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Medicaid Home and Community-Based Settings Final Rule: In Brief

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Introduction

On January 16, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a final rule for Medicaid participants receiving home and community-based services (HCBS).[1] Effective March 17, 2014, the rule establishes certain requirements for home and community-based settings. To receive federal reimbursement, states must ensure that Medicaid HCBS are delivered in such settings.[2] CMS states that the purpose of the rule is to ensure that Medicaid participants have full access to community living and opportunities to receive Medicaid services in the most integrated setting appropriate.[3] According to CMS, the rule also provides additional protections to Medicaid HCBS program participants, and it is intended to enhance the quality of such services.[4] The rule supports various administrative activities over the past decade to expand Medicaid HCBS, in part, prompted by the U.S. Supreme Court decision in *Olmstead v. L.C.*,[5] which held that the institutionalization of people who could be cared for in community settings was a violation of Title II of the Americans with Disabilities Act (ADA). The Olmstead decision, also known as the "integration mandate," affirmed the rights of individuals with disabilities to receive services in the most integrated and least restrictive setting appropriate. This report describes key provisions of the final rule as outlined.

Key Provisions of the Medicaid HCBS Settings Final Rule

- Defines, describes, and aligns HCBS setting requirements across three Medicaid authorities [§1915(c) HCBS waiver, §1915(i) HCBS state plan benefit, §1915(k) Community First Choice state plan benefit].
- Defines person-centered planning requirements for persons in HCBS settings under §1915(c) HCBS waiver and §1915(i) HCBS state plan authorities.
- Implements final regulations for §1915(i) HCBS state plan benefit.
- Provides states the option to combine multiple target populations within one §1915(c) HCBS waiver.
- Provides CMS with additional compliance options for §1915(c) HCBS waiver programs.
- Allows five-year renewal cycle to align concurrent waivers and state plan authorities that serve individuals eligible for both Medicare and Medicaid (i.e., dual eligibles).
- Includes a provider payment reassignment provision to allow states to make third-party payments for employee benefits.

[1] Department of Health and Human Services, "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 and Home and Community-Based Services (HCBS) Waivers; Final Rule," 79 *Federal Register* 2948-3039, January 16, 2014.

[2] For information and guidance from CMS on the HCBS regulation, see http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html.

[3] Centers for Medicare & Medicaid Services, "CMCS Informational Bulletin: Final Rule - CMS 2249-F – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and CMS 2296-F 1915(c) Home and Community-Based Services Waivers," January 10, 2014.

[4] Ibid.

[5] 527 U.S. 581 (1999). For further information on Olmstead v. L.C., see CRS Report R40106, *Olmstead v. L.C.: Judicial and Legislative Developments in the Law of Deinstitutionalization*.

Background

The original 1965 Medicaid law established that eligible Medicaid enrollees are entitled to nursing facility care.[6] In more recent decades, federal Medicaid statutory authority has expanded to help states increase and diversify their Medicaid long-term services and supports (LTSS) offerings to include optional HCBS as alternatives to institutional care.[7] With the addition of the Section 1915(c) HCBS waiver authority to Medicaid law in 1981 and subsequent statutory amendments that created new Medicaid state plan benefit options, states now have a range of options to further extend the provision of HCBS. Moreover, the share of Medicaid LTSS spending for HCBS compared with institutional care has more than doubled over time, from 18% of Medicaid LTSS spending in 1995 to about half of total Medicaid LTSS spending in 2012.[8]

As a result of state HCBS expansion, a variety of settings have emerged to serve individuals with LTSS needs in the community. These settings include residential care facilities such as assisted living facilities, board and care homes, congregate care, homes for the aged, personal care homes, and other types of shared-housing establishments. Home and community-based settings also include non-residential settings such as adult day health programs and settings offering prevocational, training, and employment services. Generally, these settings are licensed, registered, certified, or otherwise regulated by a state. It is important to note that federal Medicaid reimbursement is provided only for services in home and community-based settings such as home health, personal care assistance, and homemaker or chore services. The Medicaid program *does not* provide federal reimbursement for the cost of housing, such as a monthly rent or mortgage payment. Furthermore, federal Medicaid law prohibits federal reimbursement for the costs of room and board in community-based residential care settings.[9] This prohibition differs from Medicaid services provided in institutional settings for which federal reimbursement includes the costs of room and board.

The increased share of Medicaid LTSS spending on HCBS has led to concern among federal and state policy makers as to whether some settings indeed provide community-based alternatives to institutionalization. These concerns led CMS to develop regulations that would distinguish home and community-based settings from institutional settings for the purpose of providing HCBS. Prior to the final rule on HCBS setting requirements, determining whether a setting was home and community-based for the purposes of providing Medicaid HCBS was largely a function of state policy decisions, including state licensure and certification requirements. The final rule is the result of multiple rulemaking efforts over the past four years and represents the combined responses of an advanced notice of proposed rulemaking published by CMS on June 22, 2009, and two proposed rules published April 5, 2011, and May 3, 2012.[10] According to CMS, the final

[6] Social Security Amendments of 1965 (P.L. 89-97).

[7] For more information, see CRS Report R42345, *Long-Term Services and Supports: Overview and Financing*, by (name redacted) and (name redacted).

[8] CRS Report R43483, *Who Pays for Long-Term Services and Supports? A Fact Sheet*, by (name redacted) and (name redacted).

[9] Social Security Act (SSA) Section 1915(c)(1).

[10] Department of Health and Human Services, "Medicaid Program: Home and Community-Based Services (HCBS); Advance Notice of Proposed Rulemaking," 74 *Federal Register* 29453, June 22, 2009; Department of Health and Human Services, "Medicaid Program; Home and Community-Based Services (HCBS) Waivers; Proposed Rule," 76 *Federal Register* 21311-21317, April 15, 2011; and Department of Health and Human Services, "Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Setting Requirements for Community First Choice; Proposed Rule," 77 *Federal Register* 26362-26406, May 3, 2012.

rule reflects more than 2,000 comments received from states, providers, advocates, employers, insurers, associations, and other stakeholders.[11]

Key Provisions of the Final Rule

Home and Community-Based Setting Requirements

The final rule establishes requirements for home and community-based settings in Medicaid HCBS programs and aligns these requirements across the three Medicaid authorities described below:[12]

1. **Section 1915(c) HCBS waivers.** Authorizes the HHS Secretary to waive certain requirements of federal Medicaid law allowing states to cover a broad range of HCBS (including services not available under the Medicaid state plan) for certain persons with LTSS needs. Specifically, under Section 1915(c), states may waive rules regarding "statewideness" and "comparability" of services. States may also apply certain income-counting rules to persons in HCBS waivers that allow an individual to be eligible for Medicaid who might not otherwise qualify.
2. **Section 1915(i) HCBS state plan option.** Authorizes states to offer HCBS (similar to HCBS offered under Section 1915(c) HCBS waivers) as an optional Medicaid state plan benefit. Eligible enrollees must meet specific financial and needs-based eligibility criteria. States may tailor different benefit packages to certain groups of enrollees. States may make this option available to specific populations and may vary the benefit package as well as the amount, duration, and scope of the benefits for each of these populations.
3. **Section 1915(k) Community First Choice (CFC) state plan option.** Authorizes states to offer community-based attendant services and supports as an optional Medicaid state plan benefit and to receive an increased federal medical assistance percentage (FMAP) rate of 6 percentage points for doing so. Eligible enrollees must meet certain eligibility criteria, including needs-based eligibility criteria. States must provide these services on a statewide basis and in the most integrated community-based setting.

The rule describes the qualities that apply in determining whether a setting is home and community-based, and according to CMS, it establishes an outcome-oriented definition that focuses on the nature and quality of an individual's experiences.[13] Specifically, the final rule establishes criteria for (1) the qualities of HCB settings, (2) settings that are not home and community-based, and (3) settings presumed not to be home and community-based. It also sets forth state compliance and transition requirements. The following describes these criteria in greater detail.

[11] Centers for Medicare & Medicaid Services, "Final Rule Medicaid HCBS," webinar presentation, p. 4.

[12] For more information, see CRS Report R43328, *Medicaid Coverage of Long-Term Services and Supports*, by (name re dacted).

[13] Centers for Medicare & Medicaid Services, "Fact Sheet: Summary of Key Provisions of the Home and Community-Based Services (HCBS) Settings Final Rule (CMS 2249-F/2296-F)," January 10, 2014.

Qualities of Home and Community-Based Settings

The final rule describes and defines those qualities that HCBS settings must have based on the needs of individual enrollees, as indicated in their person-centered service plan. The rule provides additional flexibility for including other HCBS setting qualities, as the HHS Secretary determines appropriate. The five HCBS setting qualities outlined in the final rule are as follows:

1. **Integrated Setting.** The setting is integrated in and supports access 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.
2. **Setting Choice.** The setting must be selected by an individual from among setting options, including non-disability specific settings, and an option for a private unit in a residential setting.
3. **Individual Rights.** The setting must ensure an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. **Personal Independence.** The setting optimizes individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and interpersonal interaction.
5. **Service and Provider Choice.** The setting facilitates individual choice of services and supports, and who provides them.

The final rule also describes additional requirements for provider-owned or provider-controlled residential settings. These settings, such as a group home or an assisted living facility, must have the above five HCBS setting qualities as well as meet the following conditions:

- **Tenancy.** The unit or dwelling is owned, rented, or occupied under a legally enforceable agreement by the individual receiving services. Individuals have the same responsibilities and protections from eviction as all tenants under landlord tenant laws of the state, county, city, or other designated entity. If tenant laws do not apply, the state must ensure that a lease, residency agreement, or other written agreement is in place providing such protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.
- **Privacy.** Individuals have privacy in their sleeping or living unit, which has lockable entrance doors, with the individual and appropriate staff having keys to doors as needed. Individuals have a choice of roommates when sharing a unit, and the freedom to furnish and decorate sleeping or living units within the lease or other agreement.
- **Freedom.** Individuals have freedom and support to control their own schedules and activities, and have access to food at any time.
- **Visitation.** Individuals may have visitors of their choosing at any time.
- **Accessibility.** The setting is physically accessible to the individual.

Modifications of the above additional requirements must be supported by a specific assessed need and justified in the person-centered service plan. Specifically, if there are modifications, the person-centered service plan must document the following:

- identification of a specific individualized assessed need;
- documentation of prior interventions and supports and less intrusive methods that have been tried but did not work;
- a description of the condition that is proportionate to the specific assessed need;
- ongoing data measuring effectiveness of modifications;
- established time limits for periodic review of modifications;
- informed consent of the individual; and
- assurance that the interventions and supports will not cause harm to the individual.

Settings That Are *Not* Home and Community-Based

The final rule specifies those settings that are *not* home and community-based settings, but rather are institutional settings. These settings include the following:

- a nursing facility,
- an Institution for Mental Diseases (IMD),
- an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID),
- hospitals, and
- any other settings that have the qualities of institutional settings, as determined by the HHS Secretary.

Settings *Presumed Not* to Be Home and Community-Based

The final rule also specifies certain qualities of settings that are presumed not to be home and community-based. Settings presumed not to be HCB settings are

- a publicly or privately operated facility that provides inpatient institutional treatment;
- settings on the grounds of, or immediately adjacent to, a public institution; or
- settings with the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving such services.

These settings may not be considered HCBS settings for the purposes of providing Medicaid services unless the HHS Secretary determines, based on a heightened scrutiny of the evidence, that a setting does have the qualities of an HCBS setting and not the qualities of an institution. Under the heightened scrutiny process, the state or other parties submit evidence that the settings meet the HCB setting requirements and do not have the institutional qualities.

Transition Planning

The final rule requires states to develop a process, approved by CMS, to transition their current HCBS programs into compliance with the HCBS setting requirements. Effective March 17, 2014, a state submitting to CMS a *new* Section 1915(c) HCBS waiver, Section 1915(i) HCBS state plan option, or Section 1915(k) Community First Choice (CFC) state plan option must meet the new requirements to receive approval. A state with an *existing* Section 1915(c) waiver or Section 1915(i) state plan benefit option in effect on or before March 17, 2014, is required to file a statewide transition plan. States with an approved Section 1915(k) state plan benefit option that meets the setting requirements of the May 2012 proposed rule will have at least one year to make any necessary changes to come into compliance with the final rule.[14]

According to CMS, the purpose of the transition plan is to describe how the state will comply with the new HCBS setting requirements, including a state-based assessment of the extent to which the state's current policies (regulations, standards, licensing, and other provider requirements) ensure that settings meet the new federal requirements.[15] States will need to evaluate their settings to determine whether they meet these requirements and work with CMS through the development of transition plans to bring their programs into compliance. The level and detail of the plan will be determined by the types and characteristics of settings in the state.

Under current law, Section 1915(c) HCBS waivers and Section 1915(i) HCBS state plan benefit options are subject to durational time limits and renewal. Thus, the timing for when a state must submit a transition plan depends on the timing for renewal and amendment of a state's Section 1915(c) waiver or Section 1915(i) state plan option. Section 1915(c) waiver elections are for an initial three-year period and subsequent five-year renewal periods. Section 1915(i) state plan benefit elections are for five-year periods (i.e., an initial five-year period and subsequent five-year renewal periods).

For states with a renewal or amendment between March 17, 2014, and March 16, 2015, a transition plan must be submitted to CMS within 120 days after the state's submission of its first renewal or amendment. If a state *does not* renew or amend an existing Section 1915(c) HCBS waiver or Section 1915(i) HCBS state plan benefit program in that time period, a state must submit a transition plan no later than March 17, 2015. CMS waiver or amendment approval is contingent upon inclusion of an approved transition plan.[16]

The final rule requires that the public have an opportunity to provide input on the state's transition plan. Specifically, the state must provide a 30-day public notice and comment period on the transition plan the state proposes to submit to CMS. States must provide a minimum of two statements of public notice and public input procedures and ensure the full transition plan is available for public comment. States must also consider public comments and modify the plan based on such comments, as appropriate. States must submit evidence to CMS of public notice and a summary of the public comments, as well as a summary of state modifications in response

[14] Centers for Medicare & Medicaid Services, "Questions and Answers - 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) Home and Community-Based Services Waivers - CMS 2249-F and 2296-F."

[15] Ibid.

[16] Centers for Medicare & Medicaid Services, "Final Rule Medicaid HCBS," p. 21, webinar presentation.

to the public comments, and any additional evidence or supporting information when a state's determination might differ from the public comment.

State implementation of the transition plan begins upon CMS approval. CMS indicates that it expects states to transition to the new requirements in as brief a period as possible and demonstrate progress toward compliance with the new HCBS setting requirements. CMS may approve transition plans for a period of up to five years for full compliance, not to exceed March 17, 2019. Failure of a state to submit an approvable plan and/or failure of a state to comply with the terms of an approved plan may result in compliance actions by CMS.

Person-Centered Planning

The final rule defines person-centered planning requirements for Section 1915(c) HCBS waivers and Section 1915(i) HCBS optional state plan benefits. These requirements are consistent with the final person-centered planning requirements for Section 1915(k).[17] Specifically, the person-centered service plan must be developed through a person-centered planning process that is directed by an individual with LTSS needs; the plan may include a representative or others, as chosen. The rule describes the requirements for the person-centered planning process, including timeliness, cultural considerations, strategies for solving disagreement, and choice in services and supports, among other requirements.

The person-centered service plan must reflect those services and supports that are important for an individual and reflect individual preferences and desired outcomes, as specified. The plan also must include modification of the additional conditions (i.e., modifications to the tenancy, privacy, freedom, etc. requirements) as previously discussed in the home and community-based setting requirements. It must be reviewed and revised upon reassessment of functional need (as required every 12 months), when the individual's circumstances or needs change significantly, or at the request of the individual. The requirements for person-centered planning were effective March 17, 2014. CMS expects that states will implement these changes as plans are developed or updated with participants.[18] CMS further indicates that it will release additional guidance to states on the person-centered planning process.[19]

Section 1915(i) Home and Community-Based State Plan Option

Under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), Congress established an optional state plan Medicaid benefit that allows states to cover certain HCBS for eligible participants. The Section 1915(i) state plan option authority allows states to cover a new waiver-like HCBS state plan option without requiring a Secretary-approved waiver for this purpose. States may offer selected benefit packages to targeted populations to delay and/or prevent the need for institutional care. CMS published a proposed rule to implement this state plan option under Medicaid in April

[17] Department of Health and Human Services, "Medicaid Program; Community First Choice Option; Final Rule," 77 *Federal Register* 26828-26903, May 7, 2012.

[18] Centers for Medicare & Medicaid Services, "Questions and Answers - 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) Home and Community-Based Services Waivers - CMS 2249-F and 2296-F."

[19] Ibid.

2008; however, the rule was never finalized.[20] With enactment of Section 2402 of the ACA, which amended SSA Section 1915(i), the previously proposed rules would no longer comply with current law. Thus, the final rule implements SSA Section 1915(i) as amended. As previously described, the final rule also establishes requirements for HCBS settings and person-centered planning for Medicaid HCBS participants under Section 1915(c) HCBS waivers and Sections 1915(i) and (k) state plan authorities.

Five-Year Period for Certain Demonstration Projects and Waivers

As established under ACA Section 2601, the final rule provides for a five-year approval or renewal period for waiver programs through which states serve individuals who are dually eligible for Medicare and Medicaid benefits. According to CMS, this would permit a state to coordinate a Section 1915(i) HCBS state plan amendment with a Section 1915(b) mandatory managed care waiver authority.[21]

Other Section 1915(c) HCBS Waiver Requirements

The final rule addresses several additional requirements for Section 1915(c) HCBS waiver programs. Under prior regulation, states had the ability to serve only one of three target groups under a waiver, with states generally offering multiple Section 1915(c) waivers each targeting HCBS to a different group. In 2010, forty-seven states and DC offered at least one Section 1915(c) waiver, for a total of 284 waivers nationwide.

The final rule provides states with the option to combine the following target groups within one waiver:

- individuals who are aged and disabled, or both;
- individuals with intellectual disabilities or developmental disabilities, or both; and
- individuals with mental illness.

According to CMS, a state must ensure that the waiver meets the needs of each individual, regardless of target group.[22]

In addition, the final rule clarifies the effective dates of waiver amendments and the public input process for substantive changes to waiver programs. Specifically, substantive changes to waiver programs include changes in eligible populations; elimination or reduction of services; changes to the amount, duration, or scope of a service; or other modifications as defined by the HHS Secretary. Waiver amendments with substantive changes may take effect only on or after the date of CMS approval.

[20] Department of Health and Human Services, "Home and Community-Based State Plan Services Program, Waivers, and Provider Payment Reassignments (CMS-2249-F); Proposed Rule," *73 Federal Register 18676*, April 4, 2008.

[21] Ibid.

[22] Centers for Medicare & Medicaid Services, "Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule (CMS 2249-F/2296-F)," January 10, 2014.

States are currently required to provide details to CMS of the public input process for Section 1915(c) waiver amendments and renewals. The final rule establishes that states must also use a public input process for substantive waiver changes. In addition, public notice is required when states propose significant changes to the methods and standards for service rates under Section 1915(c) waivers.

The final rule also describes additional strategies available to CMS to assist with state compliance regarding waiver requirements, short of CMS terminating or not renewing the waiver. These strategies may include freezing waiver enrollment, deferring payment for a waiver service, or other actions as determined necessary by the HHS Secretary.

Provider Payment Reassignment Rules

Under federal Medicaid law, a state plan may allow payment for service only to the individual practitioner who provided the service.[23] However, there are several statutory exceptions to the general principle of direct payment to the individual practitioner. The final rule provides an additional exception when the state is the primary source of employment for a class of individual practitioners—that is, when the practitioner's source of revenue is primarily derived from the state Medicaid program. For example, personal care workers may be one class of practitioners where the primary source of employment is the state Medicaid program. This exception will allow states to make payments to a third party on behalf of the individual practitioner for employee benefits such as health insurance and skills training.

CMS states that the rule will not require any changes to state funding to the extent that practitioner payment rates under Medicaid currently factor in such costs.[24] Any amounts the state withholds from practitioners would be remitted to third parties on behalf of the practitioner for the stated purpose. CMS finds that this exception will provide additional operational flexibilities for states to fund employee benefits directly, as well as ensure uniform access to benefits and training.[25] It is likely that this change would benefit Medicaid consumer-directed LTSS delivery models in states that use public authorities and/or collective bargaining agreements. States may also use this rule change to address the ACA employer mandate by permitting state Medicaid programs, when the state is the primary source of service revenue for the practitioner, to offer health insurance.[26] For example, a state may choose to purchase health insurance for an entire class of workers (e.g., home health aides or personal care workers).

Concluding Observations

Implementation Challenges. The proposed definition of HCBS settings has evolved considerably over the five-year rulemaking process. According to CMS, the final HCBS setting rule moves away from defining such settings by what they are not and toward defining settings by

[23] §1902(a)(32).

[24] 79 *Federal Register* 3002, January 16, 2014.

[25] Ibid.

[26] Dombi, William A., Steven W. Postal, *The New Final Rule for Home and Community-Based Services: What Home Care Providers Need to Know*, American Bar Association, Health Law Section, vol. 10, no. 5.

the nature and quality of a Medicaid participants' experiences.[27] The rule does not define settings by characteristics such as location, geography, or physical features but rather emphasizes certain aspirational goals, such as personal autonomy, choice, and community integration. The challenge for state Medicaid programs will be to establish state policies and processes that effectively articulate these goals. Similar to CMS's experience in moving toward such an approach to defining HCBS settings in the final rule, states may benefit from engaging a broad stakeholder community in transition planning, including consumers, advocates, providers, direct care workers, regulators, and other interested stakeholders.

Timing. State Medicaid programs are undergoing a number of programmatic changes. The finalization of the HCBS settings rule comes at a time of significant change to state Medicaid programs in their financing and delivery of LTSS, and in particular HCBS. Forty-seven states reported activities to expand HCBS in 2015; most states reported using Section 1915(c) waiver programs and Section 1915(i) HCBS state plan options to expand.[28] Several states are in the process of transitioning to or expanding Medicaid-managed LTSS. The progress of these initiatives may be delayed or redirected in states now required to respond to transition planning and other programmatic requirements that apply under the final rule. The rule also provides states with additional flexibilities to consolidate Section 1915(c) waivers, which may ease administrative burden in implementation over time.

Application to Medicaid Managed LTSS. Some states are seeking CMS approval to expand HCBS and/or offer LTSS in a managed care financing and delivery arrangement under Section 1115 demonstration waiver authority.[29] The HCBS setting requirements in the final rule *do not* apply to Section 1115 waiver demonstrations. However, the agency has indicated that it plans to include special terms and conditions of Section 1115 demonstrations that affect individuals receiving HCBS and presumably align with the HCBS settings rule.[30] Aging and disability advocates remain concerned that managed care organizations responsible for the provision of LTSS may have a more medical approach to care planning that does not reflect the person-centered planning approach delineated in the final rule. Further clarification may be needed with respect to state compliance with person-centered planning and HCBS settings requirements when a state contracts with a managed care organization for delivery of LTSS including HCBS.

Enforcement and Protections. CMS indicates that it may take states time to transition their programs to ensure compliance; however, the agency also expects states to transition in a timely fashion.[31] Additional questions remain with respect to CMS enforcement, both in overseeing

[27] Centers for Medicare & Medicaid Services, "Fact Sheet: Summary of Key Provisions of the 1915(c) Home and Community-Based Services (HCBS) Waivers Final Rule (CMS 2249-F/2296-F)," January 10, 2014.

[28] Vernon K. Smith, K. Gifford, E. Ellis, et al. *Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015*, Kaiser Family Foundation and the National Association of Medical Directors, October 2014, p. 29.

[29] Under SSA Sec. 1115, the HHS Secretary may waive Medicaid requirements contained in Sec. 1902 (including what is known as "freedom of choice" of provider, "comparability" of services, and "statewideness"). States use this waiver authority to offer coverage to new groups of individuals not otherwise eligible, provide services that are not otherwise covered, offer different service packages in different parts of the state, cap program enrollment, and implement innovative service delivery systems, such as managed care, among other purposes.

[30] Centers for Medicare & Medicaid Services, "Questions and Answers - 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) Home and Community-Based Services Waivers - CMS 2249-F and 2296-F."

[31] Centers for Medicare & Medicaid Services, "CMCS Informational Bulletin: Final Rule - CMS 2249-F – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting (continued...)

states' transitions and compliance going forward. Questions also remain about protections available to participants regarding program compliance with person-centered planning and HCBS setting requirements. For example, once states have approved transition plans and move into transitioning their programs, what role will CMS play with enforcement? What methods of enforcement will CMS use? What protections will be available to participants? Will participants be able to raise compliance issues with the person-centered planning process or setting requirements, and if so, to whom? And furthermore, what role will CMS play in enforcement beyond the transitioning period? There is likely to be congressional interest in continued oversight and monitoring of these programs and compliance with the new requirements.

Provider Response. Finally, there is concern among providers about the applicability of the HCBS setting requirements to certain settings, including provider-owned and provider-controlled settings, such as assisted living facilities; settings that isolate, such as those designed for persons with disabilities; and non-residential care settings, such as adult day health care. CMS has released some guidance and indicated plans to release additional guidance to address implications of the regulations for certain settings.[32] However, these concerns raise questions about the provider response. If settings do not currently meet the new requirements, will providers choose to come into compliance with their state policies or practices, or will they choose not to participate in the Medicaid program? Will the rule facilitate greater participant choice and options in accessible and affordable community-residential settings, or will participants perceive more limited choice? While community-residential settings will continue to play a role in providing housing and service options for Medicaid HCBS participants, it remains to be seen whether settings and service delivery will change, and to what extent, in response to the HCBS settings rule.

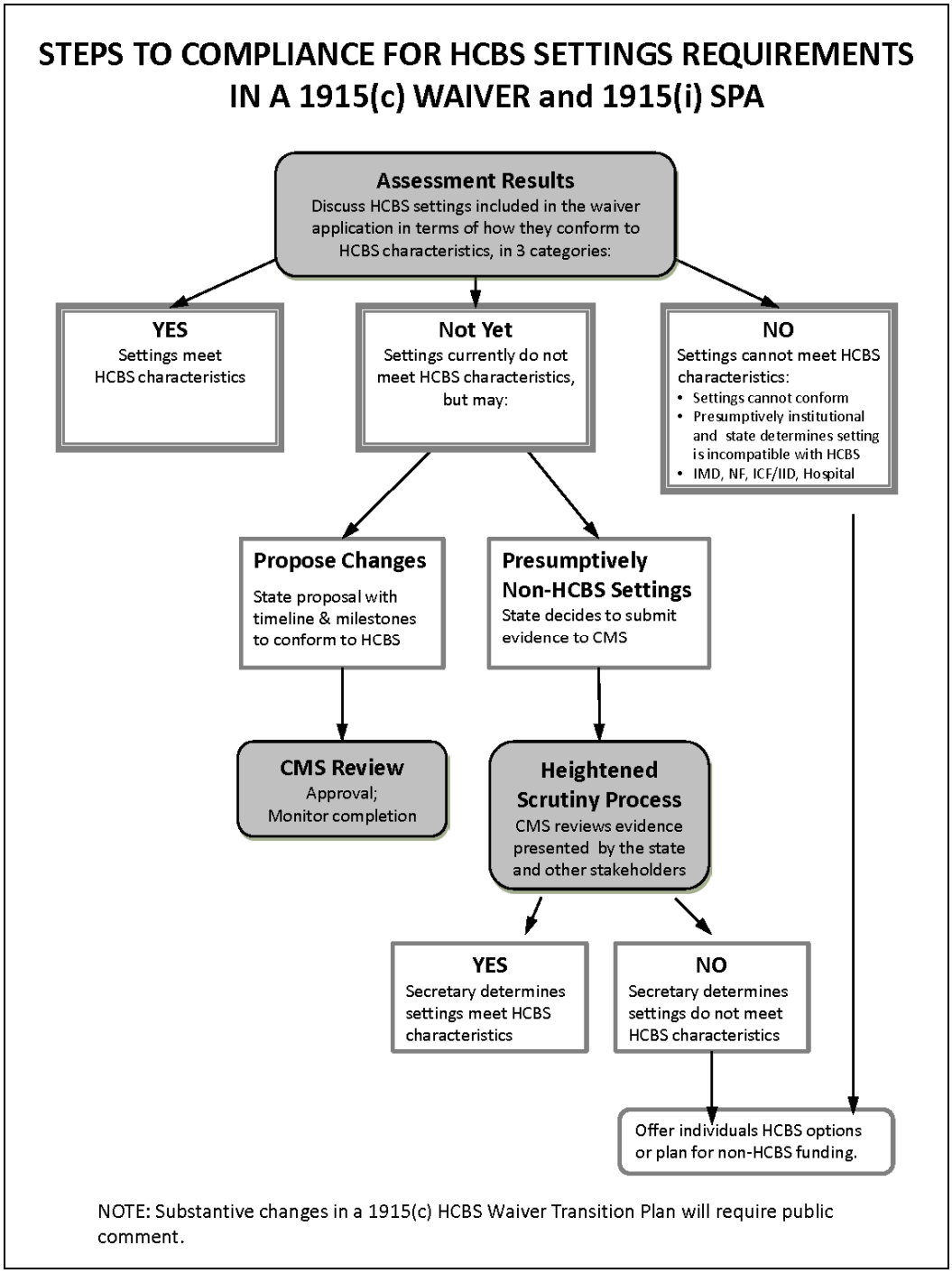
(...continued)

Requirements for Community First Choice, and CMS 2296-F 1915(c) Home and Community-Based Services Waivers," January 10, 2014.

[32] Centers for Medicare & Medicaid Services, "Guidance on Settings That Have the Effect of Isolating Individuals Receiving HCBS From the Broader Community," http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/settings-that-isolate.pdf; Centers for Medicare & Medicaid Services, "Questions and Answers - 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) Home and Community-Based Services Waivers - CMS 2249-F and 2296-F."

Appendix A. HCBS Setting Requirements

Figure A-1. Flowchart of Action Steps for State Compliance



Source: Centers for Medicare & Medicaid Services, "Compliance Flowchart," at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services.html.

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