HCBS Settings Regulations

On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) released what are commonly referred to as its Home and Community-Based Services (HCBS) settings regulations. This document outlines the Disability Law Center’s (DLC) current understanding of the HCBS settings regulations, what the state and others are required to do to comply with them, and recommendations for developing an inclusive and robust implementation process.

The DLC is a nonprofit organization, designated as the Protection and Advocacy agency for individuals with disabilities in the state. Our mission is to enforce and strengthen laws that protect the opportunities, choices and legal rights of people with disabilities in Utah. We envision a just society where Utahns with disabilities enjoy the same opportunities as others, have the right to make choices with respect to their daily routines and major life events, and receive the support needed to be as independent as possible, as well as active, productive, and contributing members of their communities.

Rather than defining HCBS settings by “what they are not,” the regulations emphasize the quality of the individuals’ experiences. They also establish a more outcome-oriented definition of HCBS settings, rather than one based primarily on location, geography, or physical characteristics. CMS views the regulations as a vehicle to “…further expand [sic] opportunities for meaningful community integration in support of the goals of the Americans with Disabilities Act and the Supreme Court’s decision in Olmstead v. L.C.” The DLC also believes the regulations point to the end of federal Medicaid funding for non-integrated HCBS settings, programs, and services in the near future.

The review and assessment process required by the HCBS settings regulations offers the promise of significantly improving the quality of life for individuals with disabilities. It may also lead to a substantial reconfiguration and realignment the support and service delivery infrastructure, ultimately transforming it into a more efficient and cost-effective system. However, it will be a massive undertaking and will not be easy. The entire community has to be actively involved if we are to realize the full potential of the regulations.

To start with, we must:

- insist drafting of waiver renewal applications be an open, transparent, and inclusive project from the beginning;
- ensure a thorough evaluation of all current and proposed HCBS services, programs, and settings is conducted in a detailed and systematic manner, using tools such as the Developmental Disability Network’s HCBS Advocate’s Worksheet and Human Services Research Institute’s National Core Indicators: Evidence for New HCBS Requirements and Revised HCBS Assurances. We cannot rely only on self-reported data from the state, providers, support coordinators, or others;
- solicit public input in all phases of transition planning, from initial development to interim proposal to final document, and every point in between; and
- guarantee a meaningful and ongoing review of compliance and enforcement.

The evaluation must determine that all residential and nonresidential settings, programs, and services funded by Medicaid HCBS dollars:

- are integrated in and support access to the broader community;
• provide opportunities to work in competitive integrated settings, engage in community life, and control personal resources;
• ensure the individual has access to services in the community to the same degree as individuals not receiving Medicaid HCBS;
• are chosen by the individual from setting options, including non-disability specific settings and an option for a private in a residential setting; and
• person-centered plans document the options based on an individual's needs, preferences, and, for residential settings, the individual's resources.

Settings presumed not to be home and community-based:

• settings in a publicly or privately-owned facility providing inpatient treatment;
• settings on grounds of, or adjacent to, a public institution; or
• settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS.

Settings that have the following two characteristics alone might, but will not necessarily, meet the criteria for having the effect of isolating individuals:

• the setting is designed specifically for people with disabilities, and often even for people with a certain type of disability; or
• the individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.

Settings that isolate people receiving HCBS from the broader community may have any of the following characteristics:

• the setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities;
• people with disabilities in the setting have limited, if any, interaction with people without disabilities in the setting or the broader community; or
• settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion);
• examples may include farmstead or disability-specific farm community; gated/secured community; residential schools; or multiple settings colocated or operationally related; or
• “Size can play an important role in whether a setting has institutional qualities and may not be home and community-based.”

These settings may not be included in states' 1915(c) HCBS programs unless:

• a state submits evidence (including public input) demonstrating that the setting does have the qualities of a home and community-based setting and not the qualities of an institution; and
• the Secretary finds, based on a heightened scrutiny review of the evidence, that the setting meets the requirements for home and community-based settings and does not have the qualities of an institution.
For renewals and amendments to existing HCBS 1915(c) waivers submitted within one year of the effective date of the regulations:

- the state submits a plan 60 days prior to submission of the renewal or amendment request detailing any actions necessary to achieve or document compliance with setting requirements for the specific waiver or amendment; and
- renewal or amendment approval is contingent on inclusion of an approved transition plan.

For ALL existing 1915(c) HCBS waivers in the state, the state must submit a plan:

- within 120 days of first renewal or amendment request date detailing how the state will comply with the settings requirements in ALL 1915(c) HCBS waivers and 1915(i) HCBS State Plan benefits; and
- the level and detail of the plan will be determined by the types and characteristics of settings used in the individual state.

The state’s transition plan must include:

- a determination of their current level of compliance with the settings requirements and provide a written description to CMS;
- the written description should be the state’s assessment of the extent to which its standards, rules, regulations, or other requirements comply with the Federal HCBS settings requirements and the description of the state’s oversight process to ensure continuous compliance; and/or
- specific actions to be taken to come into compliance, such as:
  - proposing new state regulations or revising existing ones;
  - revising provider licensing requirements or qualifications;
  - revising service definitions or standards;
  - revised training requirements or programs; and
  - changes to facility or program operation to assure residents/participants have greater control over critical activities, such as access to the community and competitive employment;
- time frames for completing these actions;
- an estimate of the number of settings that likely do not meet the requirement; and
- the time frame to bring individual settings into compliance, including plans to relocate individuals to compliant settings, if necessary.

If the assessment is based on state standards, the state needs to provide their best estimate of the number of settings that:

- fully align with the requirements;
- do not comply with the requirements and will require modifications;
- cannot meet the requirements and require removal from the program and/or the relocation of individuals;
• in instances where a system review identifies settings which are presumed not to be home and community-based and the state intends to submit evidence that the setting is home and community-based and does not have institutional characteristics, CMS expects an onsite assessment that supports the state’s assertion.

The state must provide a 30-day public notice and comment period on the plan the state intends to submit to CMS:

• provide minimum of two statements of public notice and public input procedures;
• ensure the full transition plan is available for public comment;
• consider public comments;
• modify the plan based on public comment, as appropriate; and
• submit evidence of public notice and summary of disposition of the comments, including:
  ○ the full array of comments whether in agreement or not with the state’s determination of the system-wide compliance and/or compliance of specific settings/types of settings;
  ○ a summary of modifications to the Statewide Transition Plan made in response to public comment;
  ○ in cases where the state’s determination differs from public comment, the additional evidence and rationale the state used to confirm the determination (e.g. site visits to specific settings); and
  ○ the URL where the Statewide Transition Plan is posted.

The regulations also clarify that states must establish and use a public input process for waiver changes and provide public notice of any substantive proposed change in a state’s methods and standards for setting payment rates for services. The regulation defines substantive changes as including, but not limited to, revision to services available under the waiver including elimination or reduction of services; reduction in the scope, amount, and duration of any service; a change in the qualification of service providers; changes in rate methodology; or a constriction in the eligible population. In addition, changes in the settings included in the waiver or changes to the state’s transition plan for bringing settings into compliance would require public input.

Thank you for your time and consideration of our recommendations. Please let me know if you have any questions, would like more information, or how the Disability Law Center may be of further assistance.
The Disability Law Center (DLC) is a private, non-profit organization, designated by the governor as Utah's Protection and Advocacy agency. The DLC believes in a society where abilities, rather than disabilities, are recognized; all people have an equal opportunity to participate; and where all people are treated with equity, dignity, and respect. We work toward our vision by enforcing and advancing the legal rights, choices, and opportunities of Utahns with disabilities. DLC services are available free of charge statewide, regardless of income, legal status, language, or place of residence.

If you have further questions, please contact us. Even though our focus is on cases that can help as many people as possible - because time and resources are limited - we at least offer information and/or referral options to everyone who contacts us. Materials are also available in alternative formats such as audio, large-print, Braille and Spanish. Call (800) 662-9080 or apply for help online, and our staff will contact you within 1-3 business days.

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