

## **Questions and Answers - 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(c) Home and Community-Based Services Waivers - CMS 2249-F and 2296-F**

1. What is the purpose of this final rule?

A: The final rule supports enhancement of the quality of home and community-based services (HCBS), adds protections for individuals receiving services, and provides additional flexibility to states that participate in the various Medicaid programs authorized under section 1915 of the Social Security Act (the Act). Highlights of this final rule include:

- Provides implementing regulations for section 1915(i) State Plan HCBS, including new flexibilities enacted under the Affordable Care Act to offer expanded HCBS and to target services to specific populations;
- Defines and describes the requirements for home and community-based settings appropriate for the provision of HCBS under the Section 1915(c) HCBS waiver, 1915(i) State Plan HCBS and 1915(k) (Community First Choice) authorities;
- Defines person-centered planning requirements across the 1915(c) and 1915(i) authorities;
- Provides states with the option to combine coverage for multiple target populations into one waiver under Section 1915(c), to facilitate streamlined administration of 1915(c) HCBS waivers and to facilitate use of waiver design that focuses on functional needs.
- Allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare (dual eligibles), such as 1915(b) and 1915(c).
- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs.
- Provides an additional exception to the general requirement that payment for services under a state plan must be made directly to the individual practitioner when the state is the primary source of employment for a class of individual practitioners.

2. What are the major differences between the proposed rules and this final rule?

A: This final rule is a combined response to the public comments on the proposed rule published in the May 3, 2012 **Federal Register** (77 FR 26362) that pertain to the provisions of section 1915(i) HCBS and section 1915(k) Community First Choice benefit under the Medicaid state plans, provider payment reassignment, and the authority for a 5-year duration period for certain demonstration projects or waivers as well as the comments on the proposed rules published in the April 15, 2011 **Federal Register** (76 FR 21311) that pertain to section 1915(c) HCBS waivers.

The major substantive changes between the proposed rules and this final rule relate to the requirements for the qualities of settings that are eligible for reimbursement for the Medicaid home and community-based services (HCBS) provided under sections 1915(c),

1915(i) and 1915(k) of the Act. Over the course of rulemaking related to defining the qualities of home and community-based settings and in consideration of the public comments received, CMS moved away from defining settings by the qualities they do not have to defining them by the nature and quality of the participants' experiences. The final rule establishes a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. It also requires that states develop a process, approved by CMS, to transition their current HCBS programs to include settings that meet the requirements of the final rule. For detail regarding the specific changes between the proposed and final rules, please refer to the Home and Community-Based Settings fact sheet at <http://www.medicaid.gov/HCBS>.

3. What does this final rule do for 1915(i) State plan HCBS?

A: The final rule provides implementing regulations for Section 1915(i) State Plan HCBS, including the new flexibilities and expanded service coverage enacted under the Affordable Care Act.

4. How will the final rule affect existing HCBS offered by states under 1915(c) waivers, state plan programs like the 1915(i) and 1915(k) and 1115 demonstrations?

A: The final rule establishes a set of requirements for home and community-based settings under the 1915(i), 1915(c) and 1915(k) Medicaid authorities, and a set of person-centered planning requirements for Medicaid HCBS participants under 1915(c) and 1915(i). States operating existing approved Medicaid HCBS programs will be expected to meet or transition to the new requirements, in accordance with the timelines articulated in the rule. CMS will also include requirements in the special terms and conditions of 1115 demonstrations that impact individuals receiving HCBS services.

5. What are the other changes to the 1915(c) waiver program made through this final rule?

A: In addition to the HCBS settings requirements, the final rule provides states with the option of combining existing waiver targeting groups into one waiver. It adds requirements regarding person-centered planning and clarifies the timing of amendments and the public input requirements when states propose modifications to HCBS waiver programs or service rates. Finally, the final rule describes additional strategies available to CMS to ensure state compliance with the statutory and regulatory requirements for providing HCBS services under section 1915(c) of the Act.

6. What does the Five-Year Period for Certain Demonstration Projects and Waivers provision of the final rule accomplish?

A: In accordance with section 2601 of the Affordable Care Act, states have the option to request, subject to the approval of the Secretary, a five-year approval or renewal period for certain Medicaid waivers. Specifically, this time period would apply for demonstration and waiver programs through which a State serves individuals who are dually eligible for both Medicare and Medicaid benefits. This would permit, for example, a state to coordinate a 1915(i) HCBS State Plan Amendment with a 1915(b) managed care authority.

7. When must states use a public input process for 1915(c) waiver actions?  
A: States are currently asked to provide details regarding the public process for input on 1915(c) waiver amendments and renewals. This final rule clarifies that states must establish and use a public input process specifically for waiver changes. The rule also includes a provision that states must provide public notice of any substantive proposed change in a state's methods and standards for setting payment rates for services. States will describe their process for receiving public input and ensure that it is sufficient to provide meaningful opportunities for input from individuals served or who are eligible to be served, based on the scope of the proposed changes.
8. How does CMS define substantive changes with respect to the public input process?  
A: 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.
9. How does this final rule impact the Community First Choice (CFC) State Plan Option under 1915(k)?  
A: The final rule for the Community First Choice State Plan Option under 1915(k) of the Act was published May 7, 2012. All provisions of that rule were finalized at that time with the exception of the requirements for home and community-based settings. This new final rule establishes requirements for home and community-based settings in Medicaid HCBS provided under the Community First Choice State Plan option that also apply to the 1915(c) HCBS waiver and 1915(i) State Plan HCBS programs.
10. Why did CMS decide to define what settings are appropriate for the provision of home and community-based services?  
A: Section 1915(c) of the Social Security Act was established in 1981 to allow states opportunities to provide optional Medicaid services to individuals with chronic illness and disabilities as alternatives to institutional care. Over time, a variety of settings were developed to serve individuals in need of long term services and supports and questions arose as to whether certain settings presented true alternatives to institutions. It became clear that CMS needed to develop rules that distinguish home and community-based settings from institutional settings. CMS is committed to ensuring that individuals served in Medicaid home and community-based programs have access to the benefits of community living and have full opportunity to be integrated in their communities.
11. How is CMS applying the home and community-based settings requirements to day programs including settings offering prevocational and training and employment services?  
A: CMS has clarified in this final rule that requirements for home and community-based settings apply to all settings where individuals receive HCBS including employment and training settings. CMS will provide additional guidance to address the implications of the regulation for non-residential settings.

12. How do the home and community-based settings requirements impact assisted living facilities?

A: The requirements for home and community-based settings set forth in the final rule apply to all settings where individuals receive HCBS, including assisted living facilities. The rule also applies additional requirements for provider owned or controlled settings. In response to public comments, several provisions in the Notice of Proposed Rulemaking (NPRM) relevant to assisted living facilities were modified. For more detail, please refer to the HCBS Settings fact sheet at <http://www.medicaid.gov/HCBS>.

13. What is person-centered planning and why is it important?

A: Person-centered planning is a process whereby the needs and preferences of the individual receiving services are described by that person, in collaboration with family, friends and other care team members, to develop a plan of care that provides that individuals receive the covered services they need in a manner they prefer. The expectations set forth in this final rule emphasize that individuals are most knowledgeable about their services needs and the optimal manner in which services are delivered. These requirements apply across the 1915(c) and 1915(i) programs and are consistent with the final person-centered planning requirements for 1915(k).

14. When is a state required to come into compliance with the person-centered planning requirements of the new regulations?

A: States are currently required to complete plans of care for individuals; however, the final rule includes specific requirements for the person centered planning process and the resulting person-centered plan. CMS expects that states will implement these changes on an individual basis as plans are developed or updated with each participant. CMS will be issuing additional guidance to assist states to implement this process.

15. Why is CMS proposing to add an exception to the provider payment reassignment rules?

A: CMS has long sought to ensure maximum state flexibility to design state-specific payment methodologies that help ensure a strong, committed, and well-trained work force. Over the years, some states have requested that we consider adopting additional exceptions to the direct payment principle to permit withholding from the payment due to the individual practitioner for amounts paid by the state directly to third parties for health and welfare benefits, training costs, and other benefits customary for employees.

16. What impact will this policy change to the provider payment reassignment have on states, providers and beneficiaries?

A: CMS anticipates that states will appreciate the added operational flexibilities made available by the provider payment reassignment provision. With regard to providers, the final rule will offer individual practitioners a direct benefit by promoting efforts to enhance provider skills through training and providing an administratively simple method of remitting to third parties costs related to health and welfare benefits. CMS anticipates that the rule will also benefit program beneficiaries insofar as they are assured greater access to trained practitioners, continuity of care and higher quality services.

17. What is the effective date of this rule?

A: This rule is effective March 17, 2014 (60 days from the date of publication).

18. What will a state need to do when the rule becomes effective?

A: With regard to the requirements for home and community-based settings, CMS understands that states will need time to assess their service systems and determine what aspects of their existing programs meet the requirements in the rule and which may need to be transitioned. While new waivers or state plans (1915(i) and 1915(k)) must meet the new requirements to be approved, for currently approved and funded services, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) State plan programs and submit a transition plan that has been made available for public input. If there are settings that do not fully meet the final regulation's home and community-based settings requirements, the state must work with CMS to develop in the transition plan an approach to ensuring either the settings come into compliance or that the individuals are offered settings that are compliant with the rule. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress towards compliance during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that specific waiver or state plan programs meet the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment the state must submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will provide additional details in forthcoming guidance.

With regard to the 1915(k) Community First Choice State Plan Option, states with approved 1915(k) state plans (meeting the setting requirements of the NPRM published May 2012) will have a transition period of at least one year to make any needed program changes to come into compliance with these final setting requirements.

19. Will CMS be releasing additional guidance related to this final rule?

A: Yes. In addition to the Informational Bulletin and fact sheets released with the final rule and this Q&A, CMS plans to release additional guidance regarding transition planning, public input requirements, person-centered planning, application of the settings requirements to non-residential settings, and changes to the 1915(c) Waiver Technical Guide.