FINAL RULE CMS 2249-F/CMS 2296-F: A SUMMARY

I. Introduction

The final rule is known as both CMS 2249-F and CMS 2296-F, published in the Federal Register on January 16, 2014. The intent of the rule is to ensure that individuals receiving services through §1915(c), §1915(i) and §1915(k) programs have full access to the benefits of community living and to enhance their quality of life. These regulations assist states to meet their Olmstead obligation[1] to offer individuals services in the least restrictive setting.

The final rule is the combined response to public comments to the proposed rule on May 3, 2012 and April 15, 2011. More than 2000 comments were received.

The rule aligns the setting requirements of home and community-based services (HCBS) across three Medicaid authorities; §1915 (c), §1915(i) and §1915(k). The rule also defines person-centered planning requirements for §1915 (c) and §1915(i). It also implements regulations for the §1915(i) state plan benefit.

II. Highlights of the Final Rule:

- Provides **implementing regulations for §1915(i) State Plan HCBS**, including new flexibilities enacted under the Affordable Care Act to offer expanded Home and Community-Based Services (HCBS) and to target services to specific populations;
- Includes a **payment reassignment** provision;
- **Defines and describes the requirements for HCBS settings** §1915(c) waivers, §1915(i) State Plan and §1915(k) (Community First Choice) authorities;
- **Defines person-centered planning** requirements across the §1915(c) and §1915(i) authorities;
- Provides states with the **option to combine coverage for multiple target populations into one waiver** under §1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focus on functional needs;
- **Allows states to use a five-year renewal cycle** to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare such as §1915(b) and §1915(c).[2]

III. Implementing Final Regulations for §1915(i)

"The final rule implements the §1915(i) HCBS state plan option, including new flexibilities enacted under the Affordable Care Act that offer states the option to provide expanded home and community-based

[1] See CMS Press release from May 20, 2010 for a summary of Olmstead Obligations: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd10008.pdf

[2] This bulleted list is from the CMS Press Release: Home and Community Based Services. (n.d.). Retrieved April 09, 2014, from http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-10-2.html

services and to target services to specific populations."[3] This authority allows states to develop HCBS programs that are not tied directly to the institutional requirements and allows states to develop their own medical eligibility criteria. Section 1915 (i) criteria must be less stringent than institutional and waivers needs-based criteria. Person-centered planning is required. Also, individuals must receive an independent evaluation to determine eligibility with periodic redeterminations. Under this authority, the state may define a target population. As with other state plan services, the benefits must be provided statewide, and states must not limit the number of eligible people served. This authority categorically supports participant direction and all the associated support functions by urging states to afford participants with the opportunity to self-direct using both employer and budget authority.

Provider payment reassignment is also an option on the ruling. Section 1902(a)(32) of the Act provides that states may allow payments only to certain individuals or entities. More specifically, payment may only be made to an individual practitioner who provided the service. This ruling broadens the scope of the direct payment requirement to allow the state to claim as a provider payment amounts that are not directly paid to the provider, but are withheld and remitted to a third party on behalf of the provider for health and welfare benefits contributions, training costs, and other benefits customary for employees.[4]

A. Implications

The final rule provides significant support of the self-directed option. The ruling includes definitions self-direction, employer authority, budget authority, individual budgets, and requires the support functions of information and assistance and financial management services. Voluntary training must be an offering under the support system. With this final ruling, states are provided opportunities to create a set of unique services for a specific population without meeting the rigorous criteria for admissions to an institution. Many states have been waiting for the rule to be finalized to begin designing new programs. Now that the final rule is in place, more states may create self-directed opportunities for specific target groups not meeting the criteria for admission to an institution.

Now that direct payment to individuals other than to those directly providing the service is permissible, states can have the flexibility to offer workers of self-directed services health care, skills training, and other benefits customary for employees. By offering benefits to direct service workers, the quality of self-directed services will improve. Providing the workforce with the opportunity to improve its ability to function as health care providers and advance knowledge through skills training serves to strengthen this unique workforce.

IV. Defining and Describing the Home and Community-Based Setting

"The Centers for Medicare and Medicaid Services (CMS) definition of home and community-based settings has evolved over the past five years, based on experience throughout the country and extensive public feedback about the best way to differentiate between institutional and home and community-based settings. CMS is moving away from defining home and community-based settings by "what they are not" and toward defining them by the nature and quality of participant's experiences. The new approach is more outcome-oriented rather than based solely on a setting's location, geography, or physical characteristics. This change will effectuate the law's intention for Medicaid Home and Community-Based Services (HCBS): to provide alternatives to services provided in institutions, and maximize the

[3] Home and Community Based Services. (n.d.). Retrieved April 09, 2014, from http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-10-2.html

[4] Federal Register/ Vol. 79, No. 11 / Thursday, January 16, 2014 / Rules and Regulations

opportunities for waiver participants to have access to the benefits of community living, including receiving services in the most integrated setting."[5]

For 1915(c) home and community-based waivers and for 1915(i) State plan HCBS, home and community-based settings must have all of the following qualities defined in §441.301(c)(4) and §441.710 respectively, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

§441.301(c)(4):

(i) 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.
(ii) 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.
(iii) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
(iv) 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.
(v) Facilitates individual choice regarding services and supports, and who provides them.
(vi) In a provider-owned or controlled residential setting, in addition to the qualities specified above, the following additional conditions must be met:
    (i) 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. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
    (ii) Each individual has privacy in their sleeping or living unit:
        (1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
        (2) Individuals sharing units have a choice of roommates in that setting.
        (3) Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.
    (iii) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
    (iv) Individuals are able to have visitors of their choosing at any time.
    (v) The setting is physically accessible to the individual.
    (vi) Any modification of the additional conditions specified in §441.301(c) (4) (vi) (A) through (D), 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:

[5] www.nasuad.org. (n.d.). Retrieved April 9, 2014. From, http://www.nasuad.org/sites/nasuad/files/HCBS%201915%28c%29%20Final%20Rule%20Fact%20Sheet%20final%201-10-14.pdf

(1) Identify a specific and individualized assessed need.
(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(3) Document less intrusive methods of meeting the need that have been tried but did not work.
(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.[6]
(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(7) Include the informed consent of the individual.
(8) Include an assurance that interventions and supports will cause no harm to the individual.[7]

A. Settings That are Not Home and Community-Based:

1. For 1915(c) home and community-based waivers, settings that are not home and community-based are defined at §441.301(c)(5) as follows:
   (i) A nursing facility;
   (ii) An institution for mental diseases;
   (iii) An intermediate care facility for individuals with intellectual disabilities;
   (iv) A hospital; or
   (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary.
2. For 1915(i) State plan home and community-based services, settings that are not home and community-based are defined at §441.710(a) (2) as follows:
   (i) A nursing facility;
   (ii) An institution for mental diseases;
   (iii) An intermediate care facility for individuals with intellectual disabilities;
   (iv) A hospital; or
   (v) Any other locations that have qualities of an institutional setting, as determined by the Secretary.

B. Settings that are Presumed to have the Qualities of an Institution:

For 1915(c) home and community-based waivers, § 441.301(c)(5)(v) specifies that the following settings are presumed to have the qualities of an institution, and therefore are not home and community-based settings: "Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or 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."[8]

---

[6] See the electronic version of the Code of Federal Regulations: http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=ac81c0821207fd1255a4c1da2833a27d&ty=HTML&h=L&r=PART&n=42y4.0.1.1.10#42:4.0.1.1.10.7.112.2

[7] See Code of Regulations online at: http://www.gpo.gov/fdsys/pkg/CFR-2013-title42-vol4/pdf/CFR-2013-title42-vol4-sec441-301.pdf

[8] Ibid.

C. Implications

In the current system, group living, shared living, in-home residential homes, and assisted living facilities are considered home and community-based settings and are counted as diversions to institutionalization. This new definition of (HCBS) settings will require these settings to significantly modify their operations to comply with the new setting requirements. Under the new regulations, residents must be afforded greater access to the community and greater freedom within the setting. Individuals living in group homes, shared living, in-home residential homes and assisted living facilities are also provided more choice and control over the services they receive and who provides those services, so long as the services are not included in a bundled rate (services are included in the reimbursement rate). If not reimbursed using a bundled rate, the potential for self-direction in these settings may expand over time, thus promoting self-direction to a greater degree.

V. Person-Center Service Plans

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS program under §1915(c) and §1915(i) of the Social Security Act must be developed through a person-centered planning process that addresses health and long-term services and supports in a manner that reflects individual values, preferences and goals. The person-centered planning process is directed by the individual with long-term support needs, and may include a representative and others, chosen freely by the individual, to contribute to the process. Minimum requirements of the process include individually defined goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, education and others. The plan should reflect the services and supports, who provides them and whether an individual chooses to self-direct his or her services. The planning process and the resulting person-centered service plan will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.[9]

A. Implications

Person-centeredness is now a requirement for §1915(c), (i), (j) and (k). This covers most of the HCBS waiver programs but it does not cover State Plan services outside (i), (j), or (k). In the past, HCBS programs adopting the use of the person-centered approach have typically adopted the developmental disability model. This model is a formal and well-defined approach that is continuous throughout the life of the individual. It includes a team approach composed of the individual, family members, case managers, medical professionals, and friends who meet frequently to discuss the life of the individual in a collaborative manner but led by the individual. It is here that major life decisions about services, education, employment and living arrangements are discussed. This approach is more formal in nature and requires routine planning meetings.

Applying this model to other populations has been problematic and has been unsuccessful in considering the unique attributes of other populations. For example, younger persons with disabilities typically focus on people seeking personal power over their individual life situations, using the principles of the independent living movement. This model emphasizes the power of the individual to exercise control both individually and systemically thorough the direct involvement with the development and management of the service system as well as exercising active decision-making about all aspects of his or her individual services and supports. The frequency of contact will depend on the preferences of the individual and outside assistance may or may not be preferred. Another example are persons with disabilities who are elderly (65 and older). Typically elders have lived a full life and are now adjusting

[9] Home and Community Based Services. (n.d.). Retrieved April 09, 2014, from http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-10-2.html

and managing major life challenges. For example, elders with disabilities are adjusting to living with a chronic illness and are adjusting to functional and social limitations. They are interested in maintaining the same lifestyle and they are focused on the "now" of the situation as opposed to the "future." Applying the principles of developmental disability person-centered practices to a disabled/elderly population has been challenging due to these particulars. Now that person-centered planning is a requirement, programs may face difficulties adapting person-centeredness to fit the unique culture of the various populations and adjusting to individual preferences. This requirement will not be successfully implemented with a one-size-fits-all approach, so training must adapt to each culture. Individual targeted training must be developed for participants, front-line staff, and organizations and consider the unique attributes of each target group. As a required function/activity, the process must be monitored to ensure compliance with the regulation and requires the development of a new set of performance indicators to measure the success of how well person-centeredness is implemented and managed from the system and individual perspective.

The practice of person-centeredness has been an original and essential element of participant direction. As an essential element, individuals must be provided with appropriate support in decision-making and self-expression. With this legislative mandate, the Center is in a unique position to offer training to staff, promote a person-centered system, assess the health of this person-centered system and apply performance standards to the provision of person-centeredness.

VI. Combining Waiver Populations

With the finalization of the §1915(i), states have the option to combine coverage for multiple target populations into one waiver under §1915(c), to streamline the administration of HCBS waivers, and to facilitate the use of waiver designs that focus on functional need rather than diagnosis. A state can combine target groups within one waiver individuals who are aged, or disabled, with intellectual or developmental disabilities, and/or with mental illness. States must ensure that no group is dropped when combining waivers.

The final rule clarifies the effective dates of the waiver amendments. Waiver amendments with substantive changes can only be approved for the future, not retrospectively.

States must provide public notice when proposing significant changes. States are required to provide a public input process for changes that are substantive.

A. Implications

This new rule allows participant-directed programs to be combined under the same administrative structure. Combining the administration of programs can help achieve economies of scale for FMS functions, greater attention to the provision of information and assistance, streamlined efficiencies in monitoring, closer scrutiny to developing individual budget methodologies and standardizied quality assurance and improvement strategies..

This new ruling may significantly impact the Medicaid waiver culture. The results of an informal survey by CMS noted that over 50% of the waiver programs are considering combining multiple waivers into one. Prior to this ruling, states were permitted to combine programs only under the §1115 Demonstration authority.

Critics of this new rule cite concerns over the fear that the more robust individual budgets for the developmental and intellectual disability populations may be reduced when directly compared to the limited budgets for adults and elders with disabilities.

VII. Adjust Renewal Cycle

The final regulations allow states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare such as §1915(b) and §1915(c); this simplifies administration of the program for states.

A. Implications

States, who normally manage multiple waivers with different reporting requirements, timelines, and renewal time periods, could have their administrative burden greatly reduced as a result of the regulations. Currently, most states electing managed care are adopting §1115 Demonstration. But states may now be more likely to use the authority found at §1915(b) and (c).

VIII. Conclusion

The final ruling has significant implications for home and community-based services. It provides states with additional flexibility and opportunity to support not only home and community-based services but self-direction as a service delivery system. It allows states to target specific populations under self-direction, requires person-centered planning, clarifies home and community-based settings, and permits payment assignment to support direct service workers, and combines populations to improve operationally efficiencies. It serves to positively impact the state's ability to provide valuable programs in the manner of their choosing.