Implementation of the Home- and Community-Based Services Settings Rule

In 2014, the Centers for Medicare & Medicaid Services (CMS) finalized a rule establishing new requirements for the settings in which Medicaid home- and community-based services (HCBS) are delivered (CMS 2014a). Under the rule, states must develop implementation plans and determine which providers meet the new requirements. HCBS providers must comply with these requirements by March 17, 2022, or they will not be able to receive Medicaid payment for HCBS.

This issue brief provides an overview of the HCBS settings rule and describes the status of federal and state implementation activities. It then discusses the results of interviews with federal and state officials, beneficiary advocates, and provider associations regarding these activities and implications for beneficiary access to HCBS. While stakeholders generally agreed that the rule will expand opportunities for community integration, uncertainty remains about how states and CMS will evaluate compliance of certain provider types.

Background

Medicaid HCBS include a wide range of services that help individuals with disabilities live in the community, such as personal care services provided in residential and non-residential settings, adult day services, supported employment, and home-delivered meals. Unlike institutional services, state Medicaid programs are not required to cover HCBS, but all do.

Medicaid coverage of HCBS was first authorized in 1981 under Section 1915(c) of the Social Security Act (the Act), and various state plan authorities have been added since then. States can also provide HCBS through demonstration waivers authorized under Section 1115 of the Act (Appendix). Over time, states have used these authorities to shift the delivery of long-term services and supports (LTSS) away from institutional care and toward HCBS, referred to as rebalancing. This change has been encouraged by the Americans with Disabilities Act of 1990 (ADA, P.L. 101-336), which requires states to serve individuals in the most integrated setting that meets their needs, and the U.S. Supreme Court's *Olmstead v. L.C.* decision, in which the Court ruled that the unjustified institutionalization of individuals with disabilities by a public entity is a form of discrimination. Federal and state efforts to support rebalancing have included the Money Follows the Person demonstration program and the Balancing Incentive Program (MACPAC 2019).

Since 2013, Medicaid programs have been spending more on HCBS than institutional care (Eiken et al. 2017). In fiscal year 2016, Medicaid programs spent $94 billion on HCBS, accounting for 57 percent of total Medicaid spending on LTSS (Eiken et al. 2018).

HCBS Settings Rule

Until the 2014 rule, there were few specific Medicaid requirements for HCBS settings. According to CMS, the intent of the rule is to ensure that HCBS settings are different from institutional settings, they facilitate community integration, and their coverage of services is defined by the nature and quality of individuals' experiences rather than solely by the physical location. Under the rule, beneficiaries who use HCBS in community-based settings should have the same degree of access to employment, control of personal resources, and engagement in community life as others in the community.

In the preamble to the rule, CMS noted that it seeks to ensure that Medicaid supports state efforts to meet obligations under the ADA and *Olmstead v. L.C.*, commenting that the rule is in the spirit of those mandates (CMS 2014a). Services provided under the Act's Section 1915(c) waivers and Sections 1915(i) and 1915(k) state plan options must be provided in settings that comply with the rule. In addition, CMS has said it will include these requirements in the terms and conditions of Section 1115 demonstration waivers (CMS 2014b).[1]

The rule included requirements that states implement a person-centered planning process by which beneficiaries or their representatives participate in the development of a written service plan. The regulation outlines a number of requirements for this process, such as ensuring it enables the beneficiary to make informed choices and decisions. The written plan that results from this process must reflect information including the beneficiary's strengths and preferences, clinical and support needs identified through a functional assessment, goals and desired outcomes, and risk factors, along with measures to minimize risks (e.g., backup plans). The plan must also reflect what services and supports will assist the beneficiary in achieving plan goals, including both paid services and natural supports (CMS 2014a). The rule requires that HCBS settings have qualities that promote community integration, and other qualities based on an individual's needs as indicated in the person-centered service plan (Box 1).

Institutions such as nursing facilities, institutions for mental diseases, intermediate care facilities for individuals with intellectual disabilities, and hospitals are explicitly excluded from payment for HCBS. Settings located in a public or private institutional building, in a building adjacent to or on the grounds of a public institution, or those with other characteristics that have the effect of isolating individuals who use HCBS from the broader community are generally excluded, unless those characteristics are sufficiently mitigated by other factors. States can demonstrate that certain settings that presumably isolate individuals can receive HCBS payment through a so-called heightened scrutiny process in which CMS evaluates states' justifications. That process is discussed in more detail later in this brief.

BOX 1. Summary of the Qualities of Eligible Settings under the Medicaid Home- and Community-Based Services Settings Rule

The Medicaid home- and community-based services (HCBS) settings rule requires HCBS settings to have qualities that promote community integration based on an individual's needs as indicated in the person-centered service plan. Under the rule, eligible settings:

- are integrated in and support full access of individuals receiving Medicaid HCBS to the greater community;
- are selected by the individual among a variety of settings;
- ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- optimize individual autonomy in making life choices including activities of daily living, environment, and with whom to interact; and
- facilitate individual choice in services and providers.

If a residential setting is provider-owned or controlled, it must:

- consist of a specific, physical place that can be owned, rented, or occupied under a legally enforceable agreement, which provides the same responsibilities and protections from evictions that tenants have under the laws of the jurisdiction;
- give individuals privacy in their sleeping or living unit;
- provide individuals with freedom and support to control their schedules and activities, including having food available at any time;
- allow individuals to have visitors of their choice at any time;
- be physically accessible to the individual; and
- support modifications of the first four conditions above with an assessed need which is justified and documented in the person-centered service plan, which must also contain additional information regarding this modification.

Source: 42 CFR 441.

Implementation Process

The rule identifies various steps that states must take to ensure compliance with the requirements. After March 17, 2022, settings that do not meet the rule's requirements will not receive Medicaid payment for HCBS.[2]

Statewide transition plans

The rule required each state to submit a statewide transition plan to CMS by March 17, 2015, describing how the state would assess HCBS settings and how non-compliant settings would be brought into compliance. Prior to submitting their plans to CMS, states were expected to make them available for public comment and incorporate public feedback.[3] CMS would then work with states to help them meet the

requirements for initial or final approval. CMS required some states to clarify or modify their plans before it granted initial approval.

As of December 2019, 19 states had received final CMS approval of their transition plan (Table 1) (DEHPG 2019a). Examples of changes CMS has requested from states that have not yet received final approval include:

- completion of provider assessments;
- more information on monitoring and oversight for continued compliance;
- timelines for remediating HCBS settings; and
- a clear process for identifying settings that are presumed to have institutional qualities (CMS 2016a, 2017b).

TABLE 1. Status of Statewide Transition Plan Approval, December 2019

Status	Clarifications or modifications required for initial approval[1]	Initial approval only	Final approval received
Number of states in stage	5	27	19
States in this stage	IL, MA, ME, NJ, TX	AL, AZ, CA, CO, FL, GA, IA, IN, KS, LA, MD, MI, MO, MS, MT, NC, NE, NH, NM, NY, NV, PA, RI, SC, VT, WI, WV	AK, AR, CT, DC, DE, HI, ID, KY, MN, ND, OH, OK, OR, SD, TN, UT, VA, WA, WY

Notes: [1] Some states may be able to receive initial and final approval at the same time if requested changes are adequately addressed.
Sources: CMS 2019a. DEHPG 2019a, 2019b.

In addition to assessing the compliance status of HCBS settings, states must also evaluate state laws, rules, policies, processes, and forms for compliance with the new requirements. For example, Tennessee had to amend Department of Health rules limiting the hours that adult care home residents could receive visitors or access common areas, which conflicted with the settings rule provision that residents must be able to have visitors at any time (TennCare 2016).

Assessments of HCBS settings

States are required to assess the extent to which Medicaid HCBS settings comply with the new federal requirements and document the outcomes in the statewide transition plan. States have flexibility in how they evaluate settings and they must establish in their statewide transition plans how they will continue overseeing the settings for ongoing compliance after the transition period (CMS 2014c).[4]

Most states with final, approved statewide transition plans opted to allow providers to self-assess their settings using a state-developed tool, which may be validated by a number of methods including site visits. For example, the state of Alaska gave providers a self-assessment tool covering topics such as the physical location of the setting, community integration, availability for employment services and support, resident rights, choice of settings, and living arrangements (Alaska DHSS 2018). Alaska's Senior and Disabilities Services agency then reviewed all self-assessments, and conducted on-site reviews for selected settings.

Heightened scrutiny

The heightened scrutiny process allows states to justify why certain settings should be eligible for continued participation in Medicaid despite what might be considered institutional characteristics. Settings that may be subject to heightened scrutiny include those located in a public or private institutional building, in a building adjacent to or on the grounds of a public institution, or those with other characteristics that have the effect of isolating individuals who use HCBS from the broader community (Table 2). As noted above, some settings are specifically excluded from HCBS payment, such as nursing facilities.

TABLE 2. Factors Determining Whether Settings Delivering Home- and Community-Based Services are Subject to Heightened Scrutiny

Heightened scrutiny treatment	Rationale	Setting
May be required for HCBS reimbursement	Specified in the regulation as having presumptively institutional characteristics	• Located in a building in a public or private facility that also provides institutional treatment • Located in a building adjacent to or on the grounds of a public institution • Other setting that has the effect of isolating individuals receiving Medicaid-covered HCBS from the broader community
Not required	Presumed or determined to meet HCBS requirements	• Private home owned by beneficiaries or their relatives, in most circumstances • Other setting without presumptively institutional characteristics that meets requirements as specified in the rule
Not required	Excluded from HCBS payment	• Nursing facility • Institution for mental disease • Intermediate care facility for individuals with intellectual disabilities • Hospital • Other location with qualities of an institution that are not submitted to CMS for heightened scrutiny

Notes: CMS is Centers for Medicare & Medicaid Services. HCBS is home- and community-based services.
Sources: MACPAC analysis of 42 CFR 441. DEHPG 2019b.

In March 2019, CMS released guidance describing the heightened scrutiny process, which included factors that the agency will use to determine whether a setting has the effect of isolating individuals (CMS 2019b). A setting will be considered isolating if it:

- offers only limited, if any, opportunities for beneficiaries to interact in and with the broader community;
- restricts beneficiaries' service choices or ability to engage in activities outside of the setting;
- is located separate and apart from the broader community without giving beneficiaries opportunities to access that community consistent with their person-centered plans; or
- exhibits other state-determined factors, if the state has described these factors such that stakeholders understand what a state considers isolating (CMS 2019b).[5]

If a setting has any of these isolating factors, but the state determines the setting can comply with the rule by July 1, 2020, the state does not have to submit that setting for heightened scrutiny. However, states must identify these settings for public comment, either in the statewide transition plan or by more targeted outreach, if permissible under the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). If a significant portion of those providing public comment disagree with the state's determination that a setting's isolating characteristics have been remediated, then CMS reserves the right to review such settings.

States must submit evidence packages to CMS for isolating settings that have not completed remediation. States also must provide a numbered list of settings for each of the three categories of settings presumed to have institutional qualities. CMS will review a sample of settings from these lists that include (1) settings the state requests it to review, (2) settings that had significant public comment opposing the state's assessment, and (3) a random sample of remaining presumptively institutional settings. Evidence packages must include information on:

- the qualities of the setting;
- how it is integrated in the broader community;
- how policies and procedures support access of individuals to the community; and
- how settings support an individual's person-centered service plan.

The March 2019 guidance and an accompanying toolkit provide states with information on the types of evidence that may be used to support the factors above for each setting. Examples include descriptions of the state's review of a reasonable sample of individuals' daily schedules, documentation regarding the setting's policies and procedures, a description of a remediation plan for the setting, and a summary of stakeholder comments (CMS 2019b).

CMS will approve the state's explanation of how a presumptively institutional setting will be considered in compliance, disagree, or request additional information from states before making a final decision. If CMS determines that additional action is needed to comply with the rule, then CMS expects that states will also apply any remediation strategies across all similar settings.

CMS may request information on settings not submitted for heightened scrutiny if public comments argue that the setting is presumptively institutional (CMS 2019b).[6] The agency may also request additional

settings to review, or suggest changes in the state's process if it has concerns regarding evidence provided by the states. States are required to provide CMS with a list of settings that cannot be remediated by the end of the transition period. Services provided in such settings will no longer be covered under Medicaid HCBS authorities.

Activities to help providers comply

Transition plans must include an estimate of the number of providers unable to comply, and the number of providers who are not currently compliant but expected to meet requirements with certain changes (CMS 2014c). States must also describe how they will help providers comply. For example, the Oregon Health Authority requires that certain residential providers who do not demonstrate compliance with state administrative rules submit and complete a plan to correct areas of deficiency within 30 days (Oregon DHS 2019). The state also plans to conduct at least two on-site reviews of all HCBS residential settings by July 1, 2021.

Other states are similarly providing guidance to providers in how to implement the rule. Tennessee's statewide transition plan notes that technical assistance is available to providers having difficulty coming into compliance (TennCare 2016). Minnesota has developed a guidebook containing examples and hypothetical scenarios (Box 2) (MN DHS 2017). For example, it explains that residential providers are expected to give beneficiaries access to meals and snacks at a time they prefer, and allow residents to choose who can visit them without restricting visit times.

BOX 2. Examples from Minnesota's *A Provider's Guide to Putting the HCBS Rule into Practice*

Minnesota developed a 50-page guidebook to help providers understand and comply with the HCBS rule's requirements (MN DHS 2017). The guidebook includes hypothetical scenarios to illustrate recommended practices. Some examples of actions providers should take to comply with the settings rule are summarized below.

All HCBS providers should:

- ensure people have opportunities to be fully included into the community as they desire;
- engage with people to understand their desire to seek employment, including competitive integrated work settings; and
- respect individuals' privacy, such as their ability to have private conversations and privacy during activities of daily living (e.g., bathing, grooming, and dressing).

Residential providers should:

- provide residents with leases that provide the same responsibilities and eviction protections of other tenants in the jurisdiction;
- ensure that residential settings have lockable doors (to the front door of the unit or bedroom), with access provided only to designated staff who must get the resident's permission before entering;
- give people control over their schedules, including access to meals and snacks at the time of their preference; and
- allow residents to choose visitors without restrictions on visit times.

Source: MN DHS 2017.

Transitioning beneficiaries from non-compliant settings

Some HCBS providers may choose not to comply with the settings rule. For example, facilities that serve few Medicaid beneficiaries may not wish to invest in the necessary changes.

In such cases, states must assure that beneficiaries are given, through the person-centered planning process, the opportunity, information, and supports needed to make an informed choice among alternative settings, including a setting that complies or will comply with the rule by the end of the transition period (CMS 2014c). The statewide transition plans describe how states will communicate options and support transitions. For example, the approved plan for the District of Columbia describes its notification process and the policy governing transitions, indicating that individuals have the right to choose their new provider and transitions will be person-centered (DC DDS 2018).

Stakeholder Perspectives on the Implementation Process

From October 2018 to July 2019, MACPAC interviewed federal and state officials, beneficiary advocates, and provider association representatives to gather perspectives on the implementation of the rule.[7] These interviews solicited insights into federal and state implementation activities, the types of changes providers are making to comply, and the anticipated effects of the rule on beneficiary access to and experiences receiving HCBS. Among the key themes:

- Stakeholders generally voiced support for the rule's intended goals while noting challenges in implementation and oversight.
- Federal agencies are providing technical assistance to help states implement the rule, and have planned additional provider education activities.
- Some providers—particularly adult day centers and so-called intentional communities, farmsteads, or other providers with campus settings—are uncertain about how to comply and are seeking more direction from CMS and states.
- Beneficiary advocates voiced both optimism and concern about how beneficiaries' access and experiences will change. Advocates also told us that information is not being delivered to them in a way that allows them to provide meaningful public comment.

Federal implementation activities

CMS is working with the Administration for Community Living (ACL)—the federal agency within the U.S. Department of Health and Human Services responsible for increasing access to community supports for people with disabilities—to implement the rule. ACL's role involves interfacing with states and other stakeholders, helping draft subregulatory guidance, and providing technical assistance to states and other groups, such as protection and advocacy organizations. Federal officials from CMS and ACL emphasized the rule's potential to help change HCBS delivery systems to be more person-centered and integrate beneficiaries in the community. Agency officials also expressed their commitment to helping states implement the rule across various providers.

Federal agencies are providing technical assistance to help states comply, and have planned additional provider education activities. A CMS official described guidance designed to clarify various issues and public engagement efforts, including stakeholder meetings, webinars, and conference presentations. Although the official acknowledged that CMS has released more robust information for residential settings compared to non-residential settings, the agency has provided a list of questions to consider in assessing whether the characteristics of a setting meets compliance standards. In the future, CMS may provide more information on compliance practices that providers can implement, particularly for non-residential settings like pre-vocational services, employment supported settings, and adult day settings with social and recreational services.

ACL staff also told us they and CMS work with providers and recognize that providers need more federal assistance. After observing that a large number of providers participated in past national webinars, ACL was planning a six-part webinar series focused specifically on provider issues.

State perspectives

State officials agreed that the rule provided an opportunity for states to evaluate systems of delivering HCBS and make them more person-centered, but also reported encountering challenges in getting providers to make changes, and in communicating with CMS.

State officials reported that the goals of the rule—community integration, beneficiary empowerment, and person-centered models—align with their goals. Officials in one state told us that the rule presented an opportunity to evaluate HCBS settings to make them less institutional in nature. An official in another state said that since the rule was released, the state has seen an increase in vocational providers, which has created more choice. An official in a third state said that the rule supports work that was already underway.

State officials reported that inconsistent or piecemeal guidance from CMS complicates state implementation efforts. Since 2014, CMS has released a variety of guidance, frequently answered questions, and toolkits to assist in the implementation process (CMS 2019b, 2014b, 2014c). However, the timing of such releases has not always aligned well with states' implementation processes, with some states in the middle of or finished with certain implementation activities when CMS released clarifying information. Relatedly, officials in two states reported that CMS standards for reviewing statewide transition plans and heightened scrutiny evidence packages changed over time. One state official learned over time that CMS was not as interested in the exact results of provider assessments as it was in details on the process and timeline for bringing providers into compliance. Another state reported that it had already completed reviewing providers and submitted a comprehensive evidence package to CMS when CMS issued guidance that such packages were not needed for certain settings. While the state indicated that this work was not necessarily a waste of time, compiling the information was a significant commitment that was no longer relevant.

States with final statewide transition plans reported engaging providers, beneficiaries, families, and advocates during the implementation process. One state created and disseminated educational materials on the settings rule to providers, case managers, beneficiaries and their families. The state facilitated conversation among providers on how to comply with the rule and conducted outreach to community organizations. Another state engaged beneficiaries and families via community meetings and direct mailings. This state also engaged providers through videos of best practices, letters and presentations, focus groups, and one-on-one conversations and feedback.

Most states reported challenges in bringing providers into compliance. Most states we interviewed mentioned that some HCBS providers were initially resistant to the changes required by the rule, often due to the cost of implementing them. However, states with final statewide transition plans indicated that they had completed provider assessments, were able to bring most providers into the remediation process, and those providers would meet the 2022 compliance deadline. One state official noted providing individualized technical assistance to providers. Another state official noted framing the changes providers had to make as changes to improve quality and outcomes, rather than as a compliance exercise.

Officials in states without final approval mentioned additional challenges due to state policies that conflict with the settings rule. For example, one state official mentioned state or local rules barring locks on doors, while the HCBS settings rule requires lockable doors, with access provided only to certain staff. Another state anticipated all of its medical model adult day centers would have to go through heightened scrutiny due to conflicts between the rule and state requirements.

One state official noted that the rule may have unintended consequences on beneficiary access to certain settings. For example, settings that do not have enough Medicaid beneficiaries to justify investing in remediation may stop participating in Medicaid, potentially reducing access. Officials in one state noted that a few providers had opted out, leading to transitions for a few beneficiaries to other settings.

Provider and beneficiary perspectives

In general, provider groups and beneficiary advocates expressed support for the creation of federal standards for HCBS settings. However, beneficiary advocates had some concerns about CMS oversight, and providers were concerned that in order to comply with the rule they are incurring costs that are unaccounted for in payment rates.

Provider groups expressed concerns about applying the rule uniformly across settings serving different populations. Stakeholders told us that the needs of and services provided to people age 65 and older, people with physical disabilities, and individuals with intellectual disabilities or developmental disabilities (ID/DD) can be vastly different. Two provider groups noted the rule appears geared towards phasing out isolating settings that tend to serve the ID/DD population, such as sheltered workshops (employment settings that exclusively employ people with disabilities). In contrast, increasing community integration for the settings primarily serving the medical needs of the aging population may be less of a concern. For instance, one provider explained that individuals age 65 and older may visit medical adult day centers or other community-based settings only a few times a week primarily for medical treatment. Requiring such settings to provide activities (such as grocery shopping) could take time away from the provider meeting the needs for which beneficiaries were authorized to receive services.

Many stakeholders commented that communication from CMS and states has not been regular, clear, or transparent. However, for others, communication from CMS and states has been sufficient. A coalition of providers and beneficiaries commented that CMS had delegated communication to the states, and was not regularly communicating with them. Stakeholders also voiced concerns that states were not actively providing information or being transparent about their implementation processes, and that information on state websites was often difficult to find. A representative of a provider association said that their inability to find statewide transition plans prompted them to request that CMS post these documents. Beneficiary advocates told us that even when plans are publicly available, these documents are long, technical, and difficult to understand.

In contrast, some provider and beneficiary groups reported that their experiences with CMS were positive, noting that CMS had posted statewide transition plans directly in response to their concerns. In addition, CMS and some states have hosted webinars for provider groups and beneficiary advocates, though the stream of communications from CMS has mainly been geared towards states.

Some beneficiary advocates were concerned that a lack of oversight by CMS may weaken the rule, and were not satisfied with opportunities for public input. Beneficiary advocates were particularly concerned that CMS's increased delegation to states in the latest heightened scrutiny guidance could diminish the rule's potential to transform HCBS settings. Advocates noted that CMS, by only requiring evidence packages for settings that cannot achieve compliance by July 2020, has given states more control over determining whether settings have overcome isolating qualities than they had under previous guidance. While CMS said in its the guidance that the agency will review additional settings if it receives significant public input, beneficiary advocates described difficulties in tracking information on state implementation plans thus far, impeding public comments. One member of a beneficiary advocacy group said that it is unreasonable to expect beneficiaries to be able find, analyze, and respond to a 30-day public comment period given the complexity of the documents.

Beneficiary advocates were also concerned that the HIPAA privacy rules may prevent states from being transparent about their decision making and eliciting public feedback. CMS's March 2019 heightened scrutiny guidance noted that, in some cases, the name and address of an HCBS setting may be considered personal health information, and thus could not be disclosed under HIPAA. This means that the public would not be able to identify some settings and whether or not they comply with the rule. Instead, publicly available information might only provide general descriptions of the settings (CMS 2019b). Advocates raised concerns about lack of transparency regarding how such settings remediated to become compliant with the rule. Although CMS guidance says it can review settings when the public has disagreed with a state's assessment, advocates were concerned that they will not be able to provide this feedback unless the specific settings are identified. A CMS official acknowledged this concern, and indicated that state HIPAA compliance officers will have a great deal of responsibility for determining whether publicizing the name or address of a setting will violate privacy rights. CMS has discussed HIPAA compliance with states and expects that state decisions on this issue will vary.

Providers expressed uncertainty about the ability of adult day service providers to comply with the rule, and some said additional CMS guidance is needed. Providers expressed concerns about the ability of adult day centers that share facilities with or that are connected to nursing facilities to comply with the rule. Many of these centers are on the grounds of nursing facilities and may share administration and staff.

Responding to these concerns, a CMS official told us that settings should meet the basic tenets of autonomy and community integration, and that the rule does not intend to eliminate any specific HCBS provider type. The official acknowledged that it is possible for adult day centers located in a wing of a nursing facility to comply with the rule. Compliance will depend on how each individual setting is providing services now and what remediation is necessary.

An ACL representative also acknowledged that stakeholders are seeking guidance for day settings, noting that CMS had already dealt with similar concerns regarding settings that serve people with Alzheimer's disease and dementia, when some elements of the rule appeared to conflict with practices that prevent beneficiaries from wandering. In response to those concerns, CMS published additional information clarifying how settings could comply with the rule (CMS 2016b). The CMS official indicated that further information on adult day settings may be forthcoming.

HCBS providers were concerned that payment rates do not account for the costs of complying with the rule. Representatives from three provider associations told us that providing beneficiaries with more opportunities to engage in the community increases costs, which are not reflected in payment rates. Providers cited new costs, including transportation, additional staffing (including retaining staff at the care site for beneficiaries who are not attending off-site activities), and the activities themselves.

A CMS official acknowledged this concern but noted that CMS cannot require states to raise payment rates or provide additional funding. However, CMS encourages states to be mindful of how payment rates may affect access.

Looking Ahead

Much work remains to be completed before the 2022 compliance deadline. Many statewide transition plans have yet to be finalized, and states are in the process of helping providers remediate settings by 2022 or developing evidence packages for heightened scrutiny. Once states begin to publish information on which settings can or cannot comply, and CMS begins to make decisions on states' evidence packages, the potential effects on beneficiaries' access to HCBS will become more apparent.

Endnotes

[1] The rule does not apply to Programs of All-Inclusive Care for the Elderly (PACE). These programs primarily serve individuals dually eligible for Medicare and Medicaid in a day center that provides medical and social services, along with other services individuals need outside of the day center, including HCBS.

[2] The 2014 rule required state Medicaid programs to bring settings into compliance with the new standards by March 17, 2019 (79 FR 2947). In 2017, CMS issued guidance extending the deadline for compliance to March 17, 2022 (CMS 2017a). CMS noted that the transition process was complex, and that additional time would help states implement the rule in a collaborative, transparent, and timely manner.

[3] There is no transition period for new waiver programs; they must be compliant as of the effective date of the waiver.

[4] CMS has provided a toolkit for states on how to assess both residential and non-residential settings (CMS 2014c). Steps states can take include: (1) requiring providers to complete surveys to assess themselves; (2) conducting onsite reviews of a sample of sites, particularly when a state does not have full knowledge of the settings in their system; (3) assessing the setting's policies and standard processes, such as licensing reviews, provider qualification reviews, and support coordination; or (4) requiring providers to submit certain information to the state to support its determination of compliance.

[5] These factors replaced earlier guidance that specified settings presumed to be isolating, including farmsteads or disability-specific farms and gated or secured communities for people with disabilities (CMS 2015). The most recent guidance does not provide such examples, emphasizing that states should review each setting to determine if it meets any of the identified factors.

[6] CMS has not stated how these settings can be brought to the agency's attention.

[7] Federal officials included staff from CMS and the Administration for Community Living (ACL). State perspectives were solicited from the National Association of State Directors of Developmental Disabilities Services and ADvancing States, as well as officials from California, Minnesota, New York, Oklahoma, and Tennessee. Beneficiary and provider perspectives were obtained from interviews with the American Network of Community Options and Resources, Autism Speaks, HCBS Advocacy Coalition, LeadingAge, National Adult Day Services Association, and Together for Choice.

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APPENDIX: Statutory Authorities Used for Medicaid Home- and Community-Based Services

Medicaid-covered home- and community-based services (HCBS) include personal care services delivered in residential or non-residential settings, adult day center services, supported employment services, home-delivered meals, and transportation. States cover HCBS through one or more statutory authorities (Table A-1).

The HCBS settings rule applies to settings that are eligible for payment under Social Security Act Section 1915(c) waivers and Sections 1915(i) and 1915(k) state plan options. In addition, CMS has said it will include these requirements in the terms and conditions of demonstration waivers authorized under Section 1115 of the Social Security Act.

TABLE A-1. Statutory Authorities Used for Medicaid Home- and Community-Based Services

Type of authority	Authority	Description
Waiver	Section 1915(c)	Allows states to forego certain Medicaid requirements to target HCBS benefits to specific populations, cap the number of beneficiaries who receive these benefits, or create waiting lists for people who cannot be served under the cap.
	Section 1115	Not specific to HCBS, Section 1115 demonstration waiver authority is a broad authority that allows states to test new delivery models.
State plan	Section 1915(i)	Allows states to offer HCBS under the state plan to people who need less than an institutional level of care, the typical standard for Medicaid coverage of HCBS. States can also establish specific criteria for people to receive services under this authority.
	Section 1915(j)	Gives authority for self-directed PAS, providing beneficiaries with the ability to hire and direct their own PAS attendant. States may also give beneficiaries the authority to manage their own individual service budget.
	Section 1915(k)	The Community First Choice option, established in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) provides states with a 6 percentage point increase in the federal medical assistance percentage for HCBS attendant services provided under the state plan.

Notes: HCBS is home- and community-based services. PAS is personal assistant services.
Sources: §§ 1115, 1915(c), 1915(i), 1915(j), and 1915(k) of the Social Security Act.