NHeLP
NATIONAL HEALTH LAW PROGRAM

Q & A: Medicaid Home and Community-Based Services–Final Rules[1]

Prepared By: Elizabeth D. Edwards
Date: February 2014

Q. I have heard that the final rules regarding home and community based settings for 1915(c) waivers and 1915(i) and 1915(k) state plan options have been released. What should advocates know about these rules?

A. The final rules for home and community based settings set forth standards for determining whether a setting is actually home and community based and therefore a permissible site at which Medicaid-funded HCB services may be provided. It also allows states to serve multiple populations under a single 1915(c) waiver, requires person-centered planning, restricts the use of retroactive effective dates for 1915(c) waivers to non-substantive changes, and expands the coverable services under a 1915(i) program.

Discussion

The final rules issued by the Centers for Medicare and Medicaid Services (CMS) regarding Medicaid-funded home and community-based services (HCBS) are not significantly different from the proposed rules.[2] The intent of the final rules is to ensure HCBS are provided in settings that are integrated into the community and to maximize opportunities for waiver participants to have access to the benefits of community living. In defining HCBS settings, CMS focuses on the nature and quality of participants' experiences rather than the setting's location, geography, or physical characteristics. Although the final rule provides further clarity about the features of home and community-based settings, there are still many areas about which advocates will have questions, especially in terms of how these rules will be implemented and monitored.

---

[1] Produced by the National Health Law Program (NHeLP) with a grant from The Atlantic Philanthropies and the Training Advocacy Support Center (TASC), which is sponsored by the Administration on Developmental Disabilities, the Center for Mental Health Services, the Rehabilitation Services Administration, the Social Security Administration, and the HealthResources Services Administration. TASC is a division of the National Disabilities Rights Network (NDRN).

[2] CMS published an Advance Notice of Proposed Rulemaking (ANPRM) on June 22, 2009 and a Notice of Proposed Rulemaking (NPRM) on April 15, 2011 for 1915(c) waiver changes. CMS published a proposed rule on May 3, 2012 for 1915(i) provisions. *See generally* Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers, 79 Fed. Reg. 2948, 3011 (Jan. 16, 2014) (to be codified at 42 C.F.R. pts. 430, 431, 435, 436, 440, 441 & 447. [hereinafter HCBS Final Rules] (briefly discussing the evolution of the CMS' definition of HCBS setting characteristics).

Impacts on the 1915(c), 1915(i) and 1915(k) Programs
In addition to the provisions regarding HCBS settings, the rules require person-centered planning (PCP) that meets certain minimum requirements for all service planning for participants in 1915(c) waivers and 1915(i) and 1915(k) state plan options.[3] One of the most significant changes is that all HCBS under these programs must be provided in settings that meet the home and community-based setting standards, including residential and non-residential settings.

1915(c) Waiver Program:

- Allows states to combine multiple target populations into one waiver.
    - The state must assure CMS that each individual in the waiver has equal access to all needed services and that the state is able to meet the unique service needs of individuals in each target group.
- Clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates.[4]
- Adds compliance options for CMS, short of waiver termination, for HCBS programs. CMS expects to use these options rarely and only after exhausting other options. The compliance mechanisms could include a moratorium on waiver enrollments, withholding of a portion of Federal payment, or other actions as determined by the Secretary. Such actions would be taken after an agency received notice of CMS' findings and had an opportunity to rebut the findings.[5]
- Only allows waiver amendments with substantive changes to take effect on or after the date that the amendment is approved by CMS.
    - If the state is making substantive changes, it must also submit information on how it has assured smooth transitions and minimal adverse impacts on individuals. Substantive changes include, but are not limited to, changes in eligible populations; constriction of amount, duration, or scope of a service; and other modifications as determined by the Secretary.[6]

---

[3] *Id.* at 2990-95. The rules regarding PCPs include conflict of interest provisions and the role of an individual's representative, if he or she has one. *Id.*
[4] *Id.* at 3019-20 (to be codified at 42 C.F.R. § 441.304(f)). The State agency must establish and use a meaningful public input process for any changes in the services or operations of the waiver. The process must be completed at least 30 days prior to implementation of the proposed change or submission of the proposed change to CMS, whichever comes first.
[5] *Id.* at 3020-21 (to be codified at 42 C.F.R. § 441.304(g)(1)).
[6] *Id.* at 3018-19 (to be codified at 42 C.F.R. § 441.304(d)). If the change is not substantive, modifications may be made effective retroactive to the first day of a waiver year, or another date after the first day of a waiver year, in which the amendment is submitted.

1915(i) State Plan Option:[7]

- Allows states to target a plan benefit to particular groups of participants.[8]
- Implements optional eligibility criteria added by the Affordable Care Act.[9]
- Includes as coverable services:
    - any of the HCBS permitted under section 1915(c) HCBS waivers,
    - certain services for mental health and substance use disorders, and
    - other services requested by a state and approved by the Secretary.[10]
- Requires states to establish needs-based criteria for eligibility and an independent assessment process.[11]
- Requires all HCBS services be provided in settings that meet the home and community-based standards.

The final rule also provides a five-year approval or renewal period for demonstration and waiver programs in which a state services individuals who are dually eligible for Medicare and Medicaid benefits. The rules also add an exception that will allow Medicaid payments to be made to a third party on behalf of the provider for health and welfare benefit contributions, training costs, and other customary employee benefits.[12]

Defining Home and Community-Based Settings

The definition of HCB settings in the final rule is more outcome-oriented and, according to CMS, intended to maximize a participant's opportunity to access the benefits of community living and receive services in the most integrated setting.

---

[7] Under 1915(i) state plan options, states can provide HCBS to individuals who require less than institutional level of care in addition to serving individual who have needs that would meet entry requirements for an institution. As a state plan service, the benefit must be offered statewide and states may not limit the number of eligible people served. Although they cannot limit the number of eligible people, states may try to limit the program through defining a narrow target group. 1915(i) state plan benefits also do not have to show cost neutrality to institutional level of care. *Id.* at 2951.

[8] A State may target groups defined on the basis of any combination of age, diagnosis, disability, and/or Medicaid eligibility group. Although targeting criteria cannot have the impact of limiting the pool of qualified providers or require an individual to receive services from the same entity from which they purchase their housing, the State may limit the availability of specific services or vary the amount, duration, or scope of those services, to one or more of the groups. HCBS Final Rules, 79 Fed. Reg. at 5035 (to be codified at 42 C.F.R. § 441.710(e)(2)).

[9] *Id.* at 2955-56, 3028 (to be codified at 42 C.F.R. §§ 435.219, 436.219). Prior to the Affordable Care Act, states could only serve individuals eligible under the State plan with incomes at or below 150 percent of the Federal poverty level or below.

[10] *Id.* at 2954-55 (to be codified at 42 C.F.R. § 440.182).

[11] *Id.* at 2982-2984 (to be codified at 42 C.F.R. §§ 441.715, 441.720)

[12] State plans can usually only allow payments to be made to certain individuals or entities, specifically the practitioner who provided the service, with some exceptions. CMS says the new exception is intended to address the situation when a Medicaid program is functioning as a practitioner's primary source of revenue and previously the program was prohibited from fulfilling basic responsibilities associated with that role. *Id.* at 2949 (to be codified at 42 C.F.R. 447.10(g)(4)).

An important difference in the final rules is that this definition applies to all settings where HCBS are delivered, including non-residential settings such as day programs and pre-vocational training settings. CMS also makes it clear that if an individual is participating in any HCBS, that individual must live in a setting that meets the HCBS requirements.[13]

Some settings are specifically excluded or are presumed to have institutional qualities. Specifically excluded settings include: nursing facilities, institutes of mental disease, intermediate care facilities for individuals with intellectual disabilities, 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; 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. The emphasis is on access to an individual's chosen and activities and whether the individual has the same degree of access to such activities as individuals not receiving Medicaid HCBS.[14]

All HCB settings must meet certain qualifications, 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.[15]

Provider-owned or controlled HCB residential settings must also provide an individual:

- A lease or other legally enforceable agreement providing similar protections.
    - In a state where landlord tenant laws do not apply to such units or dwellings, the state must ensure that a lease, residency agreement or other form of written agreement will be in place that provides protections comparable to those provided under the jurisdiction's landlord tenant law.
- Privacy in his or her unit including lockable doors.[16]

---

[13] *See, e.g., id.* at 2960; *see also* CMCS Informational Bulletin (Sept. 16, 2011), http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf (providing guidance on integration requirements for employment related services under 1915(c) waivers).

[14] CMS is not expressing preference in regard to the proximity of activities to where an individual lives. The determination is not based on whether the setting is rural, urban or suburban community, but whether it has the qualities of home and community-based settings. HCBS Final Rules, 79 Fed. Reg. at 2975.

[15] *See, e.g., id.* at 3030-31 (to be codified at 42 C.F.R. § 441.301(c)(4)).

- Choice of roommate(s), with the provider facilitating the individual's choice regarding roommate selection.
- 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.[17]
- 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 should not be presented with narrow options, decided by someone else, without input from the individual.[18]
    - 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.[19]
- The right to have visitors at any time.[20]
- Physical accessibility of the setting.[21]

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. If an individual chooses to receive HCBS in a provider-controlled setting, the individual is choosing that provider for the services that are included in the bundled rate paid to the provider. The individual may select the same or a different qualified provider for supplemental services. States must ensure that when an individual chooses a HCB setting, the individual has made an informed choice among options. States are not precluded from structuring the service delivery system to promote separation.

The additional conditions for provider-owned or controlled residential settings may be modified on an individual basis, but the modification must be supported by a specific assessed need and justified in the person-centered service plan. [22] The rules set forth eight requirements that must be documented for such a

---

[16] The language of the regulation is intended to curtail issuing resident keys to all employees or staff regardless of the employee's responsibilities—only appropriate individuals should have access to an individual's room. *Id.* at 2963-64.
[17] *Id.*
[18] *Id.* 2966.
[19] *Id.* at 2977.
[20] It would be reasonable for there to be limitations on the amount of time a visitor can stay as to avoid occupancy issues, but such limitations should be clearly stated in a lease, residency agreement, or other form of written agreement. HCBS Final Rules, 79 Fed. Reg. at 2966.
[21] This condition cannot be modified as physical accessibility could be a safety hazard. *Id.* at 2967, 3033, 3034 (to be codified at 42 C.F.R. §§ 441.530(a)(1)(vi)(F), 441.710(a)(1)(vi)(F)).
[22] *Id.* at 3030, 3032, 3033, 3034, (to be codified at 42 C.F.R. §§ 441.301(c)(2)(xiii), 441.301(c)(4)(vi)(F), 441.530(a)(1)(vi)(F), 441.710(a)(1)(vi)(F), 441.725(b)(13)). For more information about balancing risk with restrictions on independence or access to resources, *see, e.g., id.* at 3008.

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.[23]

CMS received many comments about settings such as continuing care retirement communities (CCRCs) that are designed to allow an individual to "age in place." CMS responded that it does not want to stand in the way of innovation and will engage in conversations with states about such settings, but the settings will need to meet HCBS requirements. CMS also responded that it may be that case that the independent living units and assisted living units of CCRCs would be presumed to be institutional and receive heightened scrutiny. However, such units would not be excluded from being considered home and community-based if they are structured and operate in a manner that adheres to the requirements of the rule.[24]

Differences in the Final Rules

The effect of the final rules is not substantially different from the proposed rules, but CMS clarified or changed the language in several areas. The most notable areas include:

- Eliminated the use of "disability specific complex" in the list of settings presumed not to be home and community-based. The language on other settings now reads, "any other setting that has the effect of discouraging integration of individuals from the broader community…."
- Replaced the proposed rebuttable presumption for certain settings that are not home and community-based with "heightened scrutiny." Under the heightened scrutiny standard, states will be allowed to present evidence to CMS that the setting is home and community-based setting and does not have qualities of an institution. This heightened scrutiny process will require the state to solicit public input and CMS will consider input from stakeholders and its own reviews.
- Clarified that when an individual is selecting a provider owned or controlled setting where the provider is paid a single rate for a bundle of services, the individual is choosing the residential provider to provide that bundle of services.
- Clarified that states, as opposed to individual providers, are responsible for ensuring individuals have options for both private and shared residential units.
- Clarified that the home and community-based settings requirements apply to all settings where HCBS are delivered, not just residential settings.

State Transition Plans and Amendments

These rules are effective March 17, 2014. Any new 1915(c) waivers or 1915(i)

[23] *See, e.g., id. at* 3033 (to be codified at § 441.530(a)(1)(vi)(F)(1)-(8)).
[24] *Id.* at 2972.

state plans must meet the new requirements before CMS will approve the programs. Any 1915(c) waiver renewals or amendments submitted before March 17, 2015 may require a transition plan to meet the new rule. A state must submit a plan that lays out timeframes and benchmarks for **all** the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs within 120 days of the submission of a 1915(c) waiver renewal or amendment. For existing waivers and programs, states have a maximum of one year to evaluate the settings currently in 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.

The public will have an opportunity to provide input into the transition plans.[25] 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. Input by advocates to states and to CMS as to how a setting does or does not meet HCBS standards will be critical as states begin to identify settings and create transition plans. While the new HCBS requirements may create great change, these changes are intended to ensure that HCBS is provided in community settings; non-community settings may still be Medicaid funded as institutions in certain instances.

Future Guidance Expected from CMS[26]

The rules establish the requirements, but there are many questions about how the heightened scrutiny process will work and how the requirements will be interpreted and applied. In the comments section of the final rule, CMS stated it planned to issue further guidance on**:**

- Applying the regulations regarding the transition plan requirements.
- "Other services" that a state may propose and define for a 1915(i) state plan.[27]
- Using components of the regulation regarding the right of the individual to be free from coercion and restraint as well as the PCP process to address concerns about an individual choosing between accepting certain services or moving.[28]

---

[25] *Id.* at 3031 (to be codified at 42 C.F.R. § 441.301(6)(iii)). States must provide at least a 30-day public notice and comment period regarding the transition plan(s) with at least two statements of public notice and public input procedures. The state must also ensure the full transition plan(s) is available to the public for comment and the State must consider and modify the transition plan, as the State deems appropriate, to account for public comment.

[26] In a webinar regarding the HCBS final rules, CMS indicated it expects to issue guidance on some subjects, such as non-residential settings, before the rules become effective on March 17, 2014.

[27] HCBS Final Rules, 79 Fed. Reg. at 2954.

[28] Although several comments requested the inclusion of a right to refuse services in a provider-owned or controlled setting, CMS declined to include this option, saying that individuals cannot be compelled to receive any Medicaid service and the person-centered plan process, along with the requirements that an individual be free from coercion and restraint, achieve the same purposes as a right to refuse. However, CMS said it plans to issue additional guidance to try to

- Applying the regulations to non-residential HCBS settings.[29]
- How an individual's available financial resources may impact the residential options available to that individual, including options for a private room.[30]
- Identifying other settings that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.[31]
    - CMS plans to include examples of specific settings that will require heightened scrutiny and may identify additional qualities, including the size of the facility, that may trigger such scrutiny.[32]
- Determining whether a setting meets the home and community-based criteria.[33]
- Reviewing and monitoring of quality requirements.[34]
- Applying the person-centered process.[35]
    - Because the rule expresses what must occur regarding person-centered planning, not how the planning must be conducted, CMS may issue, as needed, additional guidance to states to assist in the interpretation and implementation of the rule.[36]
- Identifying instances when a modification of the conditions might be supported by a specific assessed and documented need, including further descriptions.[37]
- Using telemedicine or other technology in assessments.[38]
- Identifying the options for a state to provide financial management supports and employer functions using FFP.[39]
- Demonstrating cost neutrality for a 1915(c) waiver serving multiple groups.[40]

---

provide tools to address these concerns about individuals being coerced into services through threat of eviction, etc. *Id.* at 2958.

[29] *Id.* at 2972.

[30] This is in response to concerns about the rule that a residential 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." *Id.* at 2964-65 (to be codified at 42 C.F.R. §§ 441.301(b)(4)(ii), 441.530(a)(1)(ii), 441.710(a)(1)(ii)).

[31] *See, e.g., id.* at 2968.

[32] CMS' 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. *Id.* at 2968-70, 3014. CMS also plans to take into account concerns about group homes on the grounds of an institution that is recently closed. *Id.* at 2971.

[33] HCBS Final Rules, 79 Fed. Reg. at 3014.

[34] *Id.* at 2976.

[35] *Id.* at 2978.

[36] *Id.* 79 Fed. Reg. at 3004.

[37] *Id.* at 2978, 2980.

[38] *Id.* at 2986.

[39] A State may use FFP for these functions as a Medicaid administrative activity or as a Medicaid service, as long as the activity meets Medicaid requirements. HCBS Final Rules, 79 Fed. Reg. at 2996.

In addition, in future guidance, CMS plans to reinforce the importance of complying with other federal requirements, such as the Americans with Disabilities Act and the Supreme Court's *Olmstead* decision.[41] CMS intends to include non-medical quality measures, such as quality of life, community integration and factors specific to participant-directed services, in the development of future guidance.[42] CMS will also provide more information about a state's ability to use 1915(i) to target populations, provide different benefits, serve multiple populations, etc. [43] Future guidance will elaborate on the statement that the "role of the assessor is to facilitate free communication from persons relevant to the support needs of the individual."[44] CMS will also consider addressing the issue of providers or representatives who may be using excessive control and how to better protect an individual's "free choice" of representative.[45]

Advocacy Recommendations

Advocates should be actively involved in the transition plan process as states begin to identify changes that must occur for waivers and 1915(i) state plan options to meet the standards in the HCBS rules. The requirements for public input in this process are important opportunities for advocates and individuals to tell CMS how specific settings do or do not meet the HCBS standards. Because many settings that advocates believe are not community based will likely fall under having "the effect of discouraging integration", it will be critical for advocates to clearly describe to CMS how such settings fail to meet the standards. Advocates should also provide information in the areas CMS plans to issue future guidance. The guidance CMS issues about applying HCBS to non-residential settings and when modifications are allowed are all key in how these rules are implemented.

---

[40] *Id.* at 3015.
[41] *Id.* at 2976. *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 119 S. Ct. 2176, 144 L. Ed. 2d 540 (1990).
[42] HCBS Final Rules, 79 Fed. Reg. at 3001.
[43] *Id.* at 2981.
[44] This is already included at 42 C.F.R. § 441.720(a)(2), but CMS plans to include the explanation in future guidance. *Id.* at 2988.
[45] CMS believes the proposed language broadly covers concerns about a participant's access to a representative and that representatives should conform to good practice concerning free choice of the individual. *Id.* at 2995.