

The Medicaid Home and Community Based Services Settings Rules: What You Should Know!

A companion resource to:

[HCBS Setting Rules: How to Advocate for Truly Integrated Community Settings](#)

[HCBS Rules Q&A: Settings Presumed to be Institutional & the Heightened Scrutiny Process](#)

Created by the HCBS Advocacy Coalition

December 2015

Website:
<http://hcsadvocacy.org/national-resources/>

Email:
hcsadvocacy@gmail.com

Contents

Introduction	3
Why are these recent HCBS rules important?	5
Why is state-level advocacy around these rules important?	6
How are states expected to come into compliance with the rules?	7
What is the role of advocates in a state’s transition to HCBS compliance with the rules?	8
Which Medicaid programs are covered by the new HCBS rules?	10
When do states have to be compliant with the rules?	11
What types of HCBS settings are covered by the rules?	12
How do the rules affect provider-owned or operated residential settings?	13
How do the HCBS settings rules apply to non-residential settings?	15
Are institutional services covered by the rules?	16
How do states determine if a setting meets the HCBS requirements?	17
What is the “heightened scrutiny” process?	18
What types of settings are presumed to be institutional in nature?	19
Can a state apply higher standards for HCBS settings than the rules require?	21
What happens to people using <i>non-compliant</i> services? Will they lose services?	22
Do the HCBS rules affect provider choices for HCBS participants?	23
HCBS Advocacy Coalition & Contact Information	24

**KNOW THE
RULES!**



Introduction

In January 2014, the Centers for Medicare & Medicaid Services (CMS) announced new rules that will potentially have a far-reaching and positive impact on the nature of residential and day service settings funded through Medicaid as part of Home and Community Based Services (HCBS). The final settings rules took into account thousands of public comments reflecting a wide range of perspectives that were gathered over five years. The final rules, which took effect in March 2014, require that all HCBS settings must:

- Be integrated in and facilitate full access to the greater community;
- Optimize autonomy and independence in making life choices;
- Be chosen by the individual from among residential and day options, including non-disability specific settings;
- Ensure the right to privacy, dignity, respect and freedom from coercion and restraint;
- Provide an opportunity to seek competitive employment;
- Provide individuals an option to choose a private unit in a residential setting; and
- Facilitate choice of services and who provides them.¹

The rules have additional requirements for provider-owned residential settings.

The rules reiterate long standing federal law that institutions (such as nursing homes, psychiatric hospitals, or intermediate care facilities for individuals with intellectual disabilities (ICF/IDDs)) cannot be funded as HCBS settings.² The rules also describe settings presumed to be institutional in nature – and therefore not home and community based – unless a state can overcome the

¹ See *generally* Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, [79 Fed. Reg. 2948](#), 3030-31 (Jan. 16, 2014) (to be codified at 42 C.F.R. § 441.301(c)(4)).

² [Intermediate Care Facilities \(ICFs\)](#) are Medicaid funded and licensed institutions for individuals with intellectual disabilities. They range from large state-operated facilities to smaller privately operated facilities.

institutional presumption with evidence through a heightened scrutiny review process. The rules also establish detailed person-centered planning requirements for all HCBS programs.³ Importantly, the rules focus on the experiences of HCBS participants and require that they have the same degree of access to their communities as their neighbors who are not receiving Medicaid HCBS.

³ This FAQ is focused on the parts of the rule describing requirements for HCBS settings.

HCBS

Settings

Rules:

Questions

and

Answers

Why are these recent HCBS rules important?

These rules are an important step forward in federal policy, supporting inclusion and integration of people with disabilities in the community. They build on decades of disability policy, including major federal legislation such as the Americans with Disabilities Act, the Rehabilitation Act, Developmental Disabilities Act, and Individuals with Disabilities Education Act and Executive Branch programs such as the New Freedom Initiative and Year of Community Living. The fact that these policies are now in federal regulation provides a significant impetus to move state systems closer to the reality of person-centered practices, full inclusion, and integration into the community.

Why is state-level advocacy around these rules important?

The extent to which the rules are a catalyst for positive change will depend on the strength of each state's transition plan, as well as the ability of stakeholders and advocates to influence the plan and monitor its implementation.

The next several months are an important time to become involved because this is when important decisions at the state level will be made and the parameters of state plans will be set. CMS has indicated that they are looking closely at public comments — advocates' voices matter!

To assist advocates and stakeholders in providing input into state transition plan development and refinement, a consortium of national advocacy organizations has prepared this and other materials about the rules and ways stakeholders can get strategically involved. All of these resources are available at www.hcbsadvocacy.org.

How are states expected to come into compliance with the rules?

All states have until March 17, 2019 to meet the new settings requirements. All states were required to submit a transition plan to CMS by March 17, 2015.

State transition plans include the following:

- Explanation of how the state will update state policies to conform with the rules;
- Description of the process for assessing current settings for compliance with the HCBS requirements and any process to remedy settings not currently in compliance;
- A timeline for when the state expects to achieve important milestones in the transition plan process, such as assessments, changes in licensing and certification standards, and developing ongoing monitoring processes; and
- Responses to public comments on the plan.

Plans varied widely in the breadth and depth of the information provided. Many plans have been sent back by CMS for revisions and additional public comment opportunities.⁴ It is anticipated that many states will have to undergo multiple revisions to their state plans during the transition period, each of which will be subject to public comment requirements.

⁴ See the status of state transition plans, including any letters from CMS, on the [CMS State Transition Plan website](#).

What is the role of advocates in a state's transition to HCBS compliance with the rules?

Successful implementation of these rules depends on an active and engaged stakeholder community. Because of the importance of these rules and their potential to reshape systems in a positive direction, it is crucial that advocates and stakeholders weigh in to support states' efforts to comply. There will be numerous opportunities to provide input throughout the process, therefore advocates should track upcoming public comment opportunities and be prepared with information.⁵

Public comments are an important part of a state transition plan. In accordance with the new rules, all states must provide at least one 30-day opportunity for public comment on the statewide transition plan. States are required to have an additional public comment period any time they make "substantive" changes to their plan, such as setting or changing any timelines, completing assessments of settings, making decisions about a setting's compliance, or submitting settings to CMS through the heightened scrutiny process.⁶

⁵ There are a number of places that stakeholders and advocates can secure information about the state's transition process including at www.HCBSadvocacy.org or www.Medicaid.gov⁵ and on the state's website. Also, advocates should ask to be added to any listservs the state may use to provide information regarding the HCBS transition. This could include listservs generally targeted to Medicaid recipients, providers, or those tracking all administrative rule changes. Most of the state transition plans have timelines that indicate when the state expects to have public comment opportunities and these dates should be on advocates' calendars. In advance of public comment periods, advocates should gather information regarding such issues as settings that should be phased out, state rule changes that need to take place, barriers to implementation, and ongoing monitoring and quality assurance.

⁶ See, e.g., 42 C.F.R. § 441.710(a)(iii) (requiring 30-day public comment period for the initial plan); see also CMS, [Statewide Transition Plan Toolkit for Alignment with the HCBS Final Regulation's Setting Requirements](#) 7 (Sept. 5, 2014); CMS, [Steps to Compliance for HCBS Settings Requirements in a 1915\(c\) Waiver and 1915\(i\) SPA](#), (noting that the public comment process must be used when a plan undergoes a substantive change).

What is the role of advocates in a state's transition to HCBS compliance with the rules?

This means that stakeholders need to be prepared to comment on plans multiple times during the transition period. CMS anticipates that many states will have to undergo multiple revisions to their state plans during the transition period. Other public input opportunities in the transition process include waiver amendments; changes to state rules, policies, and procedures related to the HCBS programs; and changes to state statutes or code.

***What Do
the New
Rules
Cover?***

Which Medicaid programs are covered by the new HCBS rules?

The rules apply to all settings funded through Medicaid HCBS programs. This includes settings are funded through 1915(c) waivers (generally known as “waiver programs”); state plan home and community based services through 1915(i) and the 1915(k) Community First Choice state plan options; 1115 demonstration waivers; and HCBS provided under 1915(b)(3) managed care savings arrangements. The rules do not apply to settings funded under non-HCBS programs, such as general state plan services.

When do states have to be compliant with the rules?

The HCBS settings rules give states and providers time to implement the new requirements through a transition process that supports continuity of services for Medicaid participants and minimizes disruptions in service systems during implementation.⁷

States have up to five years (until March 2019) to come into compliance with the settings rules.⁸

This means that any necessary changes will occur over several years, with protections for HCBS program participants. In other words, regardless of changes to the status of particular providers, participants will not lose the services and supports in their individual plan because of the HCBS changes. States are required to develop a transition plan describing how they will come into compliance, seek public input on the plan, and submit it to CMS for approval. These initial transition plans were due in March of 2015.

CMS is in the process of reviewing the plans, and as of December 2015, no statewide transition plans have yet been approved.

In addition, states must have a process for on-going monitoring of HCBS settings for quality and continued compliance with the rules. All of these new standards, if properly implemented, can contribute to better quality services and more opportunities for individuals with disabilities to fully engage in community life.

⁷ CMS, [CMCS Informational Bulletin 1](#) (CIB-01-10-14).

⁸ States are already supposed to be complying with the part of the rules regarding the person-centered planning process. CMS, [Q&A – 1915\(i\) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915\(c\) Home and Community-Based Waivers – CMS 2249-F and 2296-F](#).

What types of HCBS settings are covered by the rules?

The rules apply to all residential and non-residential settings funded through Medicaid HCBS programs. This includes settings such as group homes, day programs, employment options, and other independent living situations. Provider-owned or controlled residential settings, such as group homes, must follow additional requirements (detailed in the following question).

For setting that are in planning stages or are new construction, whether or not the settings are compliant with the HCBS settings requirements cannot be determined based on plans and physical descriptions.⁹ Instead, the setting must be operational and occupied by beneficiaries because individuals need to actually experience the setting and how it promotes independence and community integration before a state would have evidence to present to a heightened scrutiny process.

⁹ CMS, HCBS Final Regulation: Frequently Asked Questions on Planned Construction and Person Centered Planning Requirements (Apr. 12. 2016), <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/faq-planned-construction.pdf>.

How do the rules affect provider-owned or operated residential settings?

The rules do not prohibit provider-owned or operated settings, such as group homes. However, in addition to meeting the general requirements of the rules regarding community based settings, these residential settings must meet the additional conditions below:

- A lease or other legally enforceable agreement to protect from eviction;
- Privacy in their unit including entrances lockable by the individual (necessary staff may have keys as needed);
- Choice of roommates;
- Freedom to furnish and decorate their unit;
- Control of their schedule and activities;
- Access to food at any time;
- Visitors of their choosing at any time; and
- Physical accessibility for the individual.

If any of these requirements are limited, the reason must be documented in the individual's person-centered plan, be based on a specific and individualized need, include a clear description of that condition that is directly proportionate to the specific assessed need, include the informed consent of the individual, and have an established time limit for the modification, including periodic review.¹⁰ There must also be documentation in the person-centered plan that identifies previously tried less restrictive interventions, lists the positive interventions and supports used prior to any modification, assures that no harm will come to the individual from the modifications, and includes regular collection and review of data to determine the effectiveness of the modification. Controls on personal freedoms and access to the community cannot be imposed on a class or group of individuals. Restrictions or modifications that would not be permitted under the HCBS settings regulations cannot be

¹⁰ See, e.g., 42 C.F.R. § 441.301(c)(4)(vi)(F). Physical accessibility may not be modified in the person-centered planning process.

implemented as “house rules” in any setting, regardless of the population served and must not be used for the convenience of staff.¹¹ Although person-centered planning processes are already supposed to be compliant with the HCBS changes generally, the provisions about modifications in provider owned and controlled settings are implemented in the five-year transition period with the settings requirements. Although STPs are not supposed to include plans to come into compliance with the changes to person-centered planning generally, they may include a process for adding specific requirements into the person-centered planning process regarding modifications to settings characteristics in a provider owned or controlled setting.

Some disability-specific, provider-owned, or congregate settings may have characteristics of “settings that isolate” (see the following question). If states identify such settings, they must describe in their transition plans whether these settings will continue to be eligible to be funded as HCBS providers, and if so, how these settings may need to update their practices to come into compliance with the rules.

¹¹ CMS, HCBS Q&A Planned Construction and Person Centered Planning Requirements, *supra* note 9.

How do the HCBS settings rules apply to non-residential settings?

The HCBS settings rules apply to any setting in which HCBS services are provided — both residential and non-residential. CMS created a set of “Exploratory Questions” to assist states in assessing non-residential settings for compliance with the rules.¹² As with residential settings, all non-residential settings must comply with the federal requirements that the setting provide opportunities for participants to engage in community life, to have access to the community, to control their personal resources, and to seek employment and work in competitive settings.

Any non-residential settings, including employment settings and day programs must be assessed using the same criteria that apply to all other settings. Specifically does the program have characteristics that isolate participants from the broader community? In other words, do participants have the same level of access to their community as individuals who do not receive Medicaid? If these factors are not in place, the state must indicate how these characteristics will be addressed in the state’s transition plan. CMS has also noted that pre-vocational services need not be facility-based and may be offered in a variety of settings in the community.¹³

¹² For more information on settings, see the following resources from CMS: Exploratory Questions on [Residential](#) and [Non-Residential Settings](#), [Guidance on Settings that May Potentially Isolate](#), and [FAQ Regarding the Heightened Scrutiny Review Process](#).

¹³ For more information about non-residential settings, see CMS, [Questions and Answers Regarding Home and Community-Based Settings](#), 9-12.

Are institutional services covered by the rules?

HCBS programs are an alternative to institutional services. Institutional services have never been allowed to be funded under Medicaid's HCBS programs and have their own Medicaid funding streams that come with different requirements. The HCBS rules make clear that institutions services such as hospitals, nursing homes, Institutions for Mental Disease or ICF/IIDs cannot be considered HCBS settings. Settings other than those in the previous list may be so institutional in nature that they do not meet the standards of an HCBS setting.

How Are States Assessing HCBS Setting Compliance?

How do states determine if a setting meets the HCBS requirements?

The rules require that all HCBS settings meet the requirements of the rules. One of the first things states have to do is determine the level of compliance that providers/settings currently have with the rules. Knowing current compliance is important for developing the state's transition plan and identifying where changes must be made.

States are supposed to make an initial assessment as to whether their HCBS settings are currently in compliance with the Federal HCBS setting requirements. Initially, the state categorizes every HCBS service setting into one of four categories:

1. Settings that fully comply with the HCBS requirements;
2. Settings that do not comply with the HCBS requirements and will require modifications;
3. Settings that cannot meet the HCBS requirements and require removal from the HCBS program and/or the relocation of individuals; and
4. Settings that are **presumed not** to be home and community based (i.e., are institutional in nature) but for which the state will provide justification/evidence through the *heightened scrutiny process* to show each setting does not have the characteristics of an institution and has the qualities of HCBS settings.

For all settings, once a state has made an initial determination of compliance or non-compliance, any remediation outlined in the plan should be completed well before the end of the transition period. The determination of settings must be available for public comment and comments from advocates, given their knowledge about how settings truly operate, are critical to an accurate evaluation of the HCBS settings.¹⁴

¹⁴ See hcbadvocacy.org for advocacy tools and other resources.

What is the “heightened scrutiny” process?

If a state plans to continue HCBS funding for settings that appear to have some institutional characteristics (e.g., in terms of size, location, availability of transportation, and/or physical connection with an institutional setting), states have the option of submitting evidence to CMS, through a process called “heightened scrutiny,” that shows that the setting overcomes the institutional characteristics and instead is sufficiently community based to meet the HCBS criteria.¹⁵ This process also includes an opportunity for public input, such as for advocates, to inform the state about whether certain settings are more institutional or community than the state has assessed.

CMS created a set of “Exploratory Questions” to assist states in evaluating residential settings for compliance with the rules.¹⁶ A state may only include such settings in HCBS programs if CMS agrees with the evidence presented. Evidence to overcome presumed institutional qualities should focus on how the setting is integrated in and supports full access of individuals receiving home and community based services into the greater community, not on the characteristics and/or severity of the disabilities of the individuals served in the setting. The primary vehicle for assessing settings that will necessitate heightened scrutiny is the state transition plan. With respect to those settings, the state should also include any feedback that was solicited during the public comment period. In addition to information in the plan, CMS will also consider information submitted directly from other parties.¹⁷

¹⁵ For more information about heightened scrutiny, see CMS, [Steps to Compliance for HCBS Settings Requirements](#); see also HCBS Advocacy Coalition, [HCBS Q&A: Settings Presumed to be Institutional & the Heightened Scrutiny Process](#).

¹⁶ See Exploratory Questions, *supra* note 8.

¹⁷ One mechanism to submit public comment directly to CMS is through email at hcbs@cms.hhs.gov. Public comment to CMS is most effective soon after a state has responded to the public comment and advocates can provide additional information on the topics that the state did not respond to or did not make changes.

What types of settings are presumed to be institutional in nature?

The rule identifies certain types of settings that are presumed to be institutional in nature. The following settings are presumed to be institutional:

- Publicly or privately owned facilities that provide inpatient treatment;
- Settings on the ground of, or immediately adjacent to, a public institution; and
- Settings that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

The first two types of settings are relatively easy to identify, but the last category of “settings that isolate” is less definite and more focused on how the setting affects the participants. Settings that isolate may have some or all of the following characteristics:

- The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability;
- The individuals in the setting are primarily or exclusively people with disabilities and the staff that provides services to them;
- The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities;
- The individuals in the setting have limited, if any, interaction with the broader community; or settings that use practices that are used in

institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion or restraint).¹⁸

CMS provided some guidance about settings that isolate, including identifying as potentially isolating the following settings: farmsteads, gated or secured communities for people with disabilities, residential schools, and multiple settings clustered together and operationally related. Depending on their structure and operations, some day service settings, such as sheltered workshops and day treatment programs, may have characteristics that isolate HCBS participants and will need to be examined closely.

¹⁸ See CMS, [Guidance on Settings that have the Effect of Isolating Individuals Receiving HCBS from the Broader Community](#), *supra* note 8. The guidance includes examples of residential settings that may isolate, including disability-specific farmsteads, gated communities for people with disabilities, and residential schools.

Can a state apply higher standards for HCBS settings than the rules require?

Yes. The federal rules regarding HCBS settings establish the minimum requirements for what constitutes a community setting. A state may require higher standards. For example, a state may decide that it only wants to use HCBS funds to support integrated and competitive employment for HCBS participants and may choose not to fund settings with more segregated services, such as sheltered workshops. CMS has said that although all states have to ensure every HCBS setting meets the minimum federal requirements, states have some flexibility in how they apply more stringent HCBS standards.¹⁹ A state may decide to stop new admissions, suspend approvals for new providers, or suspend authorization for settings that only meet the minimum standards while establishing standards for all new settings that promote service models that satisfy the state's more enhanced standards. A state may continue this practice, referred to by CMS as "tiered settings."

States that plan to use tiered standards must describe their approach in the state's transition plan. This flexibility allows a state to gradually phase out certain settings or provider types as it builds capacity of more integrated community based settings and services.

¹⁹ For more information about setting requirements, heightened scrutiny, and state flexibility to establish tiered standards, see CMS, [FAQ Regarding the Heightened Scrutiny Review Process](#), *supra* note 8.

What happens to people using *non-compliant* services? Will they lose services?

No. Under no circumstances will participants be left without services as a result of the rule.²⁰ States have until March of 2019 to bring settings into compliance. Hopefully most settings will be able to come into compliance through the process described in the state's transition plan. However, there may be some settings that – because of structural, programmatic, or other reasons – will not come into compliance. If the state finds that it will need to decertify certain settings as HCBS providers, the transition plan must describe the process for transitioning people into settings that meet the HCBS requirements and how the state will protect individuals' rights during the transition process.

Alternatively, the state may facilitate a change in funding authority for the provider, such as becoming licensed as an intermediate care facility or nursing home to receive other types of Medicaid funding. States may need to create new capacity to replace any settings that cannot come into compliance and ensure that all HCBS participants are offered a choice of non-disability specific settings.

²⁰ For more information, see [Joint Statement by Joint Statement by NASDDDS, ANCOR and Disability and Aging Groups Regarding Continuity of Services during Implementation of the HCBS Rule.](#)

Do the HCBS rules affect provider choices for HCBS participants?

In addition to participants having choice among providers – already a requirement for HCBS services – the new rules require that HCBS participants must also be offered a choice of a non-disability specific setting as part of their person-centered planning process. Examples of non-disability services settings include a person living and receiving services in his or her own apartment or home instead of a group home, or working and receiving employment supports in a typical job in the community instead of in a sheltered workshop. State transition plans will likely need to include steps to create additional capacity so all participants can be offered a choice of residential and day services in non-disability specific settings.

For more information about the HCBS settings rules, see www.HCBSadvocacy.org or www.Medicaid.gov/HCBS.

HCBS Advocacy Coalition & Contact Information

These national organizations are all working on HCBS implementation and are working collaboratively to assist state advocates in understanding the process, evaluating state plans and assessment processes, crafting effective comments, and advocacy planning.

State advocates may contact these organizations by emailing hcbsadvocacy@gmail.com. You can also visit the coalition website: hcbsadvocacy.org.

The HCBS Advocacy Coalition is a voluntary association of the following organizations working together to advance state compliance with HCBS setting requirements:

- [American Network of Community Options and Resources](#)
- [Association of People Supporting Employment First](#)
- [Association of University Centers on Disabilities](#)
- [Autistic Self Advocacy Network](#)
- [Bazelon Center for Mental Health Law](#)
- [Coalition to Promote Self-Determination](#)
- [Justice in Aging \(formerly National Senior Citizens Law Center\)](#)
- [Human Services Research Institute](#)
- [National Association of Councils on Developmental Disabilities](#)
- [National Consumer Voice for Quality Long Term Care](#)
- [National Council on Independent Living](#)
- [National Disability Rights Network](#)
- [National Down Syndrome Congress](#)
- [National Health Law Program](#)
- [TASH](#)
- [The Arc of the United States](#)