Health Advocate

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Home and Community Based Settings: A Primer

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Key Resources

HCBS Final Rules, available here.

NHeLP Q&A: Home and Community Based Services Final Rules, available here.

CMS Letter Regarding Integrated Settings for 1915(c) Vocational Services, available here.

Coming in March's Health Advocate:

Issues with Section 1115 Premium Assistance

Medicaid-funded home and community based services (HCBS) provide necessary supports to help older adults and persons with disabilities integrate into their communities and prevent institutionalization. Federal rules say that HCBS may only be provided in a home and community based setting, but what "home and community based setting" means has not had a final regulatory definition until recently. This definition is critical because if Medicaid HCBS dollars can just flow to settings which are really institutional in nature, then Medicaid programs will not have an incentive to develop the supports infrastructure and resources to take care of people in their homes. The cycle of older adults and persons with disabilities being forced to get the services they need in institutions will be perpetuated. On January 16, 2014, the Centers for Medicaid and Medicare Services (CMS) issued final rules describing the types of settings in which Medicaid-funded HCBS could be provided. These final rules also require person-centered planning for individuals receiving HCBS and set forth requirements as to what that planning process must include, as well as a few other changes.

Background

HCBS programs are intended to support states in creating a comprehensive system of long-term care services in the community, as is consistent with the community integration mandate established by the Supreme Court in the Olmstead v. L.C. case in 1999.[1] In Medicaid, HCBS programming has developed in a piecemeal fashion over time through various different mechanisms. Many states provide HCBS through waiver programs under 1915(c) of the Social Security Act, which allows states to waive certain Medicaid rules and provide community-based services as an alternative to institutional care. These programs serve specific populations, such as individuals with intellectual or developmental disabilities, and allow a state to waive certain Medicaid requirements.

States also have options for HCB programs under sections 1915(i) and 1915(k), which authorize different types of HCB programs. States may use 1915(i) to craft a program of services for individuals who need less than an institutional level of care. The 1915(k) option, known as Community First Choice, was created by the Affordable Care Act (ACA) to allow states to provide attendant services and supports to Medicaid participants under a State plan. The final rules recently issued by CMS on HCBS affect 1915(i) and 1915(k) programs as well as 1915(c) waivers. One of the over-arching purposes of the new regulation is to promote more uniformity in the core definitions

[1] 527 U.S. 581 (1999).

that shape all of the HCBS program options in Medicaid. Although Medicaid State plan services, such as personal care services, are community-based services, the new rules are for 1915(i) and 1915(k) programs and 1915(c) waivers.

Defining "Home and Community Based"

The definition of a home and community based setting for Medicaid waiver services has been evolving over the past four years. In previous proposed rules, CMS focused on defining what makes a setting institutional in nature and included standards such as limiting the number of individuals living in a residence. The proposed rules also used the term "disability specific complex" as a type of setting that would be presumed not to be home and community based. Although disability specific complex housing has in some instances generated alternatives to traditional state-run institutions, it has historically resulted in settings that are institutional in nature, reduced people's ability to integrate into the broader community, and reduced investment in supports that could allow them to live wherever they choose. The final rules do not use the term "disability specific complex" and instead have a general prohibition against "any setting that has the effect of discouraging integration of individuals from the broader community…" This broader, community integration focused approach is indicative of the final rules generally in that, other than listing settings that are considered institutional, the final rules focus on the nature and quality of a participant's experience as compared to individuals not receiving HCBS services.

All places in which HCBS are provided must meet the requirements of the new rules. This includes not only residential settings, but also settings in which supplemental services such as day programs, pre-vocational programs, and supported employment programs are located. The application of the HCBS standards to non-residential programs is one of several areas where CMS expects to provide further guidance to address questions of implementation of the rules.

Settings with Institutional Characteristics

The rules provide that certain settings are presumed to have institutional qualities and specifically prohibit HCBS from being covered in those locations. Specifically excluded settings include: nursing facilities, institutes for mental disease, intermediate care facilities for individuals with intellectual disabilities (ICF/IDs formerly ICF/MRs), and hospitals. Settings that are presumed to have institutional qualities and do not meet the threshold for HCBS include:

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

If a state seeks to include a setting that is presumed to have institutional qualities and thus considered not to meet the threshold for HCBS settings, CMS will apply heightened scrutiny to such settings. In the heightened scrutiny process states will be allowed to present evidence to CMS that the setting is a home and community-based setting and does not have qualities of an institution (CMS previously proposed a "rebuttable presumption" for such settings). The heightened scrutiny process will also require the state to solicit public input and CMS will also consider input from stakeholders and its own reviews. This process should be a way for advocates to ensure that all the settings their state is proposing to include as a setting option for an HCBS program actually meet the definition of a community setting.

If a setting does not meet the requirements of a HCBS setting, it cannot receive HCBS funding, but it may still be eligible for other sources of Medicaid funding. For example, if a residential setting serving individuals with intellectual disabilities does not meet HCBS standards, it cannot receive HCBS funding for its programs and services. However, that HCBS-ineligible setting may be able to become licensed as an ICF/ID and receive Medicaid

funding as that type of institutional setting. Advocates may face opposition from groups wanting to keep certain types of settings and it is important to remember that the purpose of these final rules is to make sure HCBS are provided in appropriate settings and that the HCBS Medicaid funding is used as intended. Other funding, if available and including possible Medicaid funding for certain institutions, may be used for non-community settings.

Home and Community Based Qualifications

In addition to excluding the institutional settings described above, the rule also requires all HCB settings to meet certain critical standards, including that 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.

The final rules recognize that an individual's experience living in a provider-owned or controlled setting may be different from living in his or her private home. Thus there are additional requirements for settings that are owned or controlled by a provider. A setting is considered provider-owned when the physical place in which an individual resides is owned, co-owned, and/or operated by a provider of HCBS. Provider-owned or controlled HCB residential settings must also provide an individual:

- A lease or other legally enforceable agreement providing similar protections.
- Privacy in his or her unit including lockable doors.
- Choice of roommate(s), with the provider facilitating the individual's choice regarding roommate selection. The state is responsible for ensuring a range of living options, including private and shared units.
- Freedom to furnish or decorate the unit. This freedom may have reasonable limits as long as the limits are not discriminatory or otherwise deny rights granted to tenants under the state law.
- Control of his or her own schedule including access to food at any time. Access to food is more than water and a few snacks and should include access to food storage and preparation space.
- An individual may choose to participate in group or congregate activities, but the individual must have 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.
- The right to have visitors at any time.
- Physical accessibility of the setting.

These requirements represent an important step forward towards ensuring the independence and dignity of individuals in provider-owned or controlled settings. All of the requirements specific to provider-owned or controlled setting, except for physical accessibility, may be modified for certain individuals if the modification is supported by a specific assessed need and justified in the person-centered service plan. Modifications may not be based on an individual's disability or diagnosis, but rather on individualized, specific needs. The rules set forth eight requirements that must be documented for such a modification, including documenting less intrusive methods of meeting the need that have been tried but did not work, regular collection and review of data to measure the effectiveness of the modification, informed consent of the individual, and established time limits for periodic review of the modification. Advocates should monitor the use of modifications and ensure that they are specific to the individual and adhere to documentation requirements, especially the areas that are intended to recognize that risk and independence are important for an individual.

Implementation of the HCBS Requirements

These rules are effective March 17, 2014. Any new 1915(c) waivers or 1915(i) state plans must meet the new requirements before CMS will approve the programs. For existing waivers and programs, states have a maximum of one year to evaluate the settings in which services are currently provided under their 1915(c) waivers and 1915(i) state plans and submit a transition plan to CMS describing how the state will bring their program(s) into compliance. CMS may approve transition plans for a period up to five years, depending on the individual states' circumstances, but a state is expected to transition as quickly as possible and show substantial progress during any transition period.

Importance of Advocates in Identifying Non-community Settings

Advocates will play an important role in closely monitoring what types of settings states identify as meeting the HCBS standards. For example, because many settings that advocates believe are not truly community based will likely have "the effect of discouraging integration," it will be critical for advocates to clearly and specifically describe to CMS how such settings fail to meet such standards during the public comment period for transition plans. Advocates should also provide information in the areas CMS plans to issue future guidance. The guidance CMS issues about how the final HCBS rules apply to non-residential settings, including when modifications are allowed, is key to fulfilling the intent of HCBS programs. The new HCBS requirements may cause changes in current programs, but if well implemented, these requirements and changes will improve community integration for countless older adults and persons with disabilities in the short-term and promote the investment of Medicaid HCBS dollars into home-based services infrastructure in the long-term.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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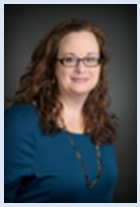

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