OVERVIEW OF THE FEDERAL REQUIREMENTS FOR HOME AND COMMUNITY-BASED SETTINGS
January 16, 2015

Background—In January 2014, the federal Centers for Medicare and Medicaid Services (CMS) published final rules defining what constitutes a home and community-based setting for Medicaid reimbursement purposes under Section 1915(c) Home and Community-Based Services (HCBS) waivers, Section 1915(i) HCBS State Plan programs, and Section 1915(k) Community First Choice State Plan Options. The effective date of the regulations is March 17, 2014.

CMS spent several years developing the final regulations through its rule making process, compiling and analyzing numerous comments from consumers, advocates, providers, state and local government agencies and the public. The final regulations provide guidance about the qualities that make a setting home and community-based, rather than focusing on what settings are institutional in nature.

Regulatory Standards—Home and community-based settings must have all of the following qualities, based on the needs of individuals as indicated in their person-centered service plans:

- The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive, integrated settings, 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.

- The 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. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

- Facilitates individual choice regarding services and supports, and who provides them.

- In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following conditions must also be met:

    1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

    2. Each individual has privacy in their sleeping or living unit:

        - Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.

        - Individuals sharing units have a choice of roommates in that setting.

        - Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

    3. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

    4. Individuals are able to have visitors of their choosing at any time.

    5. The setting is physically accessible to the individual.

    Any modification to these additional conditions for provider-owned or controlled residential settings must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

    - Identify a specific and individualized assessed need.

    - Document the positive interventions and supports used prior to any modifications to the person-centered service plan.

    - Document less intrusive methods of meeting the need that have been tried but did not work.

    - Include a clear description of the condition that is directly proportionate to the specific assessed need.

    - Include regular collection and review of data to measure the ongoing effectiveness of the modification.

    - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

- Include the informed consent of the individual.

- Include an assurance that interventions and supports will cause no harm to the individual.

Settings That Are Not Home and Community-Based—The final regulations state that the following settings are not home and community-based settings for Medicaid reimbursement purposes under HCBS waivers or HCBS State Plan programs:

- Nursing facilities

- Institutions for mental diseases

- Intermediate care facilities for individuals with intellectual disabilities

- Hospitals

- Other locations that have qualities of an institutional setting, as determined by the Secretary of the federal Department of Health and Human Services

Additionally the regulations specify the types of settings that CMS presumes to have the qualities of an institution as:

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment;

- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution; or

- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

However, states may seek to include such settings in the Medicaid HCBS programs by presenting documentation to CMS that demonstrates a particular setting presumed to be institutional in nature meets the standards of a home and community-based setting. CMS will make a determination using the heightened scrutiny process.

State Transition Plans—CMS is requiring state Medicaid agencies to develop transition plans, with public input, to assure that its service providers fully meet the home and community-based settings requirements of the final regulations. As California's Medicaid agency, the Department of Health Care Services (DHCS) is developing a general Statewide Transition Plan (STP) covering all existing Section 1915(c) HCBS waivers and Section 1915(i) HCBS State Plan programs in California. DHCS held public meetings on draft STPs on October 21, 2014, and December 2, 2014. The final STP was submitted to CMS for approval on December 19, 2014. The STP includes a timeline that identifies the key phases of implementation. The STP can be accessed at

www.dhcs.ca.gov/services/ltc/Pages/HCBSStatewideTransitionPlan.aspx. Full compliance with the regulations must be accomplished by March 17, 2019.

Each department administering a Medi-Cal HCBS waiver or HCBS State Plan program will be developing a transition plan specific to its program area. The Department of Developmental Services (DDS) will be developing a transition plan for its HCBS Waiver for Californians with Developmental Disabilities and its HCBS State Plan program.

Implementation—There are several major phases involved in full implementation of the home and community-based settings rules. Each will require significant input from stakeholders. DDS is convening an HCBS Advisory Group and stakeholder workgroups to support all aspects of implementing the home and community-based settings requirements.

The major phases include:

- Education and outreach to consumers, advocates, providers, government agencies and the public regarding the impact of the federal regulations on service delivery and program administration.

- Assessing state statutes, regulations, policies and other written requirements for compatibility with federal home and community-based settings requirements, and determining the steps to take to achieve compliance.

- Developing criteria, tools and processes for assessing providers.

- Determining individual provider compliance through self-assessments, sampling, and on-site inspections.

- Developing policy and procedures for providers to achieve compliance.

- Modifying consumer complaint and provider appeal processes to cover issues involving home and community-based settings.

- Performing data collection, analysis, and reporting to CMS, the California Health and Human Services Agency, the Legislature and the public.

- Providing ongoing technical assistance to, and compliance monitoring of, providers.