



January 16, 2014

Overview of Key Policies and CMS Statements of Intent Regarding the Medicaid State Plan HCBS Benefits and HCBS Waiver Final Rule

On January 10, 2014, the Centers for Medicare and Medicaid Services (CMS) circulated a copy of the final rule implementing changes to the Medicaid Home and Community-Based Services (HCBS) benefits and waiver program as well as the Community First Choice Option (CFC) program. The final rule was published in the Federal Register on January 16, 2014 and is available at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>.

Below is a summary of the key provisions in the revised rule and statements of intent by the CMS accompanying the final rule (in the form of “comments” by interested stakeholders and “responses” by CMS). The following topics are covered by this memo.

- Scope of HCB services and benefits;
- Person-centered service plan and process;
- Definition of home and community-based settings and transition/phase-in; and
- Additional sub-regulatory guidance.

This memo does not attempt to analyze the implications of these statements. Such an analysis will be prepared in the near future.

State Plan Home and Community-Based Services:

The revised rule adds a new section 440.182, which lists services considered home and community-based services. The services listed include, among others, personal care services, adult day health services, habilitation services, which include expanded habilitation as defined in 440.180(c), day treatment or other partial hospitalization services, psychosocial rehabilitation services, and other services requested by the state agency and approved by the Secretary as consistent with the purpose of the benefit.

NOTE: Expanded habilitation is defined in 440.180(c) to include prevocational services which means services that prepare an individual for paid or unpaid employment and that are not job-task oriented but are, instead, aimed at a generalized result. These services may include, for example, teaching an individual such concepts as compliance, attendance, task completion,

problem solving and safety. Prevocational services are distinguishable from vocational services that are not covered by using the following criteria:

- The services are provided to persons who are not expected to be able to join the general workforce or participate in transitional sheltered workshop within one year (excluding supported employment programs);
- If the recipients are compensated they are compensated at less than 50 percent of the minimum wage;
- The services include activities which are not primarily directed at teaching specific job skills but at underlying habilitative goals (for example attention, span, motor skills); and
- The services are reflected in a plan of care directed to habilitative rather than explicit employment objectives.

According to CMS, home and community-based services include, among other things, habilitation services, including expanded habilitation. [79 FR 2954]

Person-Centered Service Plan and Person-Centered Planning Process:

The revised rule includes a new subsection [441.301(c)(1); 441.725(a)] prescribing the **person-centered planning process**. Key provisions include:

- The individual will lead the process, where possible;
- The individual's representative should have a participatory role, as needed and as defined by the individual, unless state law confers decision-making authority to the legal representative;
- All references to individuals include the role of the individual's representative;
- Includes people chosen by the individual;
- Provides necessary information and support to enable the individual to make informed choices and decisions;
- Offers informed choices to the individual regarding the services and supports they receive and from whom; and
- Records the alternative home and community-based settings that were considered by the individual.

The revised rule also specifies the **contents of the person-centered services plan** [441.301(c)(2); 441.725(b)]. Key provisions include:

- The plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional needs, as well as what is important to the individual with regard to preferences for the delivery of such services and supports;
- The plan must reflect that the setting in which the individual resides is chosen by the individual. The state must ensure that the setting chosen by the individual 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;

- Reflect the individual's strengths and preferences;
- Include individually identified goals and desired outcomes;
- Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports;
- Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed;
- Prevent the provision of unnecessary and inappropriate services and supports;
- Document that any modification of the additional conditions described below relating to residential settings must be supported by specific assessed need and justified in the person-centered service plan. [Specific requirements are articulated in the rule related to documentation]; and
- Review the plan at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

Below are CMS statements of intent regarding the person-centered planning process and the person-centered services plan.

Full Array of HCBS

CMS concludes that the final rule regarding home and community-based settings must continue to permit the full array of home and community-based services, as defined in the Medicaid HCBS statute and regulations and included in the individual's person-centered service plan. The final rule continues to convey this flexibility to the states. [79 FR 2954]

Choice And Person-Centered Plans

The final rule includes requirements for person-centered plans of care that document, among other things, an individual's choice of a HCBS setting from among options that meet the individual's needs. [79 FR 2949]

CMS believes that the final rule is critical to ensure that individuals have the opportunity to receive services that protects individual choice and promotes community integration. [79 FR 2957]

CMS supports individual choice and believes that individuals may vary in their choices as they seek full access and participation in the greater community. However, in order to receive approval to use Medicaid HCBS, a state must ensure that the choices available to individuals meet the requirements for community integration. [79 FR 2975, 2977]

The section on person-centered planning clarifies CMS’s expectations with regard to services being delivered in a manner that promotes/supports community integration to the extent of the individual’s preferences and desired outcomes. [79 FR 2975]

CMS believes that individuals should be supported in seeking employment when interested in being employed and that the statement “opportunities to seek employment” implies choice. [79 FR 2976]

While the person-centered service plan can and does assist individuals with integration into the community, it is not the vehicle to determine whether a setting meets the requirements for being home and community-based. [79 FR 2990]

The process of choosing among the housing and service options available to a participant is an extraordinarily multi-faceted issue. A truly person-centered planning process is the best venue for facilitating this important choice.

- Part of a meaningful choice is to be presented with all available options.
- A person-centered planning process is not about promoting certain options deemed to be more “person-centered” or otherwise desirable, than other options.
- A person-centered process is one that puts the individual in the center, facilitated to make choices that may be agreeable or disagreeable to some participating in the process.
- The process of informed choice must be documented. A new provision reads “reflect that the setting in which the individual resides is chosen by the individual. The state must ensure that the setting chosen by the individual 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.” [79 FR 3010]

CMS believes that individual choice is important and worked to promote choice in the final rule. In addition, it is important to note that HCBS waiver funding is only one way in which federal Medicaid finances long-term services and supports; a setting that may not meet the HCBS definition may still qualify for Medicaid financing, but not as a home and community-based service. [79 FR 3011]

The rule includes 12 months as the minimum period for an individual’s person-centered service plan to be reviewed and revised. The person-centered plan should also be reviewed and revised when the individual’s circumstances or needs change significantly and at the request of the individual, authorized representative or healthcare provider. [79 FR 2991]

With respect to provider attendance at meetings to develop the person-centered service plan, it is inappropriate for the provider to be in charge of the process or plan; however provider attendance depends on the circumstance and is not a matter for blanket requirements. [79 FR 3007]

Home and Community-Based Setting Requirement:

This section focuses on the new HCBS setting requirements [441.301(c)(3); 441.710; 441.530]. Specifically, the following topics are addressed:

- Overview of HCBS setting requirement;
- General qualities of a HCBS setting;
- Additional HCBS qualities applicable to residential programs;
- Settings that are per se not home and community-based settings; and
- Heightened scrutiny to determine whether a setting is home and community-based.

Overview of Home and Community-Based Settings, In General and CMS Statements of Intent:

The following are general statements of policy by CMS regarding new HCBS settings provisions, including:

- Overall purpose;
- Alignment of policy regarding settings across State plan HCBS, HCBS waiver, and CFC option program;
- Inclusion of definition of settings in state submissions;
- Availability of other Medicaid authorities when HCBS unavailable; and
- ADA and Olmstead.

Overall purpose

The changes related to clarification of HCBS settings will maximize the opportunities for waiver 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. [79 FR 3003]

The rule is moving away from defining HCBS settings by what they are not, and towards defining them by the nature and quality of beneficiaries' experiences. These final regulations establish a more outcome-oriented definition of HCBS settings, rather than one based solely on a setting's location, geography, or physical characteristics. [79 FR 3011]

A home and community-based setting must be integrated in, and support full access of individuals receiving 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. [79 FR 3011]

CMS agrees that the definition included in the proposed rule for HCBS settings may have had the result of restricting the settings in which HCBS services can be provided in a way that CMS

did not intend and narrowing choices for participants. The final rule is more flexible and less prescriptive in that it does not preclude certain settings per se but rather establishes affirmative, outcome-based criteria for defining whether a setting is or is not home and community-based. [79 FR 3011, see also 79 FR 3014]

CMS has chosen to be less prescriptive regarding physical and geographical characteristics of settings and to focus instead on the critical role of person-centered service planning and on characteristics that are associated with independence, control of daily routines, privacy, and community integration. With respect to certain types of settings, the final rule specifies that the Secretary will determine through heightened scrutiny, based on information presented by the state and other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings. [79 FR 3014]

Alignment State Plan HCBS, HCBS Waiver, and CFC

CMS has aligned the requirements pertaining to home and community-based settings across State plan HCBS (section 1915(i), HCBS waivers (Section 1915(c), and Community First Choice (CFC) option (section 1915(k). [79 FR 2949]

Definition of HCB Setting Included In State Submissions

CMS expects that states electing to provide benefits under State plan HCBS, HCBS waiver or CFC to include a definition of home and community-based setting that incorporates specific qualities set out in the rule. [79 FR 2952; 2956]

Availability of Other Medicaid Authorities When HCBS Unavailable

CMS believes that individuals must have the opportunity to receive services in settings that support integration with the greater community. Therefore, HCBS must be delivered in a setting that meets the HCBS setting requirements and since this authority provides states the opportunity to provide individuals HCBS and not institutional services, individuals must be living in settings that comport with the HCBS setting requirement. For settings that do not meet the setting requirement, CMS notes that there are other Medicaid authorities under which such services may be covered. [79 FR 2970]

In response to a question regarding the viability of public and private specialized residential facilities for persons with severe and profound cognitive-developmental disabilities, e.g., non-urban community-based models, CMS believes that the Medicaid program provides many options for states to develop delivery systems that meet the needs of individuals regardless of where they fall on the continuum of care. [79 FR 2974]

Medicaid continues to provide other service options that can support individuals who choose to receive services in non-HCBS settings. [79 FR 2974]

CMS is not eliminating the choice of institutional options; CMS is specifying the qualities necessary for settings to be considered home and community-based settings. [79 FR 2976]

CMS believes that individual choice is important and worked to promote choice in the final rule. In addition, it is important to note that HCBS waiver funding is only one way in which federal Medicaid finances long-term services and supports; a setting that may not meet the HCBS definition may still qualify for Medicaid financing, but not as a home and community-based service. [79 FR 3011]

The final rule defines general tenets and characteristics of HCBS that will preclude institutional settings from qualifying as HCBS, although they might qualify for Medicaid financing under other authorities. [79 FR 3012]

ADA and Olmstead

CMS seeks to ensure that Medicaid is supporting needed strategies for states in their efforts to meet their obligations under the ADA and the Supreme Court decision in *Olmstead v. L.C.* In the *Olmstead* decision, the Court affirmed a state's obligations to provide covered program services to eligible individuals with disabilities in the most integrated setting appropriate to their needs. A state's obligation under the ADA and section 504 are not defined by, or limited to, the services provided under the State's Medicaid program. However, the Medicaid program can support compliance with the ADA, section 504 and Olmstead through the provision of Medicaid services to Medicaid eligible individuals in integrated settings. [79 FR 2951]

CMS seeks to ensure that Medicaid is supporting needed strategies for States in their efforts to meet their obligations under the ADA and *Olmstead*. [79 FR 2956]

CMS does not have the general authority to enforce the ADA independently of its oversight of the Medicaid program. [79 FR 2968]

General Qualities of HCBS Setting:

The revised rule specifies that home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

- 1) 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;
- 2) 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;

- 3) Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;
- 4) 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; and
- 5) Facilitates individual choice regarding services and supports, and who provides them.

The following are general statements of intent regarding the qualities of HCBS settings:

The rule establishes that home and community-based settings must exhibit specific qualities to be eligible for delivery of home and community-based services. [79 FR 2949] These are qualities most often articulated by persons with disabilities as key determinants of independence and community integration. [79 FR 2952] CMS believes the qualities set out in the rule will support the use of the Medicaid program to maximize the opportunities for individuals to access the benefits of home and community living. [79 FR 2952]

CMS believes that the final rule is critical to ensure that individuals have the opportunity to receive services that protect individual choice and promote community integration. [79 FR 2957] Instead of attempting to provide one singular definition to encompass all settings that are home and community-based, CMS describes the qualities that apply in determining whether a setting is community-based. [79 FR 2956]

CMS believes the most effective and consistent way to assure that individuals receiving Medicaid HCBS are offered HCBS in the most integrated setting appropriate to their needs and preferences, regardless of age or disability, is to focus on the qualities of "home" and "community" that assure independence and integration from the perspective of the individuals. [79 FR 2968]

CMS believes that there are a number of methods inherent in the flexibility of HCBS to determine who and how the individual's initiative, autonomy, and independence are optimized. [79 FR 2977]

The following are specific statements of intent applicable to whether congregate settings may be considered home and community-based settings:

It is not the intent of the rule to prohibit congregate settings from being considered home and community-based settings. HCBS must be delivered in a setting that meets the HCBS setting requirements. [79 FR 2957; 79 FR 2968; 79 FR 2975]

It is not CMS's intent to imply that all congregate settings should be categorized as nursing facilities and/or intermediate care facilities for individuals with intellectual disabilities. [79 FR 2959]

Assisted living facilities are not excluded from being considered home and community-based if they are structured and operate in a manner that adheres to the HCBS setting requirements. [79 FR 2972] However, assisted living or independent living units would be presumed institutional and receive heightened scrutiny if they are located in the same building as a nursing unit or other facility providing inpatient treatment or if they are located on the grounds of, or immediately adjacent to a public institution. [79 FR 2972]

Questions were raised regarding the continued viability of sheltered workshops, adult day care services, and other congregate settings and non-residential facilities solely for persons with disabilities. In response, CMS stated that HCBS must be delivered in a setting that meets the HCBS setting requirements as set forth in the rule. In addition, since the purpose of this authority is to provide individuals with HCBS alternatives to institutional settings, individuals receiving HCBS must be living in settings that comport with the HCBS setting requirements set forth in the rule regardless of whether they are receiving HCBS in that residence. This is consistent with CMS's longstanding policy regarding HCBS. [79 FR 3013]

Given the variability within and between types of housing arrangements (e.g., group homes, adult foster care, and assisted living facilities) CMS cannot determine simply by the type of group housing, whether it complies with HCBS characteristics. As a result, particular settings, beyond those specifically excluded in the regulation text (e.g., nursing homes and ICF/ID) will not automatically be included or excluded, but rather will be evaluated using the heightened scrutiny approach described in the regulation. [79 FR 3013]

Additional HCBS Qualities Applicable to Residential Programs:

Overview of the Revised Rule

In a provider-owned or controlled residential setting, in addition to the general qualities of home and community-based settings described above (1-5), the following additional conditions must be met:

- 6) 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.
- 7) 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.
- 8) Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
- 9) Individuals are able to have visitors of their choosing at any time.
- 10) The setting is physically accessible to the individual.
- 11) Any modification of the additional conditions, under 6-10, 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.

The following are statements of CMS's intent regarding the additional qualities applicable to residential programs, including the following topics:

- Number of residents
- Separation of the housing provider from provider of other HCBS services
- Reasonable limits imposed by landlords
- Lockable rooms and access to rooms
- Access to food
- Visitation rights, respecting rights of others
- Modification of general policies

Number of Residents

CMS does not believe there is a maximum number beneath which it could determine with certainty that the setting would meet the requirements of HCB settings. The focus should be on the experience of the individual. In addition, CMS respects a state's right to establish state laws to implement such a requirement regarding size. [79 FR 2968]

The rule no longer includes the number of residents as an HCBS characteristic. [79 FR 3011]

CMS has determined not to include or exclude specific kinds of facilities from qualifying as HCBS settings based on the number of residents in that facility. CMS, however, has established a list of specific conditions that must be met in provider-owned or controlled residential settings in order to qualify as HCBS. [79 FR 3014]

Separation of the Housing Provider from the Provider of HCBS

The final rule does not require the separation of the housing provider from the provider of HCBS. CMS believes that the issue of choice regarding the provision of services can be addressed as part of the person-centered planning process and reflected in the individual's person-centered service plan. [79 FR 2958]

Reasonable Limits Imposed By Landlords

In provider-owned or controlled settings, the individual's freedom to furnish and decorate sleeping or living units may contain limits within the scope of the lease or agreement. [79 FR 2963]

Lockable Door, Private Room, And Access To Private Rooms By Staff

The requirement for a lockable entrance door may be modified if supported by a specific assessed need and justified and agreed to in the person-centered service plan. [79 FR 2963]

The rule does not require that every individual receiving HCBS have their own bedroom when receiving residential services. The rule requires that individuals be provided options of residential settings, including the option of a private room. This rule does not require every provider to have a private room option. Instead, it requires the State to ensure that there are private room options available within a State's HCBS program. [79 FR 2964]

Only appropriate individuals should have access to an individual's room, not all staff. [79 FR 2963]

Access To Food

CMS expects that the individual will have access to food. This requirement does not pertain to full dining services or to meal preparation, only access to food. [79 FR 2966]

Visitation Rights, Shared Living Arrangements And Respect For The Rights Of Others

CMS acknowledges that in certain living situations the preferences of others must be respected. CMS expects that there will need to be communication and coordination between all parties affected. [79 FR 2966]

Modifications To The Conditions For Provider-Owned Or Controlled Residential Settings

The rule specifies that any modification of the conditions for provider-owned or controlled residential settings must be supported by a specific assessed need and documented in the person-centered service plan. [79 FR 2978; 79 FR 3008-3009]

Settings that are Per Se Not Home and Community-Based:

Settings that are not Home and Community-Based. Home and community-based settings do not include the following:

- 1) A nursing facility;
- 2) An institution for mental diseases;
- 3) An intermediate care facility for individuals with intellectual disabilities;
- 4) A hospital; and
- 5) Any other locations that have qualities of an institutional setting, as determined by the Secretary.

Settings Subject to Heightened Scrutiny:

In addition to the per se settings not considered home and community-based, the revised rule specifies that:

any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the State or other parties, that the setting does not have

the qualities of an institution and that the setting does have the qualities of home and community-based settings.

Statements of CMS Intent Providing Greater Flexibility

According to CMS, the final rule has been revised to be more flexible and less prescriptive. Instead of automatically excluding certain settings from qualifying as HCBS, the language in the final rule includes a presumption that these settings are not HCBS but affords states the opportunity to refute this categorization by providing additional information about the characteristics of specific settings. [79 FR 2977] More specifically, the rule specifies that “any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the state or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of home and community-based settings.” [79 FR 2969]

This policy is included because CMS recognizes that not all settings co-located, or closely located with an institutional setting exhibit the same institutional characteristics. [79 FR 2971] For example, a residential setting that allows individuals to have full access to community services, and allows for active participation in neighborhood/community events, resources, and integrated activities, but is located in close proximity to a VA hospital, might meet the qualities for a home and community-based setting and not the qualities of an institution. [79 FR 2971]

Disability Specific Housing Complexes And Programs Offering Specialized Services For Persons With Autism And Other Disabilities

The proposed rule created a rebuttable presumption that a disability-specific housing complex was institutional in nature. The final rule removes this phrase and replaces it with the following language “...or any other setting that the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS...” CMS plans on issuing future guidance to provide examples of the types of settings that will be subject to heightened scrutiny. [79 FR 2974; 79 FR 2975]

A question was raised regarding the viability of public and private specialized residential facilities for persons with severe and profound cognitive-developmental disabilities, including non-urban community-based models. CMS’s response is that settings that are designed to prevent an individual from having the opportunity to participate in the broader community are not home and community-based. CMS believes that individuals, regardless of service need, can benefit from having the opportunity to participate in the broader community. The goal of this regulation is not to take services from individuals, or make individuals move from a location where they have always lived, but to describe the qualities of settings in which services intended

to provide an alternative to institutional care may be delivered. The goal of the regulation is to widen the door of opportunity for individuals receiving Medicaid HCBS to support the same choices to participate in community activities as are available to persons not receiving HCBS and to have a choice in how, when, and where they receive services and to remove unnecessary barriers and controls. CMS believes that the Medicaid program provides many options for states to develop delivery systems that meet the needs of individuals regardless of where they fall on the continuum of care. [79 FR 2974; see also 79 FR 2974 and 79 FR 3014]

Under the requirements of the rule, for a setting to be home and community-based it may not discourage an individual's integration with the broader community. The determination would not be based on whether the setting is rural, urban, or suburban community, but on whether it has the qualities of home and community-based settings as specified in the rule. [79 FR 2974]

The term "community" refers to the greater community and not solely a community of one's peers and, that integration also means more than integration in a community of peers. [79 FR 2975]

CMS agrees that certain kinds of specialized settings may prove highly beneficial to particular populations and may be well integrated into the community. These factors will be taken into account when deciding whether or not a setting should qualify for HCBS waiver funding. [79 FR 3014]

CMS Statements of Intent Regarding Clusters of Homes in Gated Communities

The Secretary will determine through heightened scrutiny, based on information presented by the state and other parties, whether clusters of homes in gated communities do or do not qualify as an HCBS setting, i.e., have the qualities of an institution and whether these complexes have or do not have the qualities of home and community-based settings. CMS will evaluate both rural and urban settings based on whether they have the characteristics required under the regulation. [79 FR 3014]

With respect to programs located adjacent to community colleges and universities, stores, businesses and residential communities, CMS explains that the term "public institution" is defined in the Medicaid regulations for purposes of determining the availability of Federal Financial Participation. Medical institutions, intermediate care facilities, child care institutions, and publicly operated community residences are not included in the definition, nor does the term apply to universities, public libraries, or other similar settings. CMS will apply this definition in implementing the provisions in the rule. [79 FR 2972]

CMS believes that if the setting meets the HCBS setting requirements, is not among the categories of institutions which are never considered HCBS (e.g., nursing home, ICF/ID), and does not exhibit the qualities of an institutional setting, the program may be considered HCBS even though it is adjacent to other buildings such as local community colleges and universities, stores and businesses and residential communities. [79 FR 2972]

CMS Intent to Issue Additional Guidance

Further, CMS intends to provide additional guidance to states to identify any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. CMS plans to include in the guidance examples of specific settings that will require heightened scrutiny and may identify additional qualities, including the size of the facility, triggering such scrutiny. Research and experience indicates that size can play an important role in whether a setting has institutional qualities and may not be home and community-based. [79 FR 2968]

Home and Community-Based Settings: Compliance and Transition

States submitting new and initial waiver requests must provide assurances of compliance with the requirements of this section for home and community-based settings as of the effective date of the waiver.

CMS will require transition plans for existing section 1915(c) waivers and approved state plans providing home and community-based services under section 1915(i) to achieve compliance with this section, as follows:

- 1) For each approved section 1915(c) HCBS waiver subject to renewal or submitted for amendment within one year after the effective date of this regulation, the State must submit a transition plan at the time of the waiver renewal or amendment request that sets forth the actions the State will take to bring the specific waiver into compliance with this section. The waiver approval will be contingent on the inclusion of the transition plan approved by CMS. The transition plan must include all elements required by the Secretary; and within one hundred and twenty days of the submission of the first waiver renewal or amendment request the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.
- 2) For States that do not have a section 1915(c) HCBS waiver or a section 1915(i) State plan benefit due for renewal or proposed for amendments within one year of the effective date of this regulation, the State must submit a transition plan detailing how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit in accordance with this section. This plan must be submitted no later than one year after the effective date of this regulation. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

A State must provide at least a 30-day public notice and comment period regarding the transition plan(s) that the State intends to submit to CMS for review and consideration, as follows:

- 1) The State must at a minimum provide two (2) statements of public notice and public input procedures.
- 2) The State must ensure the full transition plan(s) is available to the public for public comment.
- 3) The State must consider and modify the transition plan, as the State deems appropriate, to account for public comment.

A State must submit to CMS, with the proposed transition plan:

- 1) Evidence of the public notice required.
- 2) A summary of the comments received during the public notice period, reasons why comments were not adopted, and any modifications to the transition plan based upon those comments.

Upon approval by CMS, the State will begin implementation of the transition plans. The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation.

CMS explains the intent of the provisions relating to transition/phase-in:

The final rule establishes home and community-based setting requirements. The rule allows states a transition/phase-in period for currently approved 1915(i) State plan HCBS [79 FR 2949] and 1915(c) HCBS waivers [79 FR 2950] to demonstrate compliance with these requirements. CMS acknowledges that for some settings, implementing the final rule will require a change to operational protocol, and perhaps change in licensure requirements, but CMS believes that the requirements are achievable and provide a reasonable transition time to facilitate changes as may be necessary. [79 FR 2957]

CMS recognizes that there may be some residential facilities that may not currently meet all of the HCBS setting requirements for provider-owned or controlled settings. CMS will allow states a transition/phase-in period for states to demonstrate compliance with the requirements. The transition period may encompass a period of up to five years after the effective date of the regulation if the state can support the need for such a period of time. [79 FR 2979; see also 79 FR 2980]

States are expected to demonstrate substantial progress toward compliance throughout any transition period. For states submitting renewals early in the first year this final regulation takes effect, states may submit a request for a temporary extension to allow time to fully develop the transition plan for that HCBS waiver program. [79 FR 3012]

Provision of Additional Sub-Regulatory Guidance:

On a number of occasions, CMS indicated its intent to issue sub-regulatory guidance regarding specific topics.

CMS will provide further guidance regarding applying the regulations to non-residential HCBS settings. [79 FR 2968; 79 FR 2972]

CMS intends to provide additional guidance to states to identify any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. CMS plans to include in the guidance examples of specific settings that will require heightened scrutiny and may identify additional qualities, including the size of the facility, triggering such scrutiny. Research and experience indicates that size can play an important role in whether a setting has institutional qualities and may not be home and community-based. [79 FR 2968; 79 FR 2974]

The guidance will also specify the process CMS will use to determine if a setting meets the home and community-based criteria. [79 FR 3014]