Issue Brief:
CMS Final Rule on Home and Community-Based Services Settings and other Requirements in the 1915(i) State Plan Option, 1915(c) Waiver, and 1915(k) Community First Choice Option

January 13, 2014

Background

On May 3, 2012 the Centers for Medicare and Medicaid Services (CMS) posted a notice of proposed rulemaking (NPRM) in the *Federal Register* regarding home and community-based services (HCBS).[1] The proposal would update the regulations to reflect changes made in the Deficit Reduction Act of 2005 and the Patient Protection and Affordable Care Act of 2010 and align the definition of a home and community-based setting for services delivered under 1915(c) waiver, 1915(i) State Plan Option, and 1915(k) Community First Choice Option, among other requirements.

Summary

On January 10, 2014 CMS released the final rule.[2] The final rule largely reflects the proposed rule with some changes that provide more clarity and respond to the approximately 1,700 public comments. It strengthens the requirements for personal autonomy, community integration, and choice in home and community-based services funded through Medicaid. It makes clear that the requirements apply to both residential and non-residential settings and sets specific and more stringent rules for provider-owned or controlled residential settings. It requires an independent assessment of individual needs and strengths and a person-centered planning process ensure that individuals receive the services they need in a manner they prefer. The rule establishes more public notice and input requirements related to proposed changes to waivers. States must work with CMS to create transitional plans to bring current programs into compliance and allow for public input on those transitional plans.

Home and Community-Based Settings

The final rule creates a single definition of a home and community-based setting for 1915(c), 1915(i), and 1915(k) HCBS. The rule describes home and community-based settings as having the following qualities:

- The setting is integrated in the greater community, including opportunities to seek employment in competitive integrated settings and engage in the community
- The setting is selected by the individual, including the option for a non-disability-specific setting
- The setting ensures individual rights of privacy, dignity, and respect and freedom from coercion and restraint
- The setting optimizes individual initiative, autonomy, and independence in life choices

[1] For the full proposed rule, visit https://federalregister.gov/a/2012-10385
[2] For the full final rule, visit https://federalregister.gov/a/2014-00487

- The setting facilitates individual choice regarding services and supports, including who provides them

For provider-owned or controlled residential settings, the rule states the following additional requirements (that can only be modified using a process described below):

- Units or rooms must be a specific physical place, the kind that could be owned or rented in a typical landlord-tenant agreement
- Individuals have privacy in their living or sleeping units, meaning that
    - Units have lockable doors and entrances, with only appropriate staff having keys to doors
    - Individuals who share rooms 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 control their own schedules, including access to food at any time
- Individuals can have visitors at any time
- The setting is physically accessible to the individual

The rule finalizes a process for modifying the above rules for provider-owned or controlled residential settings that require written justification and must be done on an individual basis.

- Modifications must be supported by a specific assessed need and justified in the person-centered plan. The plan must document:
    - The specific and individualized assessed need
    - The positive interventions and supports used prior to any modifications
    - The less intrusive methods that have been tried but did not work
    - A description of the condition that is directly proportionate to the need
    - Regular collection and review of data to measure the effectiveness of the modification
    - Established time limits for review of the modification
    - Informed consent of the individual
    - Assurance that the interventions and supports will cause no harm to the individual

The rule states that following are never home and community-based settings:

- Nursing facilities
- Institutions for mental diseases
- Intermediate care facilities for people with intellectual disabilities
- Hospitals

The rule states that CMS will presume that a setting is not home and community-based if it is located in a building that also provides inpatient treatment or is located on the grounds of, or immediately adjacent to, a public institution or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community. CMS will presume these settings to not be home and community-based unless the CMS determines through a process of "heightened scrutiny" that the setting does not have the qualities of an institution and in fact has the qualities of a home and community based setting. The "heightened scrutiny" process will include public input and stakeholder engagement.

Person-Centered Plan

The rule requires a person-centered plan for each individual receiving Medicaid HCBS. In the planning process, the individual receiving services describes his or her needs, in collaboration with family, friends, and other team members to ensure that individuals receive the services they need in a manner they prefer. It details requirements for the plan, including writing and revisions.

Highlights of the process include requirements that it must:

- Include people chosen by the individual
- Provide necessary information and support so the individual can direct the process to the maximum extent possible
- Reflect the cultural considerations of the individual and is conducted in plain language accessible to people with disabilities and persons who have limited English proficiency
- Offer choices to the individual regarding services and supports

Highlights of the plan include that it must:

- Reflect what is important to the individual with regard to the delivery of services and supports
- Reflect the individuals' strengths and preferences, as well as clinical and support needs
- Include paid and unpaid supports (also called natural supports)
- Be understandable to the individual and written in plain language accessible to people with disabilities and persons who have limited English proficiency
- Prevent the provision of unnecessary or inappropriate services and supports
- Document the modifications made to the HCBS settings requirements outlined in the rules for provider-owned or controlled settings.

Independent Assessment

For services provided under a 1915(i) state plan, the state must conduct an independent assessment of the individual's needs and strengths to determine specific services and supports. The rule provides details on the area and methods of assessment, such as ensuring access to support during the assessment, a caregiver assessment if unpaid caregivers will be relied upon to implement the service plan, and information and supports needed to self-direct services if the individual so chooses.

Compliance and Enforcement

The rule will take effect 60 days from being published in the *Federal Register* (currently scheduled to be published on January 16, 2014). It creates both a transitional period for states to implement the rules and a new compliance mechanism. All new 1915(c) waivers, 1915(i), and 1915(k) Community First Choice state plan amendments must meet the new requirements to be approved by CMS. For current 1915(c) and 1915(i) programs, states must work with CMS to develop a transitional plan and allow for public input on the plan. States have up to one year to submit a transitional plan and CMS will approve plans of up to five years in length, depending on the circumstances in that state.

For states found to be out of compliance with the regulations, the rule also creates a new compliance mechanism for states once transitional plans are complete. If a state is found to be out of compliance, CMS may issue a moratorium on waiver enrollments, withhold a portion of Federal payment for waiver services until compliance is achieved, or other corrective strategies to ensure the health and welfare of waiver participants.

If a state seeks to make substantive changes to a waiver, states now must establish and use a public input process specifically for substantive proposed changes to a waiver, such as elimination or reduction of services, changes in rate methodology, or changes to the eligible population. States must ensure they provide meaningful opportunities for input from individuals served or who are eligible to be served.

CMS and ACL officials have indicated that they will publish additional written guidance on the final rule in the near future.