

Issue Brief:

New Medicaid Regulation Makes Changes to Home and Community-Based Services

Summary

On January 10, the Centers for Medicare and Medicaid Services (CMS) issued a new regulation regarding home and community-based services (HCBS). The rule finalizes regulations proposed in 2012 and responds to the almost 1,700 public comments.

The rule streamlines the definition of HCBS across the Medicaid program and strengthens the requirements for autonomy and community integration in services. It puts specific rules on provider-owned or controlled residential settings and requires each person receiving HCBS to have a person-centered plan. The rule applies to all HCBS settings, but the most immediate and direct impact will be on provider-owned residential settings, including traditional group homes. People living in these settings have new protections for privacy and choice and a person-centered process for any necessary modifications to the protections.

The rule creates new requirements for planning and assessment. Each person receiving HCBS will have a person-centered plan. The process of writing the plan is to be controlled – to the extent possible – by the individual receiving services. The team writing the plan should include people chosen by the individual, including family and friends. For those receiving 1915(i) state plan services, the rule finalizes the individual assessment process for determining which services are needed, including a caregiver assessment.

Background

The rule aligns regulations for home and community based services (HCBS) across the three sections of Medicaid law that govern HCBS – 1915(c), 1915(i), and 1915(k). The 1915(c) waiver is the original HCBS waiver and is used by almost all states to provide services for people with disabilities in the communities. The 1915(i) state plan option was created in 2006 and improved in the Affordable Care Act in 2010 as a way to provide HCBS without waivers. The 1915(k) Community First Choice Option (CFCO) was created in the Affordable Care Act and creates access to HCBS without a waiting list for eligible people in states that adopt the CFCO.

Details of The New Rules

Home and Community-Based Settings

The final rule creates a single definition of home and community-based settings for 1915(c), 1915(i), and 1915(k) HCBS. Home and community-based settings must be integrated in the greater community, include opportunities to seek competitive and integrated employment, be selected by the individual, and protect individual privacy, dignity, autonomy, independence, and choice in services.

For residential services where the provider owns or controls the residence, the rule creates additional requirements, including that the unit must be a specific physical place with lockable doors and entrances and with choice of roommates, furnishing, and schedules.

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These additional requirements on provider-owned or controlled settings can be modified if required for the health and safety of the individual. Modifications must be justified by a specific need and documented in the individual's person-centered plan, including many requirements for less intrusive methods and collection of data on the effectiveness of the modification, as well as individual consent and assurances that the modification will not harm the individual.

The rule also lists specific settings that are never considered home and community-based, so services in these settings cannot be funded through HCBS waivers or state plan authorities. These include:

- Nursing facilities
- Institutions for mental diseases
- Intermediate care facilities for people with intellectual disabilities
- Hospitals

The rule also states that CMS will presume certain settings are not home and community-based, unless presented with evidence to the contrary. These include settings located in buildings that also provide inpatient treatment or are located on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating people from the broader community. CMS will presume that these settings are not home or community-based unless the state presents evidence that they have the qualities of home and community settings and not institutions.

Person-Centered Plan

The rule requires a person-centered plan for each person receiving Medicaid HCBS. It lays out requirements for both the plan and the process of writing the plan. The plan writing process must include people chosen by the individual, support the individual to understand and direct the plan, and reflect the individual's cultural preferences. The plan must reflect what is important to the individual in services and supports, document his or her strengths and needs, and include paid and unpaid supports.

Individual Assessment

For services provided under a 1915(i) state plan, the state must conduct an assessment of each individual's needs and strengths to determine specific services and supports. The rule provides details on the area and methods of the assessment and includes a caregiver assessment if the individual receives services from unpaid caregivers. This means that if a person is receiving HCBS under the 1915(i) and has support from unpaid caregivers (like family) the state must include the caregivers in the assessment and even take their needs into account.

Next Steps

States have one year to create a plan to bring their current HCBS into compliance with the rules. The plan can be up to five years in length and the state must seek public input on the plan. The Centers for Medicare and Medicaid Services have promised additional information and guidance will be out soon, and the SLN will continue to keep sibs updated on any additional relevant information.