New Medicaid Home and Community-Based Services (HCBS) Rules
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About the Disability Rights Network (DRN)

- DRN is a statewide, non-profit corporation designated as the federally-mandated organization to advance and protect the civil rights of adults and children with disabilities. DRN works with people with disabilities and their families to ensure their rights to live in their communities with the services they need, to receive a full and inclusive education, to live free of discrimination, abuse and neglect, and to have control and self-determination over their services.
- For more information or assistance, call 1-800-692-7443 or go to www.drnpa.org.

What is Medicaid HCBS?

- HCBS funding provides people with the ability to receive needed Medicaid services in home and community-based settings, rather than institutional settings (like nursing homes).
- There are several different types of HCBS funding, including:
  - 1915(c) Medicaid Waivers
  - 1915(i) State Plan HCBS
  - 1915(k) Community First Option
What is the Purpose of the New HCBS Rules?

• To ensure that people who receive Medicaid services have full access to the benefits of community living and the opportunity to receive services in the most integrated setting possible.
• To enhance the quality of HCBS and provide additional protections for people receiving HCBS.

What do the HCBS Rules do?

• Establish new standards to ensure that Medicaid services are provided in home and community-based (non-institutional) settings.
  • These standards apply to residential settings (such as community homes) and non-residential settings (such as day programs).
• Establish new requirements to ensure that service plans are developed using person-centered processes.

What else do the HCBS Rules do?

• Allow states to combine target populations in a Medicaid waiver:
  • Older adults, people with disabilities, or both;
  • People with intellectual or developmental disabilities, or both;
  • People with mental illness.
• Give the federal Centers for Medicare and Medicaid Services (CMS) additional options for ensuring state compliance with Medicaid rules for 1915(c) Medicaid waivers.
• Clarify that significant changes to Medicaid waivers must be made approved before the effective date, and are subject to stakeholder input.
When are the HCBS Rules Effective?

- The rules were published in the Federal Register on January 16, 2014, and are effective as of March 17, 2014.
- States must develop transition plans to come into compliance with the new rules, and the transition plans will include specific timelines for key compliance activities.

New Standards for Medicaid Settings

New HCBS Setting Requirements

- The new HCBS setting requirements establish an outcome-oriented definition that focuses on a person’s experiences.
- The requirements maximize opportunities for people who are receiving Medicaid waiver services to receive those services in the most integrated setting appropriate, and to access the benefits of community living.
Core Standards for All Settings

• Integrated
  • The setting is integrated in and supports full access to the greater community, including opportunities to seek employment in competitive 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.

• Choice
  • The service setting is chosen by the person from among options that include settings that are not disability-specific, and the choice of a private unit in residential settings.
  • The person also has choice of services and supports and who provides them.

Core Standards for All Settings (Continued)

• Rights
  • Ensures the person’s rights to privacy, dignity and respect, and freedom from coercion and restraint.

• Independence
  • Optimizes personal initiative, autonomy, and independence in making life choices, including daily activities, physical environment and with whom to interact.

Additional Requirements for Provider-Owned or Controlled Settings

• The person has a lease or other legally enforceable agreement.
  • Including protections against eviction.

• Each person has privacy in their sleeping or living unit:
  • Units have doors that are lockable by the person, with only appropriate staff having keys.
  • People sharing rooms have choice of roommates.
  • People are free to furnish and decorate their units within the lease or other agreement.
Additional Requirements for Provider-Owned or Controlled Settings (Continued)

- People have the freedom and support to control their own schedules and activities.
- People have access to food at any time.
- People may have visitors of their choosing at any time.
- The setting is physically accessible to the person.

Additional Requirements for Provider-Owned or Controlled Settings (Continued)

- Any modification of these requirements must be supported by a specific assessed need and justified and documented in the person-centered plan, as follows:
  - Specific individualized assessed need that applies.
  - Description of the condition related to the need.
  - Prior interventions and supports.
  - Ongoing data measuring effectiveness of the modification.
  - Specific time frames for review.
  - The individual’s informed consent.
  - Assurance that the modification will not harm the person.

Settings that are Never HCBS

- Nursing facilities
- Institutions for Mental Diseases
- Intermediate Care Facilities for People with Intellectual Disabilities or Other Related Conditions
- Hospitals
Settings “Presumed” to be Institutional

- Other settings with institutional qualities
- Setting located in a public or privately-owned building that also provides inpatient institutional treatment
- Setting in a building on the grounds of, or immediately adjacent to, a public institution
- Other settings that isolate individuals receiving HCBS from the broader community

Person-Centered Planning

- The person drives the process.
- The person chooses who should participate.
- The person is provided with information and support necessary to direct the planning process and make informed choices.
- Plan meetings are held at times and places most suitable to the person.
- Cultural considerations and communication needs are considered.
**Person-Centered Planning Process**  
(Continued)  
• The planning process must:  
  • Include ways to resolve conflict  
  • Include a method for the person to request needed updates to the plan  
  • Offer informed choices about the services and supports a person receives, and by whom they are received  
  • Document the other HCBS settings considered by the person  
• A provider or individual who develops the plan may not provide other Medicaid HCBS to the person, or have an interest in or be employed by a provider of Medicaid HCBS

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**What must be in the Person-Centered Plan?**  
• The setting, chosen by the person, where the person resides and how it is integrated in and supports full access of the person in the greater community.  
• The person’s strengths, preferences, and needs.  
• Individualized goals and personal outcomes.  
• The services and supports (paid and unpaid) that will assist the person in achieving identified goals, including services that are self-directed.  
• Risk factors and ways to reduce risk, including individualized back-up plans and strategies.

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**Other Requirements for the Person-Centered Plan**  
• The plan must:  
  • Be understandable to the person and those supporting the person.  
  • Be finalized and agreed to, with the informed consent of the person in writing, and signed by everyone responsible for implementing the plan.  
  • Be distributed to the person and others involved in planning.
Other Requirements for the Person-Centered Plan (Continued)

• The plan must (continued):
  • Include ways to prevent unnecessary or inappropriate services and supports.
  • Identify the individual and/or entity responsible to monitor the implementation of the plan.
  • Be reviewed, and revised as needed, at least once every 12 months, when the person’s needs change based on a functional assessment, or at the request of the person.

HCBS Regulation Transition Plans

Transition Planning Process

• Pennsylvania must assess 1915(c) Medicaid waiver services to determine whether they meet the new setting and planning requirements.
• Areas of noncompliance must be addressed in a transition plan, which should reflect all of the 1915(c) Medicaid waivers Pennsylvania operates that have compliance issues.
• Transition plans must be submitted within a year of the effective date of the regulations, or when a 1915(c) Medicaid waiver is amended or renewed, within 120 days of the submission of the amendment or renewal.
Transition Planning Process (Continued)

- Transition plans should move to the new requirements as quickly as possible, but can span as much as five years.
- Pennsylvania must engage stakeholders:
  - There must be a public notice and comment period of at least 30 days.
  - There must be at least two public notices on the public input procedures.
  - The full transition plan must be available for public comment.
  - The transition plan must be modified, as appropriate, based on public input.

Transition Planning Process (Continued)

- Pennsylvania plans to submit the transition plan to CMS as part of amendment of some of its 1915(c) Medicaid Waivers.
- Pennsylvania will be required to submit the transition plan within 120 days of the submission of the amendments, along with:
  - Evidence of the required public notices;
  - A summary of comments received during the public input process;
  - Reasons why comments were not adopted; and
  - Any modifications made to the transition plan based on comments.

Additional Resources
Where Can You Find Additional Information?

- The final HCBS regulations, a CMS presentation on the regulations, frequently asked questions, and a compliance toolkit for states can be found at: http://www.medicaid.gov/HCBS

- A new website, developed to help advocates and other stakeholders get involved in the transition to the new HCBS regulations: http://hcbsadvocacy.org

Questions?

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