HCBS Federal Final Rules – Frequently Asked Questions

What are the HCBS Federal Final Rules?

The Centers for Medicare & Medicaid Services (CMS) implemented new regulations for Medicaid's 1915(c) Home and Community-Based Services (HCBS) waivers on March 17, 2014. Key elements of the rule include:

- *Person-Centered Service Plan:* Reflect the needs identified through an assessment, as well as the individual's strengths, preferences, identified goals, and desired outcomes
- *Person-Centered Planning Process:* Individual leads the process to the maximum extent possible and is provided information and support to make informed choices regarding his/her services, as well as providers
- *Conflict-Free Case Management:* The provider who renders case management to a participant shall not also provide another 1915(c) home and community based waiver service to that same participant, unless the provider is the only willing and qualified provider in the geographic area (30 miles)
- *Provider Settings:* The setting is integrated in and supports full access of individuals receiving HCBS to the greater community, giving the individual initiative and independence in making life choices

What are the CMS-defined levels of compliance with the HCBS Final Rules?

Providers who render non-residential and/or residential services have one of four compliance categories, which are defined by the federal Centers for Medicare and Medicaid Services (CMS). The four categories are:

1. Fully align with the federal requirements
2. Do not comply with the federal requirements and will require modifications
3. Cannot meet the federal requirements and require removal from the program and/or the relocation of individuals
4. Are presumptively non-HCB but for which the state will provide evidence to show that those settings do not have the characteristics of an institution and do have the qualities of HCB settings (to be evaluated by CMS through the heightened scrutiny process)

Providers received a category 4 based solely on their location being presumed not to be home and community-based. For more information on types of settings that were classified as category 4, please see a related question and answer further down on this page.

Why did Case Management and Home Health providers not receive a compliance category?

Providers who render case management and/or home health only received either 'Yes' or 'No' for compliance with the case management rules. The compliance categories defined by CMS relate to the setting requirements, and since case management and home health providers typically do not own a residential/non-residential setting, they did not receive a compliance category of 1-4. Compliance with all relevant HCBS Final Rules (described in a question and answer below) is mandatory upon the date that Kentucky Medicaid regulations come into effect.

How did the Cabinet for Health and Family Services (CHFS) evaluate current compliance with the HCBS Final Rules?

In the spring of 2015, HCBS waiver providers were asked to respond to a comprehensive Compliance Plan Template survey, describing their current compliance and/or plans to come into compliance with the HCBS Final Rules. Waiver staff thoroughly reviewed and evaluated each submitted survey. Waiver staff also mapped each setting location in order to determine compliance with the HCBS setting requirements. On Friday, November 6, 2015, providers received these evaluations, as well as a document outlining all first round rules of the HCBS Final Rules.

What if my agency has not submitted a completed Compliance Plan Template survey?

Any agency that has enrolled as a waiver provider after ***June, 2015***, may not have filled out a Compliance Plan Template, as those were distributed in the spring of 2015.

If your agency has not submitted a completed Compliance Plan Template survey, please reach out to the HCB Final Rules mailbox as soon as possible: cmsfinalhcbrule@ky.gov

It is critical that agencies to which the above pertains contact DMS using the above email address, to ensure that all agencies have an opportunity to come into compliance with the HCBS Federal Final Rules.

When must providers come into compliance with the HCBS Final Rules? Which HCBS Final Rules are applicable to certain provider types?

The revised Acquired Brain Injury (ABI) ABI, ABI Long Term Care (ABI-LTC), Michelle P. Waiver (MPW), and Supports for Community Living (SCL) Medicaid waiver regulations were filed in August, 2015. The ABI and ABI-LTC regulations are expected to be effective in February, 2016. The MPW and SCL regulations are expected to be effective in March, 2016.

The Home and Community Based (HCB) waiver regulations were filed in October, 2015 and are expected to be effective in April, 2016. At this time, providers must be in compliance with the following first-round rules:

Case Management and/or Home Health Providers

- Person-Centered Service Plan requirements (compliance not required if Case Management is not rendered)
- Person-Centered Planning Process requirements (compliance not required if Case Management is not rendered)
- Individual selects both the setting (location) and provider (compliance not required if Case Management is not rendered)
- Individual has rights of privacy, dignity and respect, and freedom from coercion and restraint
- Individual has autonomy, and independence in making life choices, where possible
- Individual is provided choice regarding services and supports, and who provides them

Residential and Non-Residential Providers

- Individual selects both the setting (location) and provider
- Individual has rights of privacy, dignity and respect, and freedom from coercion and restraint

- Individual has autonomy, and independence in making life choices, where possible
- Individual is provided choice regarding services and supports, and who provides them

Additional requirements for Residential Providers

- Individual has privacy in their living unit, including doors lockable by the individual, choice of roommates/housemates, and the freedom to furnish/decorate living unit
- Individual is able to have visitors of their choosing at any time
- The setting is physically accessible to the individual
- Any modification of the above rules, except physical accessibility, must be supported by a specific assessed need and justified in the person-centered service plan

For additional information on the Case Management requirements named above, please see related questions and answers within this document.

Residential and Non-Residential Providers: In addition to the HCBS Final Rules described above, CMS requires providers to come into compliance with additional setting requirements by 2019. The rules below are part of these second-round changes, compliance with which is mandatory by 2019:

- Individual is integrated in and has full access to the greater community (Residential and Non-Residential providers)
- Setting must be considered home and community based. For settings that are not considered to be home and community based, please refer to the question and answer below (Residential and Non-Residential providers)
- Individual has freedom to control his/her own schedule and activities, including access to food (Residential providers only)
- Individual has a legally enforceable agreement documenting the eviction and appeals process. The agreement must afford the individual the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity, at a minimum (Residential providers only)

For Residential and Non-Residential providers, what settings are *<u>not</u>* considered to be home and community based?

The HCBS Federal Final Rules define settings that cannot be HCB and settings that are presumed not to be HCB. *This rule will be part of the second round changes, with an effective date of 2019 in Kentucky Regulations.*

Home and community based settings do not include:

- A nursing facility
- An institution for mental diseases
- An intermediate care facility for individuals with intellectual disabilities
- A hospital

Settings presumed not to be home and community based include:

- Any other locations that have qualities of an institutional setting

- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment
- Any setting in a building on the grounds of, or immediately adjacent to, a public institution
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS
    - This includes settings that are "clustered" together where there are multiple residences/settings operationally related and co-located, as well as farmsteads

Providers that meet any of the above characteristics of settings presumed not to be home and community cased were evaluated as category 4.

It is important to note that each setting location of the provider was evaluated, so there are many providers who have settings that are in both category 2 and category 4. If the provider has at least one setting that is category 4, then the provider was classified as an overall category 4. The individual settings that are designated as category 4 were included in the evaluation.

For Residential and Non-Residential providers that are in Category 4, what are the next steps in order to come into compliance with the HCBS Final Rules?

CHFS will reach out to all providers in compliance category "4", presumed not to be home and community-based, to schedule an on-site visit between February and July, 2016. CHFS wants to collect as much documentation as possible to submit to the Centers for Medicare and Medicaid Services (CMS) to help them make their decision on category 4 settings.

Once all site visits are complete, DMS will update the statewide transition plan (STP), naming all providers that remain in category 4, and will facilitate a public comment process in August, 2016. Upon completion of the public comment process, DMS will submit the STP and provider documentation to CMS for their review in September, 2016. At that time, CMS will begin their evaluation process, known as "heightened scrutiny," of settings that are in category 4.

What are the possible outcomes of the heightened scrutiny process?

The provider can continue to provide HCBS waiver services when CMS determines that evidence submitted by the provider and CHFS demonstrates that participants are fully integrated into the community

The provider must not provide HCBS waiver services if CMS determines the provider does not fully integrate participants into the community.

Can you provide more details on the Person-Centered Planning Process requirements?

In order for case management providers to come into compliance with the HCBS Final Rules, the person-centered planning process must exhibit the following characteristics:

- Individual leads the process
- Individual is provided necessary information to make informed choices about his/her services
- Is timely and convenient for the individual
- Reflects cultural considerations of the individual
- Includes a method for the individual to request updates to the plan as needed

- Records the alternative settings that were considered by the individual
- Includes strategies for solving conflict or disagreement within the process
- Providers of HCBS for the individual must not provide case management or develop the person-centered service plan (geographic exception allowed)

Can you provide more details on the Person-Centered Service Plan requirements?

In order for case management providers to come into compliance with the HCBS Final Rules, the person-centered service plan must exhibit the following characteristics:

- Reflect the needs identified through a functional assessment
- Reflect the individual's strengths, preferences, identified goals, and desired outcomes
- Reflect the services and supports (paid and unpaid) that will meet the individual's needs
- Reflect that the residential setting is chosen by the individual
- Prevent the provision of unnecessary or inappropriate services and supports
- Reflect risk factors and measures to minimize them
- Identify the individual responsible for monitoring the plan
- Be understandable and distributed to the individual, and all people involved in the plan
- Be finalized, agreed to, and signed by all individuals and providers responsible for implementation

What is CHFS's plan for transitioning to Conflict-Free Case Management (CFCM)?

The following transition requirements can be found in the regulations that will soon be going into effect.

- New waiver participants must select a conflict-free case manager once the revised regulation becomes effective, unless the individual resides in an area where there is only one willing and able provider to render services within 30 miles
- Current waiver participants will transition to conflict-free service provision at their next level of care (LOC) once the revised regulation becomes effective. The regulation will state that the full transition to conflict-free case management will take place in one year from date the regulation is effective
- Current case managers will be responsible to educate the participant and team members so that the participant can make a decision to change either his/her case manager or service provider in order to have a conflict-free case manager
- If a new case manager is chosen, it will be the responsibility of the new case manager, along with the team, to develop and submit the LOC and person-centered service plan documentation. *Please note: this is NOT true of the HCB waiver.*

Does the Residential provider requirement for implementing lease agreements apply to Family Home Providers (FHPs) and Adult Foster Care providers (AFCs)?

Yes. In order to be compliant with the HCBS Final Rules, providers shall ensure that FHPs and AFCs implement a legally enforceable agreement that affords participants the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity, at a minimum. Agencies may need to include this requirement of FHPs and AFCs in their contracts with these types of providers. This requirement will be included in Kentucky regulations starting in the year 2019.