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FAQ – CMS Final Rule (CMS 2249-F/CMS2296-F) Impact on Non-Residential Services in Indiana

- *Link to BDDS training webinar on HCBS Final Rule & Non-Residential Self-Assessment (sessions of August 8 and 9, 2016) posted at* **https://indiana.adobeconnect.com/p2amy2tfth9/**
- *PDF of related PowerPoint posted at* **http://www.in.gov/fssa/files/Non-Residential%20Self-Assessment.pdf**

ABOUT THE HCBS SETTINGS FINAL RULE

1. What is the HCBS settings rule?

In January 2014, the federal Centers for Medicare and Medicaid Services (CMS) issued a new federal rule (CMS-2249-F/CMS-2296-F) impacting sections of Medicaid law under which states may use federal funds to pay for home and community based services (HCBS). The rule supports enhanced quality in HCBS programs and adds protections for individuals receiving services. In addition, this rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting.

Sometimes referred to as the HCBS settings rule, the rule impacts all HCBS waiver programs administered by the Family and Social Services Administration (FSSA). The context of this FAQ addresses impact of the rule only on the ***Family Supports (FSW)*** *and the* ***Community Integration and Habilitation (CIH) Waivers*** *serving individuals with intellectual/developmental disabilities. The FSW and CIH waivers are administered by the Division of Disability and Rehabilitative Services (DDRS)'s Bureau of Developmental Disabilities Services (BDDS).*

Relevant to the FSW and CIH, the rule defines and describes the requirements for home and community-based settings appropriate for the provision of services under our section 1915(c) HCBS waivers, and the person-centered planning requirements for section 1915(c) HCBS authority of the Social Security Act, or the Act.

The rule requires that all of the settings in which Medicaid-reimbursed HCBS are provided, including both residential and non-residential (day services), are integrated in and support full access to the greater community. This includes opportunities for people receiving HCBS to seek employment, work in integrated settings and earn a competitive wage. The rule also requires the inclusion of opportunities for people receiving HCBS to spend time with others who don't have disabilities and to use community services and participate in activities (like shopping, banking, dining, transportation, sports, fitness, recreation, and church) in their communities to the same degree of access, meaning in the same way, that people who don't have disabilities do. In other words, the opportunities and experiences offered to the waiver participant should be empowering, allowing their lives to look like ours in terms of independence, choice, and community integration.

All states must comply with the new rule. While states will be given time to come into compliance, after a reasonable period, Medicaid funding can no longer be used to pay for HCBS delivered in

settings that do not comply with the new rule. A "reasonable period" is the time needed to complete actions that are necessary to comply with the new rule. While CMS is giving states until March of 2019 to achieve full compliance, states are expected to bring settings into compliance as quickly as possible. States cannot simply continue to pay for services in noncompliant settings until the March 2019 deadline. If a setting is not expected to come into compliance, states are expected to begin helping individuals served in the setting transition as soon as possible to other services or settings that do meet the federal HCBS setting requirements.

*****For additional information, see*** 1915(i) State Plan HCBS, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) HCBS Waivers - CMS-2249-F/CMS-2296-F

2. What is a setting?

As it relates to the new federal rule, the setting is any location where home and community-based services (HCBS) paid for by Medicaid are delivered. In other words, the setting is where a waiver participant receives the waiver-funded services that he or she selected with the agreement of the Individualized Support Team. Settings may include the location where the waiver participant resides (residential setting), as well as employment sites, and any location where the waiver participant volunteers or attends therapies, day programs, or sheltered workshops (non-residential settings).

To be compliant, HCBS settings must be integrated into the community—meaning that the individuals who receive services are able to spend time with other people who don't have disabilities and access community services the same way that people without disabilities do. The setting should not look or feel like an institution.

The home and community-based setting provisions in the final rules established a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The purpose of the home and community-based settings requirements is to maximize the opportunities for participants in HCBS programs to have access to the benefits of community living and to receive services in the most integrated setting.

While a setting and a service are not the same thing, each waiver-funded service takes place in a setting (a type of program or an environment), and that setting must meet the requirements of the HCBS final rule. The setting's physical location where the service is delivered is the site. For example, a setting could be "a veterinary office" where the participant works part time or volunteers. The site might be the Animals R Us Clinic. Another example of a setting might be "a business office", and the site might be "the billing office of Dr. Care". Or, the setting might be an Adult Day Care facility, while the site might be the building at Good Day Facility at 123 East 4th Street.

*****For additional information, see §441.530 Home and Community-Based Setting at*** **http://www.ecfr.gov/cgi-bin/text-idx?SID=e9bc8bc6ca91c40d051a86914549fb27&mc=true&node=pt42.4.441&rgn=div5#se42.4.441_1530**

3. Are these changes that Indiana is making or are these federal changes?

The HCBS settings rule is a federal rule. It was issued in January 2014 by the Centers for Medicare and Medicaid Services (CMS). CMS is the federal agency that must approve each of the Medicaid waiver programs that provide home and community based services (HCBS) to people with

intellectual/developmental disabilities. CMS pays for about 2/3 of the cost of HCBS provided in these waiver programs. To keep getting these federal funds, we have to follow their rules.

4. Is every state making the same changes to their HCBS waiver programs?

The new HCBS settings rule is a federal rule and every state that receives federal Medicaid funding to provide home and community based services (HCBS) must comply with this rule in order to keep getting federal Medicaid funds. However, every state has to decide how their state will assess and comply with the new rule.

In addition to the HCBS settings rule, states must comply with other federal laws that protect the rights of people with disabilities to be served in integrated community settings, including the Americans with Disabilities Act (ADA).

5. How will the HCBS settings rule affect the sheltered workshop or facility I attend?

Sheltered workshops and facility-based day programs are designed specifically for people with disabilities and in many cases, don't appear to comply with the new federal HCBS settings rule. Except for paid staff, people receiving services in these settings usually have limited, if any, interaction with people who do not have disabilities or with the greater community during the hours this service is provided. Change may be required for facility-based programs in order to continue to receive Medicaid funding.

6. Does this mean that the sheltered workshop I attend will have to close?

The new rule does not mandate sheltered workshops close. However, it does require workshops meet a specific set of standards and dictate where services reimbursed by Medicaid can be provided.

Medicaid funds cannot be used to pay for employment (or vocational) services in a sheltered workshop. Medicaid funding can be used to pay for pre-vocational services in a sheltered workshop, but only if the services are time-limited, and intended to help prepare the person to work in an integrated setting.

It's important to note that even in those situations, there is an expectation that people are engaged in the greater community rather than being isolated in a sheltered workshop.

It's also important to understand that the impact of the HCBS settings rule on Medicaid reimbursement of services in a sheltered employment setting is not new. In 2011, CMS issued guidance to states which made clear that Medicaid waiver funding could not be used to pay for vocational services (i.e., employment services) in a sheltered employment setting. The 2011 guidance also said Medicaid payment for pre-vocational services in a sheltered setting must be time-limited, and only to prepare a person to transition into employment in integrated settings.

*****For additional information**, see the now archived version of the September 16, 2011 CMCS Informational Bulletin on* **Updates to the §1915 (c) Waiver Instructions and Technical Guide regarding employment and employment related services (archived at https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf),** *now incorporated into the January 2015* ***Version 3.5 Instructions, Technical Guide and Review Criteria*** *published by CMS to instruct states on preparing waiver applications for review and approval by CMS.*

7. Does this mean that the facility-based day program I attend will have to close?

No, the new rule does not say that facility-based day programs must close. It does, however, dictate where services that are reimbursed by Medicaid can be provided. Medicaid funds can only be used to pay for services that comply with the new HCBS settings rule and include opportunities to spend time with people in the community who don't have disabilities and aren't paid staff.

8. What changes will have to be made in order for the facility to stay open?

Each provider has the opportunity to decide how best to transition their programs into compliance with the new federal rule. Providers may engage the people they support, local advocacy groups and families in developing a transition plan. Employment providers may step up their efforts to help people that have been employed in sheltered settings find jobs and transition to integrated employment, earning a competitive wage. Providers may find ways to ensure that people participating in facility-based programs for some portion of their day or week also have opportunities to engage in work or non-work activities in integrated community settings.

The Indiana FSSA, OMPP and DDRS/BDDS are committed to helping providers with these transitions and will assist providers in their efforts to come into compliance.

9. What are some ways that a Facility Based Workshop will be able to become compliant with this rule?

Providers are asked to look at the following documents for guidance on compliance:

- *HCBS settings final rule* (1915(i) State Plan HCBS, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) HCBS Waivers - CMS-2249-F/CMS-2296-F);
- *the DDRS/BDDS waiver service definitions* (http://provider.indianamedicaid.com/media/155628/ddrs%20hcbs%20waivers.pdf); *and*
- *the Statewide Transition Plan for compliance* (Amended Statewide Transition Plan).

As each provider agency is unique, providers will need to network, compare, and decide how to expand or change/transition in order to come into compliance. Assistance will be provided by the State, but provider-specific transition plans must be submitted to the state for review, approval, and monitoring during implementation as well as ongoing maintenance of compliance.

10. What if I don't want to work or I'm not able to work?

The federal HCBS settings rule doesn't require that every person work. It does require, however, that everyone has the opportunity and the supports needed to work in an integrated setting and to participate fully in their communities. It's important that each person receiving HCBS understand that they can work and have the supports they need to work, no matter how significant their disabilities. It's also important that providers help people explore jobs that would match interests and abilities with opportunities to be productive and earn a competitive wage or develop customized employment opportunities.

If a person is no longer working age or doesn't want to work, the other services the person receives must comply with the new HCBS settings rule and include opportunities to spend time with people in the community who don't have disabilities and participate in community services and activities. This includes both residential and day services options.