Home and Community Based Services

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The Department of Health and Human Services (DHHS) issued a Federal Register earlier this year that is causing states concern. The publication speaks to Home and Community Based Services (HCBS), among many other issues. Federal Register Vol. 79, No. 11 dated January 16, 2014 is a final rule addressing many Medicaid laws under which funding is available for HCBS programming. The rule seeks to achieve balance in consumer outcomes that utilize this service, enhanced quality outcomes, assurances that consumers utilizing any of these services has a full access to the benefit in addition to clarifying where these services can be rendered.

Many of the provisions of this almost year old release are now making their way through DHHS offices around the country. CMS has asked that states examine the HCBS programming that are provided in accordance with their State Plan and gap the policies governing them against the "new" regulations in place. States should then score each program as being "compliant" or "non-compliant". For programming that does not meet the standards set forth in the new regulations, States should offer a plan to achieve conformance within a five year period.

The HCBS regulation is looking to provide new flexibilities to programming and service areas, limit service programming in institutional settings, provide more community service area settings as permissible places to provide services, develop "person-centered" care planning whenever possible, streamline the governmental waiver process states must go through to be able to provide HCBS programming, and provide states with more options to provide multiple targeted populations into one state waiver (instead of multiple waivers) to offer services, as well as creating waiver designs that focus on functional needs.

Waivers are a special designation whereby states, very simply, are asking CMS for permission to provide a program or an array of services to a select group of the population. This program or array of services is typically outside the narrow path to coverage under the Medicaid Program and the Social Security Act. National law is established to dictate to states what services they must provide. Waivers allow states to act independently, with permission, in providing services outside of the narrow path of the law because perhaps the residents in their state act and behave differently. This flexibility allows states to provide targeted programming to individuals that would benefit from these services allowing them to live more independently with this assistance.

Again, this is very a simple definition of a complex principle and funding source. The most common waivers are 1915(c) and 1915(i) State Plan Amendment.

Of concern to CMS is that HCBS programming may not be occurring in the home or community as addressed earlier in a Federal Register issued in May 2012 which spoke of a "community first benefit" concept. The new regulation was issued to enforce the community first choice, restricting HCBS in institutional settings as well as proving for a person-centered service plan. Further, to quote CMS, the programming and service area must have the following characteristics:

- 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 additional conditions must 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. 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.
    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.
    6. Any modification of the additional conditions specified in items 1 through 4 above, 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.

As you can see the rules are quite complex and states and providers have been quite busy examining their programming to ensure that they are in full compliance, or have a plan in place that will transition them to compliance within a five year period.

Further, CMS has come out and stated where HCBS service cannot be performed:

- A nursing facility;
- An institution for mental diseases;
- An intermediate care facility for individuals with intellectual disabilities;
- A hospital; or
- Any other locations that have qualities of an institutional setting, as determined by the Secretary

States are requested to submit a "Statewide Transition Plan" to CMS whenever the state is seeking a renewal of an existing program or amended program that was previously approved through a waiver or SPA. Typically, these are usually submitted annually to CMS. However, if a state existing waiver or State Plan amendment hasn't lapsed, CMS is again requesting states submit an STP by March 17, 2015 and that they be in compliance with these new regulations no later than March 17, 2019.

About the author:

Brett joined Baker Newman Noyes in 1997. He is a Senior Manager in the firm's Healthcare Management Consulting Division specializing in long-term care, and senior living consulting. Previously, Brett worked with the Centers for Medicare and Medicaid Services in the audit and reimbursement department.

Brett earned a Bachelor of Science degree, Magna Cum Laude, in Accounting from Franklin Pierce College. He is a graduate of the United States Naval Apprentice Program, and the United States Naval Nuclear Reactor Plant Inspection Program.