



**Home and Community
Services Regulations
CMS Final Rule
Review of 42 CFR Parts
430, 431, 435, 436, 440, 441,
and 447**

1/17/2014

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What the rule includes:

- Defines and describes state plan home and community based services under 1915 (c), (i), (k)
- Provides implementation regulations for state plan section 1915 (i)
- Defines person-centered planning
- Provides states with option of combining coverage for multiple target populations
- Provides for a 5 year duration for the duals projects
- Provides exception to the general requirement that payment for services under a SPA must be made directly to the individual practitioner
- Provides CMS with additional compliance options beyond waiver termination

Effective Date

- These regulations are effective 60 days from January 16, 2014

HCBS definition

- Moves away from defining HCBS based on setting location, geography, or physical characteristics
- Instead defines HCBS by the nature and quality of participants' experiences
- Outcome-oriented definition

All HCBS settings must meet certain qualifications

- Setting is integrated in and supports full access to the greater community (including opportunities for employment in competitive settings, engagement in the community, control of personal resources, receiving services in the community) to the same degree as individuals not receiving Medicaid HCBS
- Is selected by the individual from **among setting** options that include non-disability specific settings and an option for a private unit in a residential setting
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint
- Optimizes autonomy and independence in making life choices
- Facilitates choice regarding services and service providers

Additional requirements for provider-owned/controlled HCBS residential settings

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

Settings that are NOT permissible in HCBS

- Nursing facilities
- Institutions for mental disease
- Intermediate care facilities for individuals with intellectual disabilities
- Hospitals

Other institutional qualities that do not meet HCBS threshold

- Provides inpatient treatment (regardless if publicly/privately owned)
- On the grounds of, or immediately adjacent to, a public institution
- Has the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid funded HCBS

Modifications to provider-owned homes and community-based residential settings

- Must be supported by specific assessed need
- Must be justified in the person-centered service plan

If a state wants to include additional settings

- State will be subjected to additional scrutiny to ensure that the setting is home and community-based and does not have the qualities of an institution
- Additional guidance on the process will be forthcoming from CMS
 - Transition plan process
 - HCBS waiver review processes

Transitional process to ensure compliance

- New HCBS 1915 (c) waivers or 1915 (i) plans must meet the new requirements to be approved
- States must evaluate the settings in their 1915 (c) waivers and 1915 (i) plans to evaluate if they meet the new settings requirement
 - If not, states should work with CMS to develop a plan to bring the programs into compliance
 - CMS will allow states a maximum of a one year period to submit a transition plan for compliance
 - CMS will approve transition plans that will take up to 5 years to bring the state to full compliance
 - Public will have an opportunity to comment on states' transition plans

If state is submitting a waiver amendment/renewal within first year

- State must develop a transition plan to ensure that the specific waiver/state plan meets the settings requirements
- Within 120 days of the submission of waiver amendment/renewal, state needs to submit a transition plan including benchmarks and timeframes
- CMS will be issuing future guidance of requirements for transition plans

Rule Clarifies

- **Disability specific complex**—“any other setting that has the effect of discouraging integration of individuals from the broader community”
- **Rebuttable presumption**—while certain settings are presumed to have institutional characteristics and will be subject to heightened scrutiny, the rule allows states to present evidence to the contrary
- **Choice of provider** — when an individual chooses to receive HCBS in a provider-owned setting where the provider is paid a single rate for a bundle of services, the individual is choosing that provider and can’t choose an alternate provider to deliver other services within the bundle

Rule Clarifies (cont.)

- **Private rooms/roommate choice** — States, **as opposed to individual providers**, have the responsibility for ensuring that individuals have options available for both private/shared residential units
- Individual's needs, preferences, and resources are relevant to his/her options for shared v. private residential units
- Provider owned/operated residential settings will be responsible for facilitating individual's choice regarding roommate selection

Rule Clarifies (cont.)

- Application of HCBS settings to non-residential settings
 - Rule applies to all settings where HCBS are delivered, not just to residential settings (i.e. ADULT DAY)
 - CMS will provide additional information

Person-Centered Plan

- Will assist individual in achieving personally defined outcomes
 - Most integrated community setting
 - Ensures delivery of services in a manner that reflects preferences and choices
 - Contributes to the assurance of health and welfare
- Person-Centered plan must be reviewed every 12 months
- CMS will provide additional guidance on operationalizing person-centered planning in order to bring programs into compliance

Person-Centered Planning

- Service planning for 1915 (c) and 1915 (i) must be developed through a person-centered planning process
 - The plan should reflect:
 - Services and Supports (paid/unpaid)
 - Who provides the LTSS
 - If the participant is self-directing
 - The plan should include goals and preferences for:
 - Community participation
 - Employment
 - Income and savings
 - Health care and wellness
 - Education and others
 - The plan should be directed by the individual with LTSS needs
 - May include a representative chosen by the individual

Person-Centered Planning Process

- Includes people chosen by the individual
 - Conflict of interest-providers of HCSB must not develop the person-centered plan except if the state can demonstrate conflict of interest protections
- Provides necessary info to support the individual as he/she directs the process
- Is timely and occurs at times/locations convenient to the individual
- Reflects cultural considerations
- Includes conflict solving strategies
- Offers informed choices to the individual
- Includes a method to request updates to the plan

State Plan Home and Community Based Services 1915 (i)

- 1915 (i) allows states to receive FFP for services under their State Plan
- Must be provided statewide
- States do not have to prove cost neutrality
- Allows states to provide HCBS
 - To individuals who require less than institutional level of care and who are therefore not eligible for HCBS services under the 1915 (c)

Combining Target Groups Under One Waiver

- Permits states to combine existing 1915 (c) target groups into one at state's option
 - Older adults, individuals with disabilities, or both
 - Individuals with intellectual disabilities, developmental disabilities, or both
 - Individuals with mental illness
- State must assure that if the waiver is combined, the state can still meet the unique service needs of each target group

Duration, Extension and Amendment of Waivers

- New provision to clarify guidance regarding the effective dates of HCBS waiver amendments with substantive changes
- Waiver amendments with these types of changes may only take effect on or after the date when the amendment is approved by CMS
- Must include info on how the state ensures smooth transitions and minimal adverse impact on impacted individuals
- Substantive changes include:
 - Changes in eligible populations
 - Constriction of service, amount, duration or scope
 - Other modifications as determined by the Secretary

Ensuring Compliance

- Section 1915 (f) requires Secretary to monitor compliance with requirements and provides for termination of waiver
- Strategies to ensure compliance may include:
 - Moratorium on waiver enrollments
 - Withholding of FFP for waiver services until such time that compliance is achieved
 - Other actions as determined by the Secretary

More info available

Questions or comments?:

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