

2. HCBS Provided in the Community, Not in Institutions

Section 1915(i) provides States the option to provide home and community-based services, but does not define “home and community-based.” Along with our overarching interest in making improvements to Medicaid HCBS, we seek 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.*, 527 U.S. 581 (1999). In the *Olmstead* decision, the Court affirmed a State’s obligations to serve individuals in the most integrated setting appropriate to their needs. A State’s obligations under the ADA and section 504 of the Rehabilitation Act are not defined by, or limited to, the scope of requirements of the Medicaid program. However, the Medicaid program can provide an opportunity to obtain partial Federal funding that supports compliance with the ADA, section 504 of the Rehabilitation Act, and *Olmstead* through the provision of Medicaid services to Medicaid-eligible individuals.

In the April 4, 2008 **Federal Register** (73 FR 18676), we proposed to define home and community settings for this new benefit. Then in the June 22, 2009 **Federal Register** (74 FR 29453), we published an advance notice of proposed rulemaking (ANPRM) that solicited comments on potential rulemaking for a number of areas within the section 1915(c) HCBS waiver program. Specifically, we requested public input on strategies to define home and community-based settings where waiver participants may receive services. Although the ANPRM is specific to section 1915(c) waivers, the services delivered and the settings they are available in are parallel to the section 1915(i) benefit. We recognize a need for a consistent definition of this term across Medicaid HCBS.

In response to the 1915(c) ANPRM, we received comments that supported the underlying goals to promote independence, community inclusion, and the goals of the *Olmstead* decision. However, many commenters also expressed concern about definitions of home and community-based settings that limited participant choice, and that excluded settings that may, in fact, promote independence and integration. Since that time, we have facilitated and participated in multiple stakeholder discussions related to this issue, and we also included proposed language for settings in which HCBS could be provided to elicit further comments on this issue in the section 1915(k) proposed rule published on February 25,

2011 and in the 1915(c) proposed rule published on April 15, 2011. We find the public comment process to be valuable in our attempt to develop the best policy on this issue for Medicaid beneficiaries. Therefore, with this rule, we again invite public comments on proposed language to establish the qualities for home and community-based settings under both sections 1915(i) State plan HCBS and the 1915(k) Community First Choice State plan option. It is our goal to align the final language pertaining to this topic across the sections 1915(k), 1915(i), and 1915(c) Medicaid HCBS authorities.

We have included proposed language for settings in which section 1915(i) services and supports could be provided to elicit additional comments on this issue. While it is not practical to create one singular definition that encompasses all settings that are home and community-based, with this rule we propose quality principles essential in determining whether a setting is community-based. We expect States electing to provide HCBS benefits under section 1915(i) to include a definition of home and community-based setting that incorporates these principles and will review all SPAs to determine whether they propose settings that are home or community-based. We will permit States with approved section 1915(i) SPAs a reasonable transition period, a minimum of one year, to come into compliance with the HCBS setting requirements as promulgated in our final rule.

Recognizing the imperative to provide clear guidance to States and in consideration of recent proposals from States that have clearly exceeded reasonable standards for HCBS, we are proposing to clarify now that home and community-based settings must exhibit 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, in order to be eligible sites for delivery of home and community-based services:

- The setting is integrated in, and facilitates the individual's full 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, like individuals without disabilities;
- The setting is selected by the individual among all available alternatives and identified in the person-centered service plan;

- An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
- Individual initiative, autonomy, and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and
- Individual choice regarding services and supports, and who provides them, is facilitated.

In a provider-owned or controlled residential setting, the following additional conditions must be met. Any modifications of the conditions (for example to address the safety needs of an individual with dementia) must be supported by a specific assessed need and documented in the person-centered service plan:

- ✓ The unit or room 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 the tenants have under the landlord/tenant laws of the State, county, city, or other designated entity. We are soliciting comments as to whether there are other protections, not addressed by landlord tenant law, that should be included;
- ✓ Each individual has privacy in their sleeping or living unit:
 - Units have lockable entrance doors, with appropriate staff having keys to doors;
 - Individuals share units only at the individual's choice; and
 - Individuals have the freedom to furnish and decorate their sleeping or living units;
- ✓ Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time;
- ✓ Individuals are able to have visitors of their choosing at any time; and
- ✓ The setting is physically accessible to the individual.

In addition to the aforementioned criteria there are two criteria that we have not included in the proposed regulation, but wish to solicit comment regarding whether they should be added. The first is related to the proposed requirement that in a provider-owned or controlled residential setting, any modification of the conditions must be supported by specific assessed needs and documented in the person centered service plan. This requirement is meant to address

two issues:

- Individuals receiving HCBS must not have their independence or freedoms abridged by providers for convenience, or well-meaning but unnecessarily restrictive methods for providing person-centered services and supports; and
- Individuals with cognitive disabilities and other impairments may require modifications of the aforementioned conditions for their safety and welfare.

This provision is meant to establish that service planning is the process in which these decisions are made, rather than ad hoc on a daily basis. While the proposed text establishes the requirement that any modification to the conditions are supported by a specific assessed need and documented in the person-centered service plan, we are also considering including language to explicitly set forth these activities. We are considering requiring the following points to be identified: identify a specific and individualized assessed safety need; document less intrusive methods that have been tried but did not work; include a clear description of the condition that is directly proportionate to the specific assessed safety need; include regular collection and review of data to measure the ongoing effectiveness of the modification; and establishing time limits for periodic reviews to determine if the modification can be lifted. We solicit comment on these points and any other potential requirements regarding modifications of the conditions set forth in this proposed rule. We also wish to solicit comment on a second criterion that would include a requirement that receipt of any particular service or support cannot be a condition for living in the unit. In discussing this specific criterion, we discovered that it could be read one of two ways. One interpretation is that this language does not require an individual residing in a provider owned or operated setting to receive HCBS from the setting provider. Rather the individual could choose another qualified individual to provide HCBS. The other interpretation is that this language would prevent the owner of the setting from evicting an individual because the individual refused to accept a particular service. This interpretation could have an effect on residential settings, such as housing programs to address homelessness. Some of these settings include a structure in which individuals are required to participate in treatment (substance use, for example) as a condition of residing there. We acknowledge the complexities that arise, when trying to support an individual's right to choose while recognizing that there are programs and services that have been developed as a result of identified

service needs. As indicated earlier, we are specifically soliciting comments on whether these two criteria should be included as regulatory requirements.

We note that home and community-based settings do not include nursing facilities, institutions for mental diseases, intermediate care facilities for mentally retarded, hospitals, or any other locations that have the qualities of an institutional setting as determined by the Secretary. In considering whether a setting has the qualities of an institutional setting, we will exercise a rebuttable presumption that a setting is not a home and community-based setting, and will engage in heightened scrutiny, for 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 disability-specific housing complex. We expect to issue further guidance regarding such settings. Other characteristics that could cause CMS to consider a setting as “institutional” or having the qualities of an institution would include, but not be limited to, settings which are isolated from the larger community, do not allow individuals to choose whether or with whom they share a room, limit individuals’ freedom of choice on daily living experiences such as meals, visitors, and activities, or limit individuals’ opportunities to pursue community activities.

We have included these provisions to move toward a stronger articulation of the qualities that make a setting a home or truly integrated in the greater community for individuals living with disabilities. We believe that these principles of home and communitybased settings will support the use of the Medicaid program to maximize the opportunities for individuals to access the benefits of home and community living.

We specifically invite comments on whether there are settings in addition to those currently enumerated in statute, that are, by their nature, location or administration inherently noncommunity based, and therefore, should be expressly excluded from HCBS. We also invite comments on the community-based qualities we have proposed in this rule to ascertain whether additional or different characteristics should be included.

In considering comments received pertaining to this provision of the rule, we will also include consideration of all comments received pertaining to the aligned home and community-based setting requirements being proposed in this rule for the section 1915(k) Community First Choice State Plan Option. In recognizing the need for a consistent definition of this term

across Medicaid HCBS, it is our goal to align the final language pertaining to this topic across the regulations for sections 1915(i), 1915(k), and 1915(c) Medicaid HCBS authorities.

We note that this proposal in no way preempts broad Medicaid requirements, such as an individual's right to obtain services from any willing and qualified provider of a service.

We further note that States are not prohibited from funding institutional care under Medicaid. The exclusion of these settings from HCBS waivers and from the State plan HCBS benefit does not limit the availability of institutional and facility-based care for those individuals who require long-term services and supports, and who freely choose to receive services in those settings. However, we believe that these types of services should not be funded through authorities that are intended to promote community-based alternatives to institutional care. Furthermore, we believe that the fundamental requirement that the needs-based criteria for section 1915(i) be less stringent than that for institutional care creates a mandate to ensure that services are provided in settings that are not institutional in nature.

While HCBS are not available while an individual resides in an institution, HCBS should be available to assist individuals to leave an institution. Recognizing that individuals leaving institutions require assistance to establish themselves in the community, we would allow States to include in a section 1915(i) benefit, as an "other" service, certain transition services to be offered to individuals to assist them in their return to the community. We propose that community transition services could be commenced prior to discharge and could be used to assist individuals during the period of transition from an institutional residence. Additionally, services could be provided to assist individuals transitioning to independent living in the community, as described in a letter to the State Medicaid Directors on May 9, 2002 (SMDL #02-008). We further recognize that, for short hospital stays, an individual may benefit from ongoing support through the HCBS State Plan for physical needs over and above such services available in a hospital, to ensure smooth transition from clinical setting to home, and to preserve a sense of continuity and normalcy (a notion particularly important for individuals with intellectual disabilities, cognitive disabilities associated with aging, and behavioral health support needs).

Importantly, these services must be exclusively for the benefit of the individual, not the hospital, and must not substitute for services that the hospital is obligated to provide through its conditions of participation or through its obligations under the ADA.

3. Home and Community-Based Services Do Not Include Room and Board

Payments for room and board are expressly prohibited by section 1915(i)(1) of the Act. Except for respite care furnished in a setting approved by the State that is not the individual's residence, no service or combination of services may be used to furnish room and board through the State plan HCBS benefit.

When an individual must be absent from his or her residence in order to receive a service authorized by the individualized service plan, it may be impractical to obtain a meal outside the venue in which the service is provided. Therefore, in some instances and when it does not constitute a full nutritional regimen, the provision of food may be included as an incidental part of service delivery. When meals are furnished as an integral component of the service, we are proposing to permit the State to consider the cost of food in the rate it pays for the State plan HCBS, as the cost is then considered part of the service itself. We would not consider the meal to be an integral part of the State plan HCBS when two rates are charged to the public, one that includes a meal and one that does not include a meal.