

Home and Community Based Services

Title: Home and Community Based Services

For Immediate Release: Friday, January 10, 2014

Contact: press@cms.hhs.gov

Overview

The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for home and community-based services (HCBS). The rule supports enhanced quality in HCBS programs, adds protections for individuals receiving services. In addition, this rule reflects CMS' intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting. Highlights of this final rule include:

- Provides implementing regulations for section 1915(i) State Plan HCBS, including new flexibilities enacted under the Affordable Care Act to offer expanded HCBS and to target services to specific populations;
- Defines and describes the requirements for home and community-based settings appropriate for the provision of HCBS under section 1915(c) HCBS waivers, section 1915(i) State Plan HCBS and section 1915(k) (Community First Choice) authorities;
- Defines person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities;
- Provides states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses 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).
- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs.

Key Provisions of the Final Rule

1915(c) Home and Community-Based Waivers

The final rule amends the regulations for the 1915(c) HCBS waiver program, authorized under section 1915(c) of the Social Security Act (the Act), in several important ways designed to improve the quality of services for individuals receiving HCBS. Specifically, it establishes requirements for home and community-based settings in Medicaid HCBS programs operated

under sections 1915(c), 1915(i), and 1915(k) of the Act, defines person-centered planning requirements, provides states with the option to combine multiple target populations into one waiver to facilitate streamlined administration of HCBS waivers, clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, and provides CMS with additional compliance options for HCBS programs. For more detail, please refer to the 1915(c) fact sheet at <http://www.medicaid.gov/HCBS/>.

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

The final rule implements the section 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 services and to target services to specific populations. In addition, the final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. For more detail, please refer to the HCBS 1915(i) fact sheet at <http://www.medicaid.gov/HCBS/>.

Section 2601 of the Affordable Care Act: Five Year Period for Certain Demonstration Projects and Waivers

To simplify administration of the program for states, this final rule provides a five-year approval or renewal period for demonstration and waiver programs in which a state serves individuals who are dually eligible for Medicare and Medicaid benefits. This provision allows states to use a five year renewal cycle to align concurrent waivers that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c).

Home and Community-Based Settings Requirements

The final rule establishes requirements for home and community-based settings in Medicaid HCBS programs operated under sections 1915(c), 1915(i), and 1915(k) of the Act. The rule creates a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The regulatory changes will maximize the opportunities for HCBS program participants to have access to the benefits of community living and to receive services in the most integrated setting and will effectuate the law's intention for Medicaid home and community-based services to provide alternatives to services provided in institutions. For more detail, please refer to the HCBS Settings fact sheet at <http://www.medicaid.gov/HCBS/>.

The final rule includes a provision requiring states offering HCBS under existing state plans or waivers to develop transition plans to ensure that HCBS settings will meet final rule's requirements. New 1915(c) waivers or 1915(i) State plans must meet the new requirements to

be approved. For currently approved 1915(c) waivers and 1915(i) State plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) State plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress towards compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan that provides for the delivery of HCBS services within settings meeting the final rule's requirements, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will be issuing future guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences. This 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. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.

Reference: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-01-10-2.html>

HHS strengthens community living options for older Americans and people with disabilities

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The Centers for Medicare & Medicaid Services (CMS) issued a final rule today to ensure that Medicaid's home and community-based services programs provide full access to the benefits of community living and offer services in the most integrated settings. The rule, as part of the Affordable Care Act, supports the Department of Health and Human Services' Community Living Initiative. The initiative was launched in 2009 to develop and implement innovative strategies to increase opportunities for Americans with disabilities and older adults to enjoy meaningful community living.

Under the final rule, Medicaid programs will support home and community-based settings that serve as an alternative to institutional care and that take into account the quality of individuals' experiences. The final rule includes a transitional period for states to ensure that their programs meet the home and community-based services settings requirements. Technical assistance will also be available for states.

"People with disabilities and older adults have a right to live, work, and participate in the greater community. HHS, through its Community Living Initiative, has been expanding and improving the community services necessary to make this a reality," said HHS Secretary Kathleen Sebelius. "Today's announcement will help ensure that all people participating in Medicaid home and community-based services programs have full access to the benefits of community living."

In addition to defining home and community-based settings, the final rule implements the Section 1915(i) home and community-based services State Plan option. This includes new flexibility provided by the Affordable Care Act that gives states additional options for expanding home and community-based services and to target services to specific populations. It also amends the 1915(c) home and community-based services waiver program to add new person-centered planning requirements, allow states to combine multiple target populations in one waiver, and streamlines waiver administration.

For more information about the final rule, please visit:

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-10-2.html>

For more information regarding the Home and Community-Based Services available under Medicaid, please visit: <http://www.medicaid.gov/HCBS/>

For more information regarding the Community Living Initiative, please visit: <http://www.hhs.gov/od/community/index.html>

The final rule can be found here: http://ofr.gov/OFRUpload/OFRData/2014-00487_PI.pdf

Reference: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-10-2.html>

Key Message and Tips for Providers: Person-Centered Service Plans

Message

Medicaid will not cover home and community-based services (HCBS) without a person-centered service plan (service plan) that addresses the beneficiary's long-term care needs as an alternative to institutionalization.[1, 2, 3]

The beneficiary directs the planning process with input from a selected team of individuals who are aware of their strengths and capacities. The service plan is created using information gathered during this process and the results of medical assessments.[4]

Medicaid compliance requires that all services are documented in the plan.

Tips

Knowing and following these tips helps ensure beneficiaries receive the services they need and providers are paid properly:

- Make sure the service plan includes the beneficiary's name, address, date of birth, Medicaid identification number, and diagnosis;[5, 6]
- Include beneficiary needs, expectations, goals, and services in setting options that support community access;[7, 8]
- Ensure the service plan is signed by all who are responsible for its implementation;
- Provide the beneficiary with a copy of the service plan;
- Monitor the beneficiary's progress toward meeting the service plan goals;
- Track due dates for reassessments, and service plan updates;
- Review and update the service plan following reassessment (at least every 12 months), when there is a change in the beneficiary's condition, or at the beneficiary's request;[9]

and Check with your State Medicaid agency for information about services in your area since these programs vary from State to State.

For more information about Medicaid Program Integrity, visit <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the Centers for Medicare & Medicaid Services (CMS) Medicaid Program Integrity Education website.

Reference: [https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/key-messages-Person-Centered-Service-Plans-\[September-2015\].pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/key-messages-Person-Centered-Service-Plans-[September-2015].pdf)