ensure that their waivers and state plans meet the HCBS settings requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that the specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing sub-regulatory guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, education and others. The plan should reflect the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.