Medicaid Home and Community-Based Services Final Rule
CMS-2249-F/CMS-2296-F
42 CFR Part 430, 431 et al.

Background

1. On January 10, 2014, the Centers for Medicare & Medicaid Services (CMS) released a long-waited final rule (regulation) 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 final rule is the result of multiple proposed rules and public comments over the past five years.

2. The rule and related CMS fact sheets are available at www.medicaid.gov/HCBS

General Observations

1. Medicaid Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) are not directly affected by this rule. As noted by CMS in the preamble of the Rule, "Medicaid services are available in a variety of settings. This rule sets forth requirements that must be met for individuals to receive services under sections 1915(i),(c) and (k) of the Act." Nursing facilities, mental health facilities, ICFs/IID, hospitals and "any other locations that have qualities of an institutional setting, as determined by the Secretary," are "Settings that are not Home and Community-Based," according to the rule. States still have the discretion to determine the number of ICFs/IID in their states.

2. The rule continues to demonstrate an ideological bias against disabled people who find friendships and benefits from living together and accessing services and amenities "under one roof." Although CMS states that "part of meaningful choice is to be presented with all available [residential] options" and that a "person-centered planning process is not about promoting certain options deemed to be more 'person-centered' or otherwise desirable than other options," CMS goes on to say that "one of the essential purposes of the person-centered service plan is to ensure community integration" and "full access to the greater community." Per this rule, congregate care is presumed institutional and not community. The burden is on states, with input from advocates, to argue that a congregate setting is "community" per the rule's criteria.

Advocacy Opportunities

1. The rule provides for ongoing stakeholder input at the state and federal levels. States are **required** to seek public input when developing HCBS state plan or waiver requests, or transition

plans relating to current HCBS programs. In response to this rule and forthcoming CMS Guidance Letters to the States, CMS encourages questions and comments at hcbs@cms.hhs.gov.

2. State level advocacy becomes more important than ever. Advocates will first have to encourage states to apply for exceptions when a particular program is presumed "institutional" (e.g., planned residential communities), and then provide information to the state and CMS in support of HCBS criteria.

3. CMS estimates no financial impact on states, however if CMS determines some settings to be too "institutional," and requires affected individuals to choose from other eligible home and community settings, it is likely that states will realize higher costs to accommodate transitions to likely smaller, scattered settings where economies of scale will not be realized. Quality of care and access to specialized services may also be affected, exacting an untold cost on affected individuals.

4. Disability policy is being combined with aging. Within the U.S. Department of Health and Human Services, disability and aging issues have moved under the Administration on Community Living, with Sharon Lewis recently getting a promotion allowing her more access to HHS Secretary Kathleen Sebelius. Ms. Lewis now serves in the dual roles of Principal Deputy Administrator of the Administration for Community Living and HHS Secretary Sebelius' Senior Advisor on Disability Policy. In this expanded role, Ms. Lewis will likely have a major role in determining whether a setting for people with I/DD is too "institutional" to allow HCBS funding.

Overview of Key Provisions of Final HCBS Rule

1. The rule defines what CMS considers characteristics of community living and vocational opportunities for people with developmental disabilities for the purpose of receiving Medicaid HCBS 1915(c),(i), and (k) funding. Specifically, to be eligible for HCBS funding, the setting must meet the following qualifications:

- 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.

2. 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.

3. The rule includes a transitional process for states to ensure that their waivers and state plans meet the new HCBS community criteria. New HCBS 1915(c) waiver and (i) state plans applications must comply with the new requirements. For current and renewing HCBS plans and waivers, a State must submit, within one year, a transition plan detailing how the State will operate **all** section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with rule. A State must afford the public notice and a 30 day comment period. CMS will allow *up to* five years to achieve compliance based on circumstances.

4. The rule identifies other settings that are presumed to have institutional qualities, and ***not*** meet the threshold for Medicaid HCBS and thereby be subject to heighted HHS scrutiny, e.g., settings that provide inpatient care; settings on the grounds of, or immediately adjacent to, a ***public*** institution; or settings that "have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS.

5. CMS plans "to include in the guidance [to states] examples of specific settings that will require heightened scrutiny and may identify additional qualities, including the size of the facility, triggering such scrutiny." CMS further states that, "[o]ur experience through our work with other federal Departments and current research indicates that size can play an important role in whether a setting has institutional qualities and may not be home and community-based."

6. Upon state application, the HHS Secretary has the authority to override the presumption that a setting is institutional, through "heightened scrutiny, based on information presented by the State or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings," allowing for HCBS funding. The final rule amends earlier proposals by lowering the Secretary's standard of review from "rebuttal presumption" to "heighted scrutiny." CMS guidance is forthcoming.

7. The rule requires that service planning for HCBS recipients under 1915(c) and (i) be developed through a person-centered planning process that addresses the health and long-term services and support needs in a manner that reflects individual preferences and goals, consistent with HCBS criteria. A person-centered plan must support any modifications to HCBS criteria (e.g., locked food; locked home to prevent dangerous elopement, etc.); however, before such restrictions based on health, welfare and safety are allowed, there must be documentation that less restrictive solutions have first been tried. It is unclear if an individual's safety must first be compromised to demonstrate the need for certain individualized restrictions. CMS guidance is forthcoming.

8. A person-centered plan is developed by the individual, representatives of his/her choosing, and others who know the individual well. "[W]here state law confers decision-making authority to a legal representative, such as a guardian, that individual may direct the person-centered planning process on behalf of the individual."

9. The rule places the burden on the State, not assisted living providers, to accommodate single occupancy requests. This was an important change from earlier proposals as many providers require roommate situations to make Medicaid placements affordable.

10. The rule allows states to combine Medicaid beneficiaries based on functional need rather than diagnosis. This offers administrative convenience to states which can now have one HCBS program for mixed populations (e.g., serving aged, I/DD, physically disabled, and/or mentally ill under one roof).