The 2014 Federal Home and Community-Based Services Regulation:

What You Need to Know

National Policy Matters

The 2014 Federal Home and Community-Based Services Regulation:

What You Need to Know

3	Introduction
5	Home and Community-Based Setting
9	Transition Process
10	Additional Significant Changes
11	Helpful Resources

The content of this issue of National Policy Matters may not be reproduced without express permission from The Arc. Please contact communications@thearc.org if you wish to reproduce any or all material contained in this report.

Introduction

On January 16, 2014 the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services issued final rules in the Federal Register that implemented section 1915(i) State Plan home and community-based services; defined and described home and community-based setting across all Medicaid home and community-based services authorities; defined person-centered planning requirements for sections 1915(c) and 1915(i) home and community-based services; and allowed states to combine target populations in one section 1915(c) waiver.

In order to receive Medicaid reimbursement from the federal government for providing home and community-based services, states must ensure that the services are delivered in settings that meet the new definition of home and community-based (HCB) setting. The primary focus of this National Policy Matters is the new definition of HCB setting.

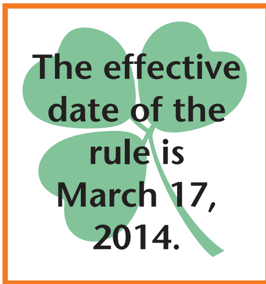
Home and community-based services (HCBS) are non-mandatory Medicaid services - States may provide HCBS to seniors and individuals with disabilities but are not required to do so. All states provide some HCBS under one or more of the following options or waivers available to them in the Social Security Act:[1]

- **1915(c) Waivers.** States may submit applications to CMS for approval to waive certain requirements of the Medicaid program in order to provide HCBS as an alternative to providing those services in institutional settings, such as nursing homes and intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDD). These waivers are permitted by Section 1915(c) of the Social Security Act and are called 1915(c) waivers. Many individuals with intellectual and developmental disabilities receive HCBS through 1915(c) waivers that enable them to live in their own homes rather than in an ICF/IDD. These waivers require periodic renewals.
- **1915(i) State Plan Amendment.** States may provide HCBS as part of their regular Medicaid program by requesting approval from CMS to amend their state plan. They can add any number of home and community-based services that normally could be provided through a 1915(c) waiver to their state plan. They can limit which services to provide and can make them available to people before they need institutional services. The Social Security Act permits this State Plan Option under Section 1915(i).
- **1915(k) Community First Choice (CFC) Option.** States also can provide attendant services and supports through their regular Medicaid programs by amending their state plans. Attendant services and supports are designed for individuals who otherwise would have to go into an institution. This option is a new option that was made available to states through the Affordable Care Act which created a new Section 1915(k) in the Social Security Act and is called the Community First Choice, or CFC, Option. States choosing the Section 1915(k) option must make attendant services and supports available to all Medicaid beneficiaries who meet eligibility criteria for the CFC option.

States can provide HCBS through 1915(c) waivers, the 1915(i) State Plan Option, and the 1915(k) Community First Choice Option. Since HCBS are alternatives to institutional services, they cannot be provided in institutional settings but must be provided in home and community-based settings. The new rule defines HCB setting. The final rule delineates requirements that must be met in both residential and non-resi-

[1] http://www.ssa.gov/OP_Home/ssact/title19/1915.htm. These section numbers are references to sections of the Medicaid program as described in Title XIX of the Social Security Act. As is common practice, this National Policy Matters will sometimes use the word "Section" and other times not, when referring to these individual sections.

dential settings before CMS will authorize Medicaid funding for provision of HCBS. The effective date of the rule is March 17, 2014.



Advocates have been awaiting release of the rule for some time. CMS worked on the definition for several years soliciting and responding to over 2,000 public comments. In the final rule, CMS moved away from a definition of HCB setting based on a setting's location, geography, or physical characteristics. CMS decided to focus on the nature and quality of people's experiences to describe HCB settings. CMS' stated intention in promulgating the final rule was to maximize opportunities for people to have access to the benefits of community living, including receiving services in the most integrated setting and to ensure that Medicaid funding and policy support needed strategies for states in their efforts to meet their obligations under the ADA and the Supreme Court decision in *Olmstead v. L.C., 527* U.S. 581 (1999).

The rule emphasizes **personal autonomy, community integration, and choice** in HCBS. The regulation establishes more stringent rules for provider owned or controlled residential settings. States must work with CMS to develop transition plans to bring non-compliant programs into compliance and must provide opportunities for public input into those transition plans.

CMS' stated intention in promulgating the final rule was to maximize opportunities for people to have access to the benefits of community living, including receiving services in the most integrated setting and to ensure that Medicaid funding and policy support needed strategies for states in their efforts to meet their obligations under the ADA and the Supreme Court decision in *Olmstead v. L.C., 527* U.S. 581 (1999).

Home and Community-Based Setting

What is a home and community-based setting?

HCBS under Sections 1915(c), 1915(i), and 1915(k) of the Social Security Act can only be provided in HCB settings. The final rule creates a single definition of a HCB setting that applies across Medicaid HCBS authorities. The Section 1115 Waiver authority of the Social Security Act is used by some states to provide HCBS. CMS has indicated that it intends to align this new HCB setting definition with HCBS provided under Section 1115 research and demonstration project authority, as well.

The rule describes **home and community-based (HCB)** settings as having the following qualities:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS
- The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting
- The setting ensures individual rights of privacy, dignity, and respect and freedom from coercion and restraint
- The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact
- The setting facilitates individual choice regarding services and supports, and who provides them

What are the additional requirements for provider-owned or operated residential settings?

Stay informed with CMS - HCBS Final Rule Webinar Schedule

Interested in the regulation text?

In provider-owned or controlled residential settings, the qualities outlined above must be present. The following additional conditions also must be met:

- The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity
- Individuals have privacy in their living or sleeping units
- Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommate in that setting
- Individuals can furnish and decorate their own units within the limits of the lease or agreement
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time
- Individuals can have visitors of their choosing at any time
- The setting is physically accessible to the individual

CMS anticipates that these requirements may pose challenges for some traditional providers of HCBS. CMS plans to offer additional guidance for states that will need to make changes to their programs. CMS will allow states to propose transition plans of up to five-years to transition those programs that do not meet the requirements of the new rule.

Can modifications or limits be placed on any of the HCB setting requirements in provider owned or controlled settings?

Yes, but only under very specific conditions. Any modification of the HCB setting requirements must be justified and documented in the person-centered plan. The plan must document:

- The specific and individualized assessed need for the modification
- The positive interventions and supports used prior to any modifications
- The less-intrusive methods of meeting the need that have been tried but failed
- A clear description of the condition that is directly proportionate to the specific assessed need
- Regular collection and review of data to measure the ongoing effectiveness of the modification
- Timelines for periodic review of data to determine if the modification is still necessary or can be terminated
- Informed consent of the individual
- Assurances that interventions and supports will cause no harm to the individual

Are there settings that are never home and community-based settings?

Yes. The rule lists settings that are institutional settings and would never be considered home and community-based settings:

- Nursing facilities
- Institutions for mental diseases (IMDs)
- Intermediate care facilities for people with intellectual disabilities (ICFs/ID)[2]
- Hospitals providing long term care services

Are there other settings that might not meet the new HCB setting requirements and not be considered home and community-based settings?

Yes. CMS will not authorize funding of HCBS in settings that have qualities of institutional settings as determined by the Secretary. CMS will presume that settings have the qualities of an institution if they:

- are located in a building that is also a facility that provides inpatient institutional treatment
- are on the grounds of, or immediately adjacent to, a public institution
- have the effect of isolating individuals from the broader community of individuals not receiving HCBS services

Through a process of "heightened scrutiny," that includes public input and stakeholder engagement, CMS will consider a state's evidence that a setting, which CMS has presumed to have the qualities of an institution, in fact, has the qualities of a home and community-based setting and does not have the qualities of an institution.

CMS indicated that in future guidance it plans to include examples of specific settings that would require heightened scrutiny and might identify additional qualities, such as the size of the facility.

[2] ICF/ID is the preferred terminology for ICF/MR and covers the same population - individuals with intellectual disability or related conditions. http://www.ssa.gov/OP_Home/ssact/title19/1905.htm

Does the rule require a separation between housing provider and service provider?

No. In the new rule, the definition of HCB setting includes the requirement that the setting "facilitates individual choice regarding services and supports, and who provides them." States must ensure that people are able to choose their providers – providers of housing and providers of services and supports. States must ensure that people receive the supports they need to be able to make informed choices. Choice of providers must be handled in the person-centered planning process.

CMS considered including a prohibition in the rule specifically prohibiting housing providers from requiring individuals to receive services from that provider or requiring an individual to receive a particular service as a condition of living or remaining in the setting. CMS weighed comments in favor of and opposed to including such a provision in the rule. Ultimately, CMS chose not to require the separation of the housing provider from the provider of HCBS.

CMS determined that just as there should be a variety of service options to meet individuals' needs, there should be a variety of residential options as well. For example, if services are tied to a residence the individual who chooses that residence also chooses the services. The individual could not bring in another provider to provide the service. CMS deferred to the person-centered planning process and decided that the issue of choice about the provision of services could be dealt with in the planning process and documented in the person-centered service plan. CMS advised states to ensure that individuals are able to make informed choices about housing and services. CMS concluded that it did not believe that a federal mandate requiring separation of housing and services was warranted. States are not precluded from requiring/encouraging separation between housing and service provider.

Do the new requirements apply to group homes and assisted living facilities?

Yes. Group homes and assisted living facilities that meet the requirements for home and community-based settings delineated in the rule would be considered home and community-based settings. If they include qualities of an institution, they would be presumed not to be home and community-based settings. Group homes which do not provide individuals with privacy in their "sleeping or living unit" or which restrict residents' rights to make choices about activities and schedules and have other qualities of an institution presumably would not be HCB settings.

In earlier iterations of the proposed definition of home and community-based setting, CMS had used the terms "disability-specific housing complex" and "housing designed expressly around an individual's diagnosis or disability." CMS received numerous comments about use of those terms. In the final rule, **CMS removed them and replaced them with: "any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS." Further, in the preamble, CMS stated that, "[C]ongregate settings may be included (as home and community-based settings) if they meet the HCB setting requirements set forth in this rule."**

Do the new requirements apply to adult day settings or day habilitation settings?

Yes. In the preamble to the new rule, CMS stated that: "1915(i) State plan HCBS and 1915(k) CFC services (for example, residential, day or other) must be delivered in a setting that meets the HCB setting requirements as set forth in the rule." CMS stated that it would provide further guidance regarding applying the regulations to non-residential HCB settings and identifying settings that have the effect of isolating individuals with disabilities from the broader community.

The language in the new rule states that HCBS, which include day services, habilitation services, and pre-vocational services, must be provided in HCB settings and may not be provided in an institutional setting or a setting that has the qualities of an institution. In response to a comment, CMS stated in the preamble that,

> We do not intend to invalidate all activities in a congregate setting. Individuals must be afforded choice regarding the activities in which they wish to participate including whether to participate in a group activity or to engage in other activities which may not be pre-planned.

CMS anticipated that the new definition could create challenges for some HCBS programs in some states. CMS has outlined a transition process for states to bring their programs into compliance with the new definition and provided a transition period of up to five years.

How do the new home and community-based setting requirements align with subsidized housing projects funded through the federal government?

CMS stated in its preamble to the rule that it had worked closely with other federal agencies on the impact the rule would have on federally supported housing options. CMS stated that it believed that the new requirements would allow for the appropriate designation of home and community-based settings and allow sufficient transition time for states to comply.

In earlier iterations of the proposed definition of home and community-based setting, CMS had used the terms "disability-specific housing complex" and "housing designed expressly around an individual's diagnosis or disability," terms that describe some housing options funded through the Department of Housing and Urban Development. CMS received numerous comments about use of those terms. In the final rule, CMS removed them and replaced them with, "any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS."

CMS also stated in response to public comments:

> It is not our intention to exclude a state from receiving FFP (federal financial participation) for a setting solely based on the fact that it is a congregate setting. Our intention is to specify qualities necessary for a setting to be considered a HCB setting. Congregate settings may be included if they meet the HCB setting requirements set forth in this rule.

CMS will provide additional guidance on:

- Applying the rules to non-residential settings
- Settings that would require heightened scrutiny
- Developing transition plans
- Requirements for caregiver assessment

What happens if settings do not meet the new home and community-based setting requirements?

CMS acknowledged that some current provider-owned or controlled residential settings would not meet all of the home and community-based setting requirements. CMS included a transition period for states to demonstrate compliance with the new HCB setting requirements. CMS indicated that it anticipates that states will transition their programs so that they comply with the new definition in as brief a period of time as possible and will make substantial progress during the transition period. However, CMS will allow states to propose transition periods of up to five years.

How long will states have to transition their programs if settings do not comply with the new HCB setting requirements?

CMS will permit states that have approved section 1915(i) state plan amendments and 1915(c) waivers to provide HCBS, but whose programs do not comply with the new HCB settings requirements, a reasonable transition period to come into compliance.

- All new 1915(c) waivers and 1915(i) state plan amendments for HCBS benefits must meet the new requirements for home and community-based settings as of the effective date of the waiver or amendment.
- If a state submits a 1915(c) waiver renewal or amendment or a 1915(i) state plan amendment to its HCBS benefit within the first year of the effective date of the rule, it must develop a transition plan concerning the specific 1915(c) waiver or 1915(i) state plan benefit.

  The plan must describe the actions the state will take to bring the specific waiver or state plan benefit into compliance with the new definition.

  Within 120 days of the submission of a waiver renewal or amendment or state plan HCBS benefit amendment request, the state must submit a transition plan detailing how it will operate all of its section 1915(c) HCBS waivers and any section 1915(i) state plan HCBS benefits in compliance with the new definition. Transition plans must include timelines and deliverables as approved by the Secretary.
- In states that do not have 1915(c) waivers or 1915(i) state plan HCBS benefits due for renewal or proposed for amendment within one year of the effective date of the new rule they will need to evaluate settings in their existing programs to make sure they meet the new HCB setting definition. If those settings do not meet the new requirements, states must submit transition plans no later than March 17, 2015 to bring all of their 1915(c) and 1915(i) programs into compliance. Plans must include timelines and all deliverables as approved by the Secretary.

States must provide opportunities for the public to give input to transition plans. CMS can approve states' transition plans for up to five years. However, CMS stated in the preamble that it expects states to complete their transitions as quickly as possible and demonstrate substantial progress during the transition period.

CMS indicated that it will issue further guidance on developing transition plans.

Additional Significant Changes

Does the new rule include other significant changes pertaining to HCBS?

Yes. The new rule includes specifics about combining target groups within one 1915(c) waiver; the person centered planning process; provider conflict of interest standards; independent evaluation and assessment; caregiver assessments; and an individual's representative.

Combining Target Groups

Under the new rule, states may combine target groups under one 1915(c) waiver. Previously, those waivers could only target one population: older adults, individuals with disabilities, or both; individuals with intellectual or developmental disabilities, or both; or individuals with mental illness.

Person Centered Plans

The new rule adds requirements for the person-centered planning process and for person centered plans for HCBS under 1919(c) waiver and 1915(i) state plan option programs. CMS has indicated that these requirements will be aligned with requirements for 1915(k), CFC Option programs, through forthcoming guidance. The rule specifies that service plans for HCBS must be developed through a person-centered planning process that provides necessary information and support so that the individual can direct the process and make informed choices. The process must be directed by the individual and the individual's freely chosen representative and must reflect individual preferences and goals. The plan must be written so that the individual can understand the plan. At a minimum, the plan must address:

- The setting chosen by the individual
- Individual health and long term support and service needs
- Community participation
- Employment
- Income and savings
- Health care and wellness
- Education
- Paid and unpaid supports
- Providers of services
- Back up plans, when needed
- Individual's choice to self-direct services
- The entity responsible for monitoring the plan

The rule directs states to ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

Provider Conflict of Interest Standards

Development of Person-Centered Plans

The rule prohibits providers of 1915(c) waiver HCBS or 1915(i) state plan HCBS and those with an interest in or employed by a provider of HCBS from developing the person-centered service plan. The individuals or entities responsible for person-centered plan development must be independent of the HCBS provider. This provision pertains to paid family/guardian caregivers. A parent/guardian who receives payment for providing HCBS may not be responsible for development of the person-centered plan.[3]

[3] Oregon transitioned its 1915(c) waiver program for individuals with intellectual and developmental disabilities into a 1915(k) Community First Choice state plan option. Under the provider conflict of interest provisions in Section 1915(k) of the Social Security Act, which also appear in 1915(i) of the Act, Oregon could no longer allow parents/guardians who received payment for provision of HCBS ("providers" under the statute and the new rule) to "sign off" on person-centered plans. The state and CMS had to design a work around since the state and stakeholders wanted to continue allowing parents/guardians to provide HCBS and receive payment for those services. http://www.dhs.state.or.us/policy/spd/transmit/ar/2013/ar13085.pdf

CMS provides an exception to this rule if there is only one willing and qualified provider in a geographical area who provides HCBS, case management, and develops the person-centered plan. However, in these situations, the state must develop conflict of interest protections to separate provider functions and obtain approval from CMS. In addition, individual recipients of services must have an alternate dispute resolution process available.

Independent Evaluation and Assessment

The rule describes provider requirements for conducting eligibility evaluations. Eligibility for Medicaid HCBS must always be determined by an independent entity.

The rule also describes provider requirements for assessing the need for services and supports delivered through a 1915(i) state plan option. Independent assessments of need must be performed by individuals or entities (CMS uses the term "agent" in the rule to distinguish the role from providers of services) that is independent. Independent means free from conflict of interest with providers of HCBS, the individual and related parties, and budgetary concerns.

CMS provides an exception for geographic areas where only one willing and qualified provider of HCBS and individual assessments is available. In those circumstances, the state must describe conflict of interest protections including separation of agent and provider functions within provider organizations in its state plan. In addition, individuals must have an alternative dispute resolution process available.

Caregiver Assessments

The rule adds a requirement that states include in the individual assessment for HCBS state plan services a caregiver assessment if unpaid caregivers will implement any portions of the person-centered service plan.

Individual's Representative

The rule provides parameters for individual representatives under 1915(i) state plan programs when individuals have a legally appointed guardian or conservator and when individuals without legal guardians choose to have a representative.

If an individual has a legal guardian, conservator, or other person who has the sole authority under state law to make decisions related to the individual's care, the state must comply with the decisions of the legal surrogate.

For individuals who do not have legally appointed guardians, an individual's representative is anyone who is authorized to represent the individual for the purpose of making personal or health care decisions, either under state law or under the policies of the state Medicaid agency and includes, but is not limited to, a parent, a family member, or an advocate. The state must put safeguards in place to ensure that the representative uses substituted judgment on behalf of the individual. The state must have policies in place that address exceptions to using substituted judgment when the individual's wishes cannot be ascertained or when the individual's wishes would result in substantial harm to the individual. States must allow someone freely chosen by the individual to act as that individual's representative unless the state can document evidence justifying rejection of the chosen representative due to inability or not acting in accordance with the state's policies.

Helpful Resources

Americans with Disabilities Act (ADA)

CMS Home and Community-Based Setting Resources: Summary of Key Provisions of the HCB Setting Final Rule; Final Rule; Informational Bulletin; Fact Sheets.

HCBS Final Rule Webinar Schedule

Questions? Contact the CMS mailbox at hcbs@cms.hhs.gov

Statement of the Department of Housing and Urban Development on the role of Housing in accomplishing the goals of Olmstead, June 2013

U.S. Supreme Court, *Olmstead v L.C., 527* U.S. 581 (1999)

The Arc of the United States
1825 K Street NW, Suite 1200
Washington, DC 20006
800-433-5255
www.thearc.org