



# Home- and Community-Based Services Rule

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# HCBS: The Basics

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# Medicaid is a State/Federal Partnership

- The Federal government matches a state contribution on an annually determined formula called the matching rate based on the state's economic picture
- The Federal share is called Federal Financial Participation
- The state share is called state match

Home- and Community-Based Services can be offered under several authorities.

# Home- and Community-Based Services: Background

- Section 1915(c) of the Social Security Act permits a state to waive certain Medicaid requirements in order to furnish an array of home- and community-based services that promote community living for certain Medicaid-eligible individuals and, thereby, avoid institutionalization.
- Waiver services complement and/or supplement the services that are available through the Medicaid State plan and other federal, state and local public programs, as well as the supports that families and communities provide to individuals.
- 1915(c) waivers remain the predominant vehicle for the delivery of HCBS nationally with more than 300 waiver programs serving more than 1 million people across the country.



# Home- and Community-Based Services

“Home- and community-based services provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.”

<https://www.medicaid.gov/medicaid/home-community-based-services/index.html>

# HCBS: Service Categories

There are four broad categories of services that states may include in Section 1915(c) HCBS waivers:

- Services that are specifically authorized or otherwise included in Section 1915(c) of the Act at Section 1915(c)(4)(b) are called Statutory Services
- Other services not specified in the statute for which the state requests the authority to provide under the provisions of 42 CFR 440.180(b)(9)
- Extended state plan services
- Supports for participant direction

These same categories of services are also available for state election within the 1915(i) HCBS as a State Plan Option

# Medicaid: HCBS Final Regulations

Watershed  
Regulations for  
Medicaid HCBS

HCBS Settings  
Character

- What is NOT community
- What is likely not community
- What is community

Person-Centered  
Planning

- Codifies requirements

Conflict-free case  
management

Was just in guidance, now it is in [rule](#)

# HCBS Final Rule Overview

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# HCBS Rule Citation

- CMS 2249-F and CMS 2296-F
- Published January 16, 2014
- Effective March 17, 2014
- Official title published in the Federal Register:

*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)*

<https://www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider>

# HCBS Rule Implementation Dates

Implementation was set for March 17, 2022, but as states responded to the Coronavirus Disease 2019 public health emergency (COVID-19 PHE), CMS recognized that its impact has necessitated changes to states' ongoing efforts to comply with the HCBS settings criteria and extended the timeline to **March 17, 2023.**

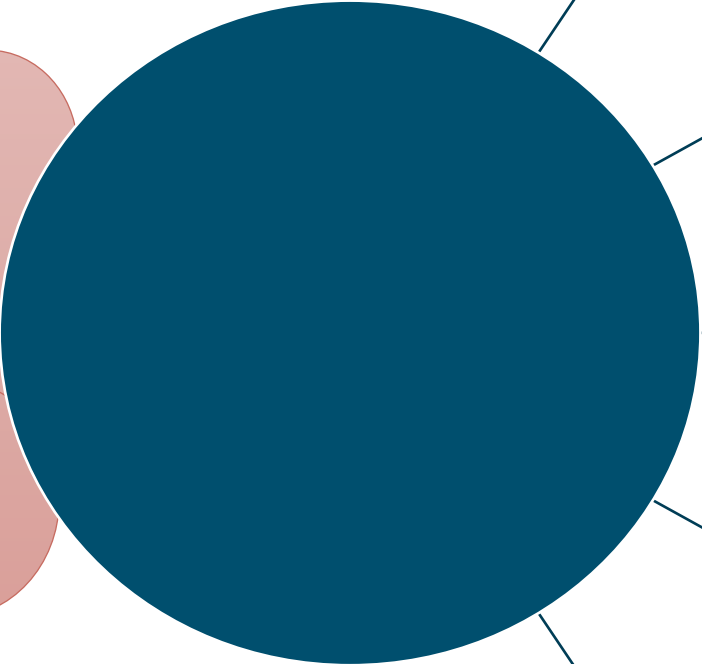
\* [Home and Community-Based Settings Regulation – Implementation Timeline Extension and Revised Frequently Asked Questions \(medicaid.gov\)](#)

# CMS Intent of the HCBS Rule

- To ensure that individuals receiving long-term services and supports through home- and community-based service 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

# Tenets of the HCBS Rule

*Friends, family, self-determination, community living, social capital and economic sufficiency*



Individual Experiences

- Focuses on the quality of the person's experiences

Community Integration

- Maximizes opportunities for community living and services in the most integrated setting

Setting Quality

- **“Qualities”** of the setting - integrated in and supports access to the greater community

Community Life Engagement

- Seek **employment** and work in competitive integrated settings, **engage in community life**, and control personal resources

Equal Access

- Receive services in the community to the **same degree of access** as people not receiving HCBS

# Tenets of the HCBS Final Rule Cont'd

- Setting is selected by the individual from among setting options
- Ensures individual rights of privacy, dignity, and respect, as well as freedom from coercion and restraint
- Optimizes autonomy and independence in making life choices
- Facilitates choice regarding services and who provides them

# HCBS Rule Broader Intent

- Aligns Medicaid funding for HCBS with the intent of the Olmstead Decision
- In line with many Department of Justice enforcement actions
- Complements the “integration mandate” of the Americans with Disabilities Act



# Person Centered Planning

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# Person-centered Service Plan....Remember...

- The person-centered plan in this context is the **overarching** plan that lays out supports, services, natural supports, addresses risks, preferences and desired outcomes
- It is NOT an individual provider plan—but may reference providers' detailed plans for achieving outcomes
- Providers contribute to but DO NOT write this plan (unless you have CMS permission under conflict of interest exceptions rule)

# Person-centered Service Plan Requirements (1 of 5)

The person-centered service plan must reflect the services and supports that are ***important for\**** the individual to meet the needs identified through an assessment of functional need, as well as what is ***important to\**** the individual with regard to preferences for the delivery of such services and supports.

## Person-centered Service Plan Requirements (2 of 5)

Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual ***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.***

# Person-centered Service Plan Requirements (3 of 5)

- Reflect the individual's strengths and preferences.
- Reflect clinical and support needs as identified through an assessment of functional need.
- Include individually identified goals and desired **outcomes.**
- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. **Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of HCBS.**

## Person-centered Service Plan Requirements (4 of 5)

- Reflect ***risk factors and measures*** in place to minimize them, including individualized backup plans and strategies when needed.
- Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with §435.905(b) of this chapter.
- Identify the individual and/or entity responsible for monitoring the plan.



# Person-centered Service Plan Requirements (5 of 5)

- Be distributed to the individual and other people involved in the plan.
- Include those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of §441.740.
- ***Prevent the provision of unnecessary or inappropriate services and supports.***



# Person-centered Planning Process (1 of 3)

- The person-centered planning process is driven by the individual
- Includes people chosen by the individual
- Offers choices to the individual regarding services and supports the individual receives and from whom
- Provides method to request updates

## Person-centered Service Planning Process (2 of 3)

- Be finalized and agreed to, with the informed consent of the individual in writing, ***and signed by all individuals and providers responsible for its implementation.***
- 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
- May include whether and what services are self-directed

# Person-centered Service Planning Process (3 of 3)

- Is the process, means and method to assure that the individual's supports reflect the person's preferences and needs
- The rules are reflective of our vision and mission statements and give us the opportunity and justification to strengthen our PCP processes  
Provides the means to identify/justify and “modifications” to individual rights
- The vehicle to develop a life that meets the expectations of the settings rules so that, (I repeat), individuals:  
“receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS...”

# Realizing Person-centered Service Planning

- PCP is not only about how case managers support the planning process
- We cannot deliver on the promise of PCP unless our system of supports and services is also person-centered
- This means individualized, customized approaches to supporting folks to have a good community life which entails new roles and business lines for providers
- Other wise we have just done “bait and switch”- by doing individualized planning and delivering the same old, same old...

# Person-centered Service Planning...Final Thoughts

- CMS has not mandated any particular method or approach, but defined a set of characteristics, processes and content that must be in the plan
- States clearly can use/propose their own approaches to fulfilling the requirements



# Conflict Free Case Management

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## Guidance is Now Rule

“Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual **must not provide case management or develop the person-centered service plan...**”

§441.301(c)(1)(vi)

# Guidance is Now Rule – 1915i (1 of 2)

- The 1915i regulation is even more prescriptive at §441.730(b)  
Provider qualifications

(b) Conflict of interest standards. The State must define conflict of interest standards that ensure the independence of individual and agency agents who conduct (whether as a service or an administrative activity) the independent evaluation of eligibility for State plan HCBS, who are responsible for the independent assessment of need for HCBS, or who are responsible for the development of the service plan. The conflict of interest standards apply to all individuals and entities, public or private.

# Guidance is Now Rule – 1915i (2 of 2)

- At a minimum, these agents [performing evaluation, assessment and service planning] must **not be any of the following**:
  - Related by blood or marriage to the individual, or to any paid caregiver of the individual.
  - Financially responsible for the individual.
  - Empowered to make financial or health-related decisions on behalf of the individual.
  - Holding financial interest, as defined in §411.354 of this chapter, in any entity that is paid to provide care for the individual.

# Exception to the Rule

- Per CMS:
  - “If a state employs this exception it must guarantee the independence of this function(s) within the provider entity.. *We also will not permit states to circumvent these requirements by adopting state or local policies that suppress enrollment of any qualified and willing provider.*”

# CMS Expectations for an Exception to the Rule

**Rural areas** with limited providers may pass muster but CMS expects a higher level of quality management and scrutiny over services by another entity such as the state or contracted quality oversight organization

**Managed care arrangements:** CMS has permitted care managers in the MCO to be case managers but has required that assessment be overseen and eligibility be determined by a separate entity (such as the State Medicaid agency) and that no provider of services listed on the plan do assessment or service planning

# Safeguards for an Exception to the Rule

“In certain circumstances, we (CMS) may require that states develop "firewall" policies, for example, separating staff that perform assessments and develop person-centered service plans from those that provide any of the services in the plan; and meaningful and accessible procedures for individuals and representatives to appeal to the state.”

# Safeguard Examples for an Exception to the Rule (1 of 2)

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

**\*\*HCBS Waiver Technical Guide p. 180**



# Safeguard Examples for an Exception to the Rule (2 of 2)

- Direct oversight of the process or periodic evaluation by a state agency;
- Restricting the entity that develops the person-centered service plan from providing services without the *direct approval of the state*; and
- Requiring the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

# Conflict Free Case Management - Final Thoughts

- CMS is serious about conflict of interest
- If we are serious about protecting individuals' choice of supports this is an opportunity to reform our systems
- We have the opportunity to create dedicated, stand-alone organizations whose only mission is case management
- The exception is really that and CMS seems to be holding firm in their expectations

# HCBS Settings

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# HCBS Settings – Important to Note

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 to NOT be HCBS

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

# Settings That Isolate (1 of 2)

- The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.
- The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.
- The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.)

## Settings That Isolate (2 of 2)

- People in the setting have limited, if any, interaction with the broader community.
- Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).

Source: CMS guidance: [settings-that-isolate.pdf](#)  
([medicaid.gov](#))

# CMS Guidance: Examples of Settings that Isolate

- Farmstead or disability-specific farm community
- Gated/secured “community” for people with disabilities
- Residential schools
- Multiple settings co-located and operationally related (i.e., operated and controlled by the same provider) that congregate a large number of people with disabilities together and provide for significant shared programming



# Presumed Settings Can Still Be Considered HCBS If....

- 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
- The rules give the Secretary of HHS the discretion to ascertain if certain settings meet the HCB settings character
- That means that with regard to the settings described on the previous slide, states may make the case that the setting(s) *does* meet HCB settings character

# HCBS Settings: Not Just Residential

*The rules are not just about where people live...the HCBS settings requirements apply to ALL HCBS settings....*

CMS noted in the rule comments...:

“To the extent that the services described are provided under [Medicaid funded HCBS] (for example, residential, day, or other), they must be delivered in settings that meet the HCB setting requirements as set forth in this rule.

# HCB Settings Requirements

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.

The setting options are identified and documented in the person-centered service plan

The setting options 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, respect and freedom from coercion and restraint

Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS

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

Optimizes individual initiative, autonomy, and independence in making life choices

Facilitates individual choice regarding services and supports and who provides them

[Assisting Providers in Ensuring Settings Facilitate Community Inclusion \(medicaid.gov\)](https://www.medicaid.gov)

# Meeting the HCBS Settings Rule: “Exploratory Questions” (1 of 2)

For residential, CMS suggest states ask things like:

- Was the individual given a choice of available options regarding where to live/receive services?
- Was the individual given opportunities to visit other settings?
- Does the setting reflect the individual’s needs and preferences?
- Does the individual shop, attend religious services, schedule appointments, have lunch with family and friends, etc., in the community, as the individual chooses?
- Does the individual come and go at any time?
- Was the individual given a choice of a roommate?
- Does the setting assure that tasks and activities are comparable to tasks and activities for people of similar ages who do not receive HCB services?
- Does the setting provide opportunities for regular meaningful non-work activities in integrated community settings for the period of time desired by the individual?

# Meeting the HCBS Settings Rule: “Exploratory Questions” (1 of 2)

For day services, CMS suggest states ask things like :

- Does the setting allow individuals the freedom to move about inside and outside of the setting as opposed to one restricted room or area within the setting? For example, do individuals receive HCBS in an area of the setting that is fully integrated with individuals not receiving Medicaid HCBS?
- Is the setting in the community/building located among other residential buildings, private businesses, retail businesses, restaurants, doctor’s offices, etc. that facilitates integration with the greater community?
- Do employment settings provide individuals with the opportunity to participate in negotiating his/her work schedule, break/lunch times and leave and medical benefits with his/her employer to the same extent as individuals not receiving Medicaid funded HCBS?

# Provider-Owned or Controlled Residential Settings (1 of 2)

- What is “provider-controlled”?
  - This means the agency or people supporting the person also own the place where the person lives
  - “Provider controlled” means if the person doesn’t want the provider to support her/him any more, the person would have to move to a new place
- CMS has laid out some specific guidance for places where the services and living arrangement are combined, that is housing and supports are “bundled” together by one provider



# Provider-Owned or Controlled Residential Settings (2 of 2)

- The rule requires that the person has a legally enforceable agreement with the landlord (the provider) about the rules about where the individual lives
- This means the person has the same responsibilities and protections from eviction as all tenants under landlord/tenant law of state, county, city or town.
- If tenant laws do not apply, state must make sure that individuals have a lease, residency agreement or other written agreement in place providing protections about eviction processes and appeals that are the same as those provided under the locality's landlord tenant law

# Provider-Owned or Controlled Residential Settings: Additional Characteristics

- The person has privacy in the sleeping or living unit
- The person's room has lockable entrance doors, with the individual and appropriate staff having keys to doors as needed
- If the person shares a room and/or the home they have a choice of roommates
- The individual has the freedom to furnish and decorate their bedroom or residence according to what the lease says
- The person has the freedom and support to control his/her schedules and activities and has access to food any time
- Individuals may have visitors at any time
- Setting is physically accessible for the person



# Settings Requirements Modifications

- CMS has developed a set of criteria that must be met when there are “modifications” to the settings requirements for an individual
- Basically this is about any restrictions such as limiting access to food or visitors
- Modifications must be part of the person-centered plan, time limited and have a specific purpose or reason

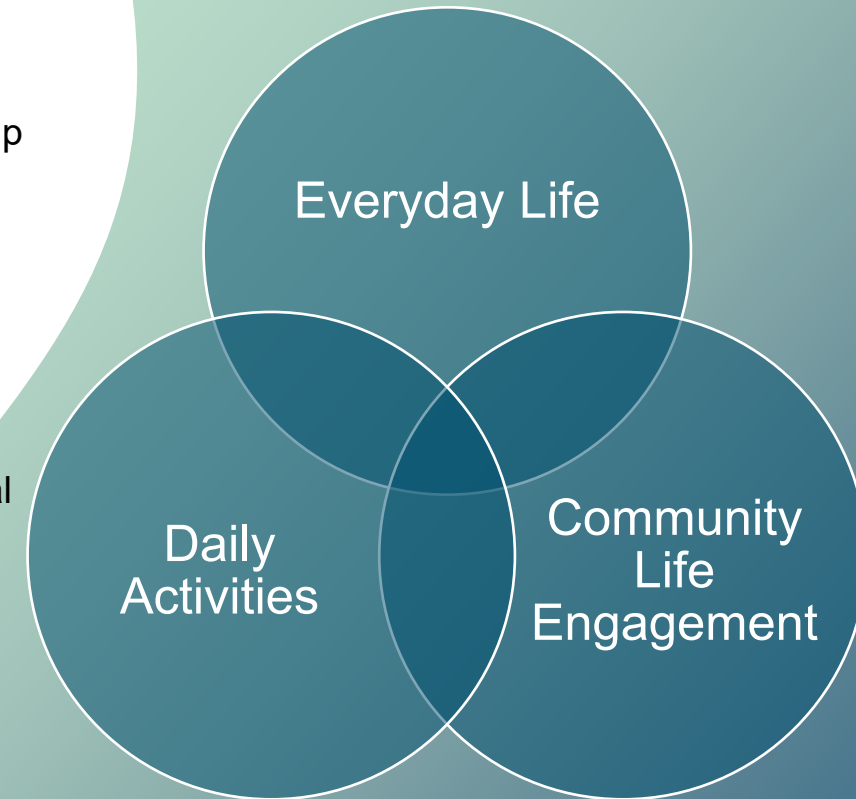
# Settings Requirements in Practice

**Planned activities** in the home community within all of life's activity domains:

- Work
- Volunteer work - at soup kitchen, community clean up, or other neighborhood service
- Learning experiences and activities; books on tape; book clubs and art classes; self-help classes;
- Joining community organizations
- Recreation – swimming, bowling, dancing, movies
- Social Life – getting together with family and friends; family and friends visit the person in their home
- Peer support groups
- Shopping
- Maintain health and wellness – walking; gym membership; diet groups; going to medical appt.
- Personal care – hairstyling, having nails done,
- Maintaining home; maintenance and improvement; cleaning; laundry
- Caring for others; relatives or friends
- Spirituality: worship; meditation; yoga classes;
- Hobbies: Pet care – walking the dog; gardening, painting; photography
- Going on vacation

## **Unplanned interaction with the community**

Quick stop at the convenience store; borrowing items from a neighbor, waiting at the bus stop, shoveling snow a neighbor, walking the dog, hanging out at the pizza parlor, greeting the delivery man, answering the door when the boy scouts collect for the food drive, etc.



# Statewide Transition Plan

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# Transition plan

- Every state is required to file a plan with CMS on how the state will comply with the new rules
- Some states have held public forums and sent in a plan on how they will figure out what might need to change
- When the state, working with stakeholders, identifies areas for change, they will work with people individually on making choices they want

# Transition plan

- Based on what the state learns about what might need to change, they will submit—with public comments—an updated plan
- This process will take some time-the state must comply with the rules by March 17, 2023
- CMS site on transition plans: [Statewide Transition Plans | Medicaid](#)

# Status of Transition plans

- As of July 8, 2021:

24 States have initial STP approval: AL, AZ, CA, CO, L, GA, HI, IN, IA, LA, MD, MI, MS, MO, MT, NE, NH, NM, NC, NY, OH, PA, RI, SC, SD, UT, VT, VA, WV, WI

- 5 States Do not Have Initial Approval yet
- 15 States have final STP approval: AK, AR, CT, DC, DE, ID, KY, MN, ND, OK, OR, TN, UT, WA, WY

# Opportunities in the new rules

- A strong focus on real jobs!!
- A strong focus on person-centered planning
- Room for new ideas about living arrangements
- Protections for people who live in provider-controlled settings
- Case management fully focused on the individual's needs and preferences

# The new rules...

- Give us a LOT to think about
- Probably a LOT to do
- But the rules represent an incredible opportunity to bring our supports and services closer to what we aspire to in our system values and vision statements....





# Questions

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# Resources

[HCBS Rule](#)

[CMS Regulation Overview](#)

[CMS Final Rule Q&A](#)


[CMS HCBS Settings Requirements](#)

[CMS HCBS Settings Q&A](#)



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