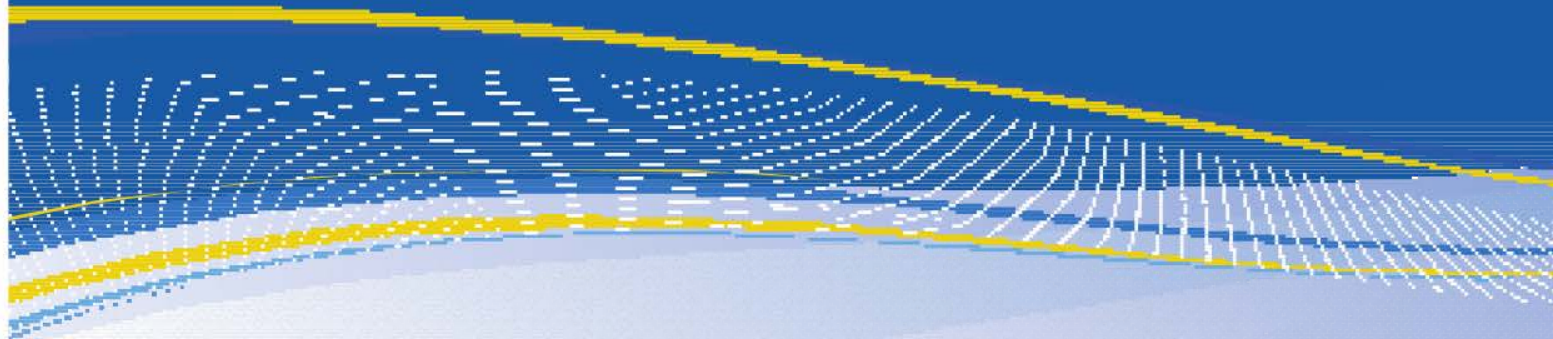




Final Rule Medicaid HCBS

Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services



Final Rule

CMS 2249-F and CMS 2296-F

Published in the Federal Register on January 16, 2014

Title:

Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice (Section 1915(k) of the Act) and Home and Community-Based Services (HCBS) Waivers (Section 1915(c) of the Act)

Intent of the Final Rule

- To ensure that individuals receiving long-term services and supports through home and community based service (HCBS) programs under the 1915(c), 1915(i) and 1915(k) Medicaid authorities have full access to benefits of community living and the opportunity to receive services in the most integrated setting appropriate
- To enhance the quality of HCBS and provide protections to participants

Input to the Final Rule

The final rule reflects:

- Combined response to public comments on two proposed rules published in the Federal register –
 - May 3, 2012
 - April 15, 2011
- More than 2000 comments received from states, providers, advocates, employers, insurers, associations, and other stakeholders

Highlights of the Final Rule

- Defines, describes, and aligns home and community-based setting requirements across three Medicaid authorities
- Defines person-centered planning requirements for persons in HCBS settings under 1915(c) HCBS waiver and 1915(i) HCBS State Plan authorities
- Implements regulations for 1915(i) HCBS State Plan benefit

Highlights of the Final Rule

- Provides option to combine multiple target populations within one 1915(c) waiver
- Provides CMS with additional compliance options for 1915(c) waiver programs
- Establishes five-year renewal cycle to align concurrent authorities for certain demonstration projects or waivers for individuals who are dual eligible
- Includes a provider payment reassignment provision to facilitate certain state initiatives

Home and Community-Based Setting Requirements

- The home and community-based setting requirements establish an outcome oriented definition that focuses on the nature and quality of individuals' experiences
- The requirements maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting

Home and Community-Based Setting Requirements

- The final rule defines, describes, and aligns setting requirements for home and community-based services provided under three Medicaid authorities
 - 1915(c)-HCBS Waivers
 - 1915(i)- State Plan HCBS
 - 1915(k)-Community First Choice

Home and Community-Based Setting Requirements

The final rule establishes:

- Mandatory requirements for the qualities of home and community-based settings including discretion for the Secretary to determine other appropriate qualities
- Settings that are not home and community-based
- Settings presumed not to be home and community-based
- State compliance and transition requirements

Home and Community-Based Setting Requirements

The Home and Community-Based setting:

- Is integrated in and supports access to the greater community
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services

Home and Community-Based Setting Requirements

- 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
 - Person-centered service plans document the options based on the individual's needs, preferences; and for residential settings, the individual's resources

Home and Community-Based Setting Requirements

- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports, and who provides them

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

Additional requirements:

- Specific unit/dwelling is owned, rented, or occupied under legally enforceable agreement
- Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity
- If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

- Each individual has privacy in their sleeping or living unit
- Units have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
- Individuals sharing units have a choice of roommates
- Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement
- Individuals have freedom and support to control their schedules and activities and have access to food any time
- Individuals may have visitors at any time
- Setting is physically accessible to the individual

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

Modifications of the additional requirements must be:

- Supported by specific assessed need
- Justified in the person-centered service plan
- Documented in the person-centered service plan

Home and Community-Based Setting Requirements for Provider-Owned or Controlled Residential Settings

Documentation in the person-centered service plan of modifications of the additional requirements includes:

- Specific individualized assessed need
- Prior interventions and supports including less intrusive methods
- Description of condition proportionate to assessed need
- Ongoing data measuring effectiveness of modification
- Established time limits for periodic review of modifications
- Individual's informed consent
- Assurance that interventions and supports will not cause harm

Settings that are NOT Home and Community-Based

- Nursing facility
- Institution for mental diseases (IMD)
- Intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Hospital

Settings PRESUMED NOT to Be Home and Community-Based

- Settings in a publicly or privately-owned facility providing inpatient treatment
- Settings on grounds of, or adjacent to, a public institution
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS

Settings PRESUMED NOT to Be Home and Community-Based-Heightened Scrutiny

These settings (slide 18) may NOT be included in states' 1915(c), 1915(i) or 1915(k) HCBS programs unless:

- A state submits evidence (including public input) demonstrating that the setting does have the qualities of a home and community-based setting and NOT the qualities of an institution; AND
- The Secretary finds, based on a heightened scrutiny review of the evidence, that the setting meets the requirements for home and community-based settings and does NOT have the qualities of an institution

Transition

- For NEW 1915(c) HCBS waivers or 1915(i) HCBS State Plan benefits to be approved, states must ensure that HCBS are only delivered in settings that meet the new requirements

Transition

For renewals and amendments to existing HCBS 1915(c) waivers submitted within one year of the effective date of final rule:

- The state submits a plan in the renewal or amendment request detailing any actions necessary to achieve or document compliance with setting requirements for the specific waiver or amendment
- Renewal or amendment approval will be contingent upon inclusion of an approved transition plan

Transition

For renewals and amendments to existing 1915(i) state plan benefits submitted within one year of the effective date of final rule:

- The state submits a plan in the SPA renewal or amendment request detailing any actions necessary to achieve or document compliance with setting requirements for the specific waiver or amendment
- SPA renewal or amendment approval will be contingent upon inclusion of an approved transition plan

Transition

For ALL existing 1915(c) HCBS waivers and 1915(i) HCBS State Plan benefits in the state, the state must submit a plan:

- Within 120 days of first renewal or amendment request detailing how the state will comply with the settings requirements in ALL 1915(c) HCBS waivers and 1915(i) HCBS State Plan benefits
- The level and detail of the plan will be determined by the types and characteristics of settings used in the individual state

Transition

When a state DOES NOT renew or amend an existing 1915(c) HCBS waiver or 1915(i) HCBS State Plan benefit for HCBS within one year of the effective date of the final rule, the plan to document or achieve compliance with settings requirements must:

- Be submitted within one year of the effective date of the final rule
- Include all elements, timelines, and deliverables as required

Transition Public Comment Period

The state must provide a 30-day public notice and comment period on the plan the state intends to submit to CMS -

- Provide minimum of two statements of public notice and public input procedures
- Ensure the full transition plan is available for public comment
- Consider public comments
- Modify the plan based on public comment, as appropriate
- Submit evidence of public notice and summary of disposition of the comments

Transition

- Implementation of the plan begins upon approval by CMS
- Failure to submit an approvable plan may result in compliance actions
- Failure to comply with the terms of an approved plan may result in compliance actions

Final Rule Changes to Address Major Comments of Concern in NPRMs

- *Disability specific complex* – Phrase replaced with “any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS ...”
- *Rebuttable presumption* – Settings presumed to have institutional characteristics will be subject to heightened scrutiny allowing states to present evidence that the setting is home and community-based
- *Choice of provider in provider owned and operated settings* – Clarified that choice of provider is intrinsic to the setting

Final Rule Changes to Address Major Comments of Concern in NPRMs

- *Private rooms/roommate choice* – Needs, preferences, and resources are relevant to option of private versus shared residential unit. Providers must offer roommate choice for shared rooms.
- *Application of setting requirements to non-residential settings* – Rule applies to all settings where HCBS are delivered, not just to residential settings and CMS will provide additional information about how states should apply the standards to non-residential settings

Person-Centered Service Plans

Final rule includes changes to the requirements regarding person-centered service plans for HCBS waivers under 1915(c) and HCBS state plan benefits under 1915(i) -

- Identical for 1915(c) and 1915(i)
- The person-centered service plan must be developed through a person-centered planning process

1915(c) and 1915(i) Home and Community-Based Services Person-Centered Service Plans

- The person-centered planning process is driven by the individual
- Includes people chosen by the individual
- Provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible
- Is timely and occurs at times/locations of convenience to the individual

1915(c) and 1915(i) Home and Community-Based Services Person-Centered Service Plans

- Reflects cultural considerations/uses plain language
- Includes strategies for solving disagreement
- Offers choices to the individual regarding services and supports the individual receives and from whom
- Provides method to request updates

1915(c) and 1915(i) Home and Community-Based Services Person-Centered Service Plans

- Conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare
- Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual

1915(c) and 1915(i) Home and Community-Based Services Person-Centered Service Plans

- May include whether and what services are self-directed
- Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others

1915(c) and 1915(i) Home and Community-Based Services Person-Centered Service Plans

- Includes risk factors and plans to minimize them
- Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the individual and his/her representative

1915(c) and 1915(i)

Home and Community-Based Services

Written Person-Centered Service Plan Documentation

Written plan reflects -

- Setting is chosen by the individual and is integrated in, and supports full access to the greater community
- Opportunities to seek employment and work in competitive integrated settings
- Opportunity to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS

1915(c) and 1915(i)

Home and Community-Based Services

Written Person-Centered Service Plan Documentation

- Reflects individual's strengths and preferences
- Reflects clinical and support needs
- Includes goals and desired outcomes
- Providers of services/supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS

1915(c) and 1915(i)

Home and Community-Based Services

Written Person-Centered Service Plan Documentation

- Risk factors and measures in place to minimize risk
- Individualized backup plans and strategies when needed
- Individuals important in supporting individual
- Individuals responsible for monitoring plan

1915(c) and 1915(i)

Home and Community-Based Services

Written Person-Centered Service Plan Documentation

- Plain language and understandable to the individual
- Who is responsible for monitoring the plan
- Informed consent of the individual in writing
- Signatures of all individuals and providers responsible

1915(c) and 1915(i)

Home and Community-Based Services

Written Person-Centered Service Plan Documentation

- Distributed to the individual and others involved in plan
- Includes purchase/control of self-directed services
- Exclude unnecessary or inappropriate services and supports

1915(c) and 1915(i)

Home and Community-Based Services

Written Person-Centered Service Plan Documentation

- Modification of the additional conditions as previously discussed in the home and community-based setting requirements
- Must be reviewed, and revised upon reassessment of functional need as required every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

1915(c) Home and Community-Based Services Waivers

Other 1915(c) provisions in the final rule -

- Allows states to serve more than one target group in a single waiver
- Clarifies timing of amendments and public input process when states propose modifications
- Describes strategies available to CMS to assist states with compliance
- Clarifies guidance regarding effective dates of waiver amendments particularly in the area of substantive changes

1915(c) Home and Community-Based Services Target Groups

- States, under prior regulation, had ability to serve only one of three target groups
- A state may combine target groups within one waiver -
 - Individuals who are aged and disabled, or both
 - Individuals with intellectual disabilities or developmental disabilities, or both
 - Individuals with mental illness
- The state must assure that the waiver meets the needs of each individual regardless of target group.

1915(c) Home and Community-Based Services Duration, Extension, and Amendment of a Waiver

- Final rule clarifies guidance regarding effective dates of waiver amendments and the influence of substantive changes
 - Substantive changes include changes in eligible populations, constriction of service, amount, duration or scope, or other modifications as defined by the Secretary

1915(c) Home and Community-Based Services Duration, Extension and Amendment of a Waiver

- Waiver amendments with changes that are substantive (as described in the rule) may take effect only on or after the date of CMS approval
- The state must provide public notice when proposing significant changes to its methods and standards for setting payment rates for services
- The state is required to establish a public input process specifically for HCBS changes that are substantive in nature (slide 43)

1915(c) Home and Community-Based Services Strategies to Ensure Compliance

- The final rule describes additional strategies CMS may employ to ensure state compliance with the requirements of a waiver, short of termination or non-renewal, such as freezing enrollment, deferring payment for a service or other actions as determined necessary by the Secretary

1915(i) State Plan HCBS Benefit

Section 1915(i) of the Act -

- Was established by Deficit Reduction Act of 2005 and was effective January 1, 2007
- Is an option to amend state plan to offer HCBS
- Is an unique type of state plan benefit with similarities to 1915(c) HCBS waivers
- Breaks the “eligibility link” between HCBS and institutional care required under 1915(c) waivers

1915(i) State Plan HCBS Benefit

The Affordable Care Act of 2010 amended 1915(i) by –

- Adding a new optional categorical eligibility group for individuals to provide full Medicaid benefits to certain individuals who will be receiving HCBS
- Authorizing states to waive comparability

1915(i) State Plan HCBS Benefit

The final rule implements the laws and requires state plan home and community based services to meet -

- Home and community-based settings requirements
- Needs-based eligibility requirement
- Minimum state plan HCBS requirement (one service at a frequency established by the state)
- Applicable targeting criteria
- Nonapplication, i.e., option to not apply certain requirements (medically needy, comparability) when determining eligibility

1915(i) State Plan HCBS Benefit

The final rule implements the laws and requires the state to establish –

- Needs-based criteria and evaluation
- Independent assessment for each individual determined to be eligible for the benefit
- Person-centered service plan
- Provider qualifications
- Definition of individual's representative
- Self-directed services
- State responsibilities and quality improvement

1915(i) State Plan HCBS Benefit – Needs-Based Criteria and Evaluation Requirement

- State establishes needs-based criteria for determining eligibility under state plan for HCBS benefit
- Needs-based criteria are factors used to determine an individual's requirements for support and may include risk factors
- State must have more stringent institutional and waiver needs based criteria
- State may modify needs-based criteria in certain situations
- Individual independent evaluation to determine eligibility with periodic redeterminations

1915(i) State Plan HCBS Benefit – Needs-Based Criteria and Evaluation Requirement

- Needs-based criteria are NOT-
 - Descriptive characteristics of the person, or diagnosis
 - Population characteristics
 - Institutional levels of care

1915(i) State Plan HCBS Benefit - Independent Assessment of Needs

- For each individual determined eligible
- Conducted at least every 12 months and, as needed, when an individual's support needs or circumstances change significantly
- Service plan is updated accordingly

1915(i) State Plan HCBS Benefit – Provider Qualifications Requirements

The state defines -

- Standards for agency and individual providers
- Standards for agents conducting evaluations, assessment, and service plan development
- Conflict of interest standards to assure independence
(Note: Conflict of interest standards apply to public and private individuals and entities)

1915(i) State Plan HCBS Benefit - Definition of Individual's Representative and Responsibilities

- Legal guardian or other person authorized under state law to make decisions regarding the individual's well-being
- Any other person authorized to represent the individual including parent, family member or advocate
- State has policies describing authorization process, extent of decision-making and safeguards
- State must meet person-centered planning process including assuring that the process provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible

1915(i) State Plan HCBS Benefit – Self-Directed Services

- Services that are planned and purchased under the direction and control of the individual (or representative)
- Services include the amount, duration, scope, provider, and location
- Person-centered service plan must meet additional requirements when individual chooses to direct some/all HCBS
- Person-centered service plan specifies employer authority, limits to authority, and parties responsible for functions outside individual authority

1915(i) State Plan HCBS Benefit

State Plan HCBS Administration

State responsibilities and quality improvement-

- Provide CMS with projected numbers of individuals to be enrolled and actual numbers from previous year
- Grant access to all HCBS needed to eligible individuals per person-centered service plan
- Implement HCBS quality improvement strategy that includes continuous quality improvement process, measures of program performance, and experience of care

Final Rule

CMS 2249-F and CMS 2296-F

- The final rule provides for a 5-year approval or renewal period for demonstration and waiver programs through which a state serves individuals who are dually eligible for Medicare and Medicaid benefits (Section 2601 of the ACA)

Final Rule

CMS 2249-F and CMS 2296-F

- The final rule provides an additional exception to the general requirement that payment for services under a state plan must be made directly to the individual practitioner when the state is the primary source of employment for a class of individual practitioners
- This additional exception will allow payments to be made to other parties in accordance with collective bargaining agreements that benefit the providers by ensuring workforce stability, health and welfare, and trainings, and provide added flexibility to states

For more information

More information about the final regulation is available:

<http://www.medicaid.gov/HCBS>

A mailbox to ask additional questions can be accessed at:

<http://www.medicaid.gov/HCBS>