JUNE 13, 2011

COMMENTS TO THE PROPOSED RULE REGARDING MEDICAID HOME AND COMMUNITY–BASED SERVICES (HCBS) WAIVERS FILE CODE: CMS-22296-P

The following comments are submitted by ACCSES regarding the proposed rule that would revise the regulations implementing Medicaid home and community-based services (HCBS) waivers. [76 Federal Register 21311 (April 15, 2011)] ACCSES represents more than 80 partner organizations that work to promote and enhance community-based solutions that maximize employment and independent living opportunities for people with disabilities through collaboration with government and other stakeholders. ACCSES believes that services and supports provided under the Medicaid HCBS waiver must recognize and support the full potential of each person with a disability to enjoy a meaningful life in the community.

The proposed rule focuses on four topics:

(1) Target groups,
(2) HCBS settings,
(3) Person-centered planning, and
(4) Strategies to ensure compliance with statutory assurances.

The following comments submitted by ACCSES focus on HCBS settings and person-centered planning.

BACKGROUND

Section 1915(c) of the Social Security Act (the Act) authorizes the Secretary of Health and Human Services to waive certain Medicaid statutory requirements so that a State may offer home and community-based services (HCBS) to State-specified group(s) of Medicaid beneficiaries who would otherwise require the level of care provided in a hospital, a nursing facility, or intermediate care facility for the mentally retarded (ICF/MR). Regulations implementing Section 1915(c) were initially published in 1994.

Home and community-based services is defined in the statute [Section 1915(c)(5) of the Social Security Act] and regulations [42 CFR 440.180] to include:

- Case management services,
- Homemaker services,
- Home health aide services,
- Personal care services,
- Adult day health services,
- Habilitation services (including day habilitation and prevocational, educational and supported employment services),
- Respite care services,
- Day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness, and
- Such other services requested by the State as the Secretary may approve.

In the June 22, 2009 Federal Register (74 FR 29453), CMS published the Medicaid Program; Home and Community-Based Services (HCBS) **Advance Notice of Proposed Rulemaking** (ANPRM). The ANPRM focused on three topics—target population, person-centered planning, and settings in which it is appropriate to provide home and community-based services under the Section 1915(c) Medicaid waiver. With respect to defining home and community-based **settings**, CMS explained that the focus of the ANPRM was on adjusting provisions in the current regulations related to the receipt of HCBS services in **residential settings**. The ANPRM made more than 10 references to terms such as "resides," "residential setting," "residence," "residents," and "living situation."

On April 15, 2011, CMS published in the Federal Register a **Notice of Proposed Rulemaking** to revise the regulations implementing Medicaid home and community-based services waivers under Section 1915(c) of the Social Security Act [76 Federal Register 21311-21317]. The NPRM focuses on the same topics identified in the ANPRM—target population, person-centered planning, and settings in which it is appropriate to provide home and community-based services under the Section 1915(c) Medicaid waiver. In addition, the NPRM focuses on strategies to ensure compliance with statutory assurances.

Along with its overarching interest in making improvements to the Medicaid HCBS program, CMS explains that it seeks to ensure that Medicaid is providing needed strategies for States in their efforts to meet their obligations under the Americans with Disabilities Act (ADA) and Supreme Court's decision in <u>Olmstead v. L.C.</u>, 527 U.S. 581 (1999). In the <u>Olmstead</u> 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 or requirements of the Medicaid

program; however, the Medicaid program provides an opportunity to obtain partial Federal funding to assist in compliance with these laws through the provision of Medicaid services to Medicaid-eligible individuals.

CMS believes that these proposed changes will have numerous benefits for individuals and States alike. In addition to providing clarity around individual and stakeholder input, CMS asserts that these proposed changes will move the system forward by enabling services to be planned and delivered in a manner driven by individual needs rather than diagnosis. These changes will enable States to realize administrative and program design simplification, as well as improve efficiency of operation.

According to CMS, the changes related to clarification of HCBS settings will support the use of waiver authority to maximize the opportunities for waiver participants to have access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate. Specifically, CMS proposes to make the following changes to its HCBS regulation related to settings. **<u>The proposed changes are highlighted in bold and underlined</u>**:

Sec. 441.301 Contents of request for a waiver.

(a) A request for a waiver under this section must consist of the following:

(1) The assurances required by Sec. 441.302 and the supporting documentation required by Sec. 441.303.

(2) When applicable, requests for waivers of the requirements of section 1902(a)(1), section 1902(a)(10)(B), or section 1902(a)(10)(C)(i)(III) of the Act, which concern respectively, statewide application of Medicaid, comparability of services, and income and resource rules applicable to individuals with spouses living in the community.

(3) A statement explaining whether the agency will refuse to offer home or community-based services to any recipient if the agency can reasonably expect that the cost of the services would exceed the cost of an equivalent level of care provided in--

(i) A hospital (as defined in Sec. 440.10 of this chapter);

(ii) A NF (as defined in section 1919(a) of the Act); or

(iii) An ICF/MR (as defined in Sec. 440.150 of this chapter), if applicable.

(b) If the agency furnishes home and community-based services, as defined in Sec. 440.180 of this subchapter, under a waiver granted under this subpart, the waiver request must--

(1) Provide that the services are furnished--

~~(i) Under a written plan of care subject to approval by the Medicaid agency;~~

<u>(i) Under a written services and support plan (also called plan of care) that is based on a person-centered approach and is subject to approval by the Medicaid agency.</u>

<u>(A) Person-Centered Planning Process. In addition to being led by the individual receiving services, the person-centered planning process:</u>

<u>(1) Includes people chosen by the individual.</u>

(2) Provides necessary support to ensure that the individual has a meaningful role in directing the process.
(3) Occurs at times and locations of convenience to the individual.
(4) Reflects cultural considerations of the individual.
(5) Includes strategies for solving conflict or disagreement within the process, including any conflict of interest concerns.
(6) Offers choices to the individual regarding the services and supports they receive and from whom.
(7) Includes a method for the individual to request updates to the plan as needed.
(B) The Person-Centered Plan. The person-centered plan must reflect the services that are important for the individual to meet individual services and support needs as assessed through a person-centered functional assessment as well as what is important to the person with regard to preferences for the delivery of such supports. Commensurate with the level of need of the individual, the plan must:
(1) Reflect the individual's strengths and preferences.
(2) Reflect clinical and support needs as identified through a person-centered functional assessment.
(3) Include individually identified goals, which may include, as desired by the individual, items related to relationships, community living, community participation, employment, income and savings, health care and wellness, education, and others.
(4) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals and the providers of those services and supports.
(5) Reflect risk factors and measures in place to minimize them, including back-up strategies when needed.
(6) Be signed by all individuals and providers responsible for its implementation.
(7) Be understandable to the individual receiving services and the individuals important in supporting him or her.
(8) Include a timeline for review.
(9) Identify the individual and/or entity responsible for monitoring the plan.
(10) Be distributed to everyone involved (including the participant) in the plan.
(11) Be directly integrated into self-direction where individual budgets are used.
(12) Prevent the provision of unnecessary or inappropriate care.
(ii) Only to recipients who are not inpatients of a hospital, NF, or ICF/MR; and
(iii) Only to recipients who the agency determines would, in the absence of these services, require the Medicaid covered level of care provided in--
(A) A hospital (as defined in Sec. 440.10 of this chapter);
(B) A NF (as defined in section 1919(a) of the Act); or
(C) An ICF/MR (as defined in Sec. 440.150 of this chapter);
(iv) Only in settings that are home and community based, integrated in the community, provide meaningful access to the community and community activities, and choice about providers, individuals with whom to interact, and daily life activities. A setting is not integrated in the community if it is:
(A) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment or custodial care; in a building on the grounds of, or immediately adjacent to, a public institution; or a housing complex designed

expressly around an individual's diagnosis or disability, as determined by the Secretary; or
(B) Has qualities of an institutional setting, as determined by the Secretary.

(2) Describe the qualifications of the individual or individuals who will be responsible for developing the individual plan of care;

(3) Describe the group or groups of individuals to whom the services will be offered;

(4) Describe the services to be furnished so that each service is separately defined. Multiple services that are generally considered to be separate services may not be consolidated under a single definition. Commonly accepted terms must be used to describe the service and definitions may not be open ended in scope. HCFA will, however, allow combined service definitions (bundling) when this will permit more efficient delivery of services and not compromise either a recipient's access to or free choice of providers.

(5) Provide that the documentation requirements regarding individual evaluation, specified in Sec. 441.303(c), will be met; and

(6) Be limited to one of the following target groups or any subgroup thereof that the State may define:

(i) Aged or disabled, or both.

(ii) Mentally retarded or developmentally disabled, or both.

(iii) Mentally ill.

Sec. 441.302 State Assurances.

Unless the Medicaid agency provides the following satisfactory assurances to HCFA, HCFA will not grant a waiver under this subpart and may terminate a waiver already granted:

(a) Health and Welfare--Assurance that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those safeguards must include--

(1) Adequate standards for all types of providers that provide services under the waiver;

(2) Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver; and

(3) Assurance that all facilities covered by section 1616(e) of the Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

(4)Assurance that the State is able to meet the unique service needs that particular target groups may present when the state selects to serve more than one target group under a single waiver, as specified in 441.301(b)(6) of this subpart.

(5) Assurance that services are provided in home and community based settings, as specified in 441.301(B)(1)(iv).

ANALYSIS—IDENTIFICATION OF ISSUES RAISED BY THE NPRM

ACCSES' comments focus on the proposed policy changes applicable to the person-centered planning process and home and community-based settings only and not the target populations or compliance strategies.

Based on a review of the NPRM, ACCSES identified the following issues for consideration related to HCBS settings and the person-centered planning process.

1. The ANPRM requested comments regarding the receipt of home and community-based services and supports in **residential** settings. Consistent with the language from the ANPRM, it appears that the language included in the NPRM is intended to regulate the circumstances under which it is permissible to use Section 1915(c) to authorize the provision of home and community-based services in residential settings. Is this interpretation correct or is the NPRM intended to regulate the provision of HCBS in all settings, including day habilitation programs, prevocational programs, supported employment work settings, and day treatment programs?

   Question for CMS:

   - A center-based employment program has 3 plant sites where "day programming" or prevocational services are provided. Two of the plants are in industrial parks, surrounded by other businesses and industry. The other is in an area zoned industrial and is across the street on one side from another industrial plant, on one side by residential and on another by rail and highway. Are these day habilitation and prevocational programs permissible under the language included in the NPRM?

2. The NPRM specifies that HCBS settings must not be a **housing complex designed expressly around an individual's diagnosis or disability**, as determined by the Secretary. Will the standards suggested impede rather than facilitate the provision of appropriate services and supports in the most integrated setting appropriate to beneficiaries in accordance with their identified needs and strengths?

   Questions for CMS:

   - Would this proposed language target (prohibit) HCBS programs provided to residents with disabilities in HUD Section 811 and 202 multi-family housing units who have leases in their own names, control access into their own apartments, and are responsible for their own daily activities?

   - Some individuals with disabilities who reside in an independent living supported apartment building pool their resources to have enough hours to cover them for services 24 hours a day, seven days a week. Under the proposed language, would these individuals no longer be eligible for services under the Medicaid HCBS waiver?

   - Under the proposed language, are group homes, including IRAs (with a specified number of residents) no longer considered home and community-based settings?

   - Would the proposed language prohibit the use of HCBS funds in assisted living type facilities for persons with disabilities or small campuses where 4-6 group homes are set around a courtyard in a residential community?

- Would the proposed language prohibit the use of HCBS funds in the wing of college dorm that is fully accessible?

3. The NPRM specifies that HCBS settings are not integrated in a community if they are located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment or custodial care; in a building on the grounds of, or **immediately adjacent to**, a public institution. Will the proposed standards impede rather than facilitate the provision of services and supports in the most integrated setting appropriate to beneficiaries in accordance with their identified needs and strengths?

   Question for CMS:

   - Does a "public institution" include a state college or university or a community college?

   - A community rehabilitation program is located across (to the east) from an ICF/MR, which was built after the CRP was built. The CRP is co-located with a local college, with which they share a parking lot. To the west is a local high school and to the south is a residential neighborhood. In another case, a CRP is located near a nursing home, hospital, elderly assisted living complex, and a technical college. Under the proposed language, do these CRPs run afoul of the prohibition of being located "immediately adjacent to a public institution?"

4. The NPRM specifies that HCBS settings are not integrated into the community if they have qualities of an institutional setting, e.g., regimented meal and sleep times, limitations on visitors, lack of privacy and other attributes that limit individual's ability to engage freely in the community.

   Question for CMS:

   - A CRP has a policy that limits visitors to certain parts of its facility, in order to protect the proprietary nature of its projects under contract with business customers and to ensure a safe work environment. Would this policy make the CRP be considered to "have qualities of an institutional setting"?

   - A CRP has policies to manage how freely individuals come and go from their day habilitation program in order to ensure the health, safety, and welfare of individuals participating in the program in accordance with the plan of care developed in accordance with a person-centered approach. Would this be considered limiting an individual's ability to "engage freely in the community"?

   - A CRP has a set time every day for a lunch break, as do many businesses. Is this considered a "regimented meal time"?

- A group home or Individual Residential Alternative (IRA) located in a residential community including some individuals whose severity of disability is such that they require legal guardians and require 24-7 supervision for safety and other reasons identified in the plan of care in accordance with a person-centered approach. Consistent with a person-centered functional assessment, certain activities of daily living may be restricted. For example, for safety reasons, it may be necessary to regulate when a person with severe dementia comes and goes. Others may require planned, supervised HCBS services in order to live in the community, i.e., there are structured activities although not all residents participate in the same day activity. Based on the layout of the group home (including IRA), there may be limited choice of whether to have a roommate, or to choose a roommate.

    - Under the proposed language, would these individuals participating in group homes, including IRAs be barred from receiving home and community-based services and supports under a Medicaid HCBS waiver program?

    - Would they be prohibited from receiving HCBS waiver day habilitation services, or would the residential services themselves, in the case of the IRA, also be considered ineligible for HCBS waiver funds?

RECOMMENDATIONS FOR REVISING THE HCBS WAIVER REGULATIONS

CMS specifies in the Preamble to the NPRM its overarching objective in proposing revisions to the current regulations implementing the HCBS waiver—maximize the opportunities for waiver participants to have access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate, consistent with the ADA and Olmstead. CMS also specifies the primary reasons for proposing these revisions at this time—the need to provide clear guidance to states in response to recent proposals by states that have "*clearly*" exceeded reasonable standards for HCBS waivers and respond to "*isolated*" situations in which states are proposing to use HCBS waivers to serve individuals in segregated settings or setting with a strong institutional nature e.g. settings on campuses of institutional facilities, segregated from the larger community. [76 FR 21312 and 21313 (April 15, 2011)]

ACCSES supports efforts by CMS to further these objectives and address these concerns. With respect to HCBS settings, we believe that the proposed language as written, will not, however, accomplish these objectives and address these concerns. The proposed language included in the NPRM with respect to HCBS settings is confusing, ambiguous, and overly-broad and could be construed to:

- Inappropriately restrict the choice of home and community-based services recognized under the statute and regulations available to program beneficiaries in accordance with their plan of care; and

- Unnecessarily restrict State flexibility and force States to eliminate longstanding successful day and residential programs (e.g., small group homes) located in the community that address the strengths, priorities, and needs of program participants.

In short, certain phrases included in the NPRM could be construed as impeding rather than facilitating the achievement of individually identified goals set out in the individual's plan of care consistent with his or her person-centered functional assessment. The final regulations must be clear—they should not include language that can be construed as restricting the provision of home and community-based services (as defined in the statute and regulations) which are identified in the State waiver program, and determined appropriate under an individual's plan of care. Set out below are specific recommendations for improving the proposed revisions to the HCBS regulations related to person-centered planning and settings consistent with CMS' stated objectives and concerns.

Person-Centered Planning

ACCSES supports much of the proposed revisions to the provisions in the current regulations regarding person-centered planning. We believe that the proposed clarifications to the person-centered process will address many of the concerns identified in the preamble. The expanded and improved person-centered planning approach will ensure that informed choice and self-determination are embedded in the process used to determine appropriate and necessary home and community-based services and supports for each individual participating in the waiver program, consistent with the ADA and Olmstead.

ACCSES recommends two modifications to clarify and strengthen the proposed revisions.

(1) ACCSES recommends that the proposed revisions include a reference to the regulatory definition of "home and community-based services" [42 CFR 440.180] the first time a reference to "services" appears in 42 CFR 441.301(b)(1)(B) (as revised). This technical and conforming change is consistent with the current approach used in other sections of the regulation. [See for example, 42 CFR 441.300[1] and 42 CFR 441.301(b)[2]]. This technical and conforming change would clarify that a participant may receive services authorized by the legislation and existing regulations and included in the state's waiver.

(2) ACCSES recommends that the person-centered planning provision, as revised, include a reference to the "most integrated setting appropriate" standard. ACCSES believes that the

[1] "Section 1915(c) of the Act permits States to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Those services are **defined in 440.180 of this subchapter**…"

[2] "If the agency furnishes home and community-based services, **as defined in 440.180 of this subchapter**, under a waiver granted under this subpart, the waiver request must…"

plan of care should ensure that program participants receive home and community-based services in the most integrated setting appropriate, consistent with the ADA and Olmstead and consistent with the person-centered functional assessment of strengths, priorities and needs. For example, in the employment context, the plan of care may specify that an individual needs expanded habilitation services in the form of supported employment that may facilitate competitive integrated employment. The plan of care may also indicate that the individual needs expanded habilitation in the form of prevocational services in a centered-based employment program or services in a day habilitation program. Further, the plan of care may indicate the need for supported employment services that enables an individual to participate in high-paying job in which he or she performs document destruction in a part of the plant that is separated from other plant operations. In addition, the plan of care may indicate the need for supported employment or prevocational services in enclaves or work crews out in the community.

Subpart G—Home and Community-Based Services: Waiver Requirements

Section 441.301 should be amended by revising paragraph (b)(1)(i). The revision reads as follows (CMS proposal language in regular print and ACCSES modifications in **bold and underlined**):

(i) Under a written services and support plan (also called plan of care) that is based on a person-centered approach and is subject to approval by the Medicaid agency.

(A) Person-Centered Planning Process. In addition to being led by the individual receiving services, the person-centered planning process:

(1) Includes people chosen by the individual.

(2) Provides necessary support to ensure that the individual has a meaningful role in directing the process.

(3) Occurs at times and locations of convenience to the individual.

(4) Reflects cultural considerations of the individual.

(5) Includes strategies for solving conflict or disagreement within the process, including any conflict of interest concerns.

(6) Offers choices to the individual regarding the services and supports they receive and from whom.

(7) Includes a method for the individual to request updates to the plan as needed.

(B) The Person-Centered Plan. The person-centered plan must reflect the services, **as defined in 441.180 of this subchapter**, that are important for the individual to meet individual services and support needs as assessed through a person-centered functional assessment as well as what is important to the person with regard to preferences for the delivery of such supports. Commensurate with the level of need of the individual, the plan must:

(1) Reflect the individual's strengths and preferences.

(2) Reflect clinical and support needs as identified through a person-centered functional assessment.

(3) Include individually identified goals, which may include, as desired by the individual, items related to relationships, community living, community participation, employment, income and savings, health care and wellness, education, and others.
(4) Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals and the providers of those services and supports.
( ) **Be provided in the most integrated setting appropriate.**
(5) Reflect risk factors and measures in place to minimize them, including back-up strategies when needed.
(6) Be signed by all individuals and providers responsible for its implementation.
(7) Be understandable to the individual receiving services and the individuals important in supporting him or her.
(8) Include a timeline for review.
(9) Identify the individual and/or entity responsible for monitoring the plan.
(10) Be distributed to everyone involved (including the participant) in the plan.
(11) Be directly integrated into self-direction where individual budgets are used.
(12) Prevent the provision of unnecessary or inappropriate care.

Community-Based Services Settings

ACCSES supports efforts to ensure that the HCBS waiver program is not used as a subterfuge to perpetuate the provision of Medicaid services in residential, institutional settings; rather HCBS must be used as intended in accordance with Section 1915(c)—to provide an array of services that an individual needs to avoid institutionalization. ACCSES also believes that individuals participating in the HCBS waiver program must continue to be permitted to receive the full array of home and community-based services, as defined by the statute and regulations, and included in the State's waiver, consistent with the individual's plan of care. These services include, but are not limited to, personal assistance services, home health aide services, respite care services as well as expanded habilitation services (supported employment in competitive integrated employment settings and prevocational services in center-based programs) and day habilitation programs and day treatment programs.

Nothing in the regulation, as revised, should be construed to restrict or in any way negate the State's flexibility to include the full range of home and community-based services authorized in the statute and regulations or restrict the choice of a program participant to access the full range of these home and community-based services in accordance with his or her individual plan of care, including those listed above.

ACCSES believes that the proposed language related to HCBS settings will not accomplish stated objectives and address concerns raised. In fact, the proposed language relating to settings raises more issues than it resolves, particularly the following phrases:

- "…immediately adjacent to…"

- “a housing complex designed expressly around an individual’s diagnosis or disability, as determined by the Secretary…”
- “has qualities of an institutional setting, as determined by the Secretary.”

This unclear, ambiguous, and overly-broad language regarding settings (see the previous section of our COMMENTS, Analysis—Identification of Issues Raised by the NPRM) could be construed to limit State flexibility regarding the scope of home and community-based services permitted and limit the choice of services for program participants to receive appropriate and necessary services. ACCSES recommends that in lieu of the language included in the NPRM, the following language be included in the final regulations (bold and underlined):

Section 441.302 be amended by adding paragraph (a)(5) to 441.302 to read as follows:

441.302 State Assurances.

(a) * * *
(5) Assurance that home and community-based services, as defined in 440.180 of this subchapter, are not provided at settings specified in 441.301(b)(2) of this subpart.

In addition, Section 441.301 is amended by adding new paragraph (b)(2) and renumbering existing paragraphs accordingly. The addition reads as follows:

441.301 Content of request for a waiver

(b) * * *
(1) * * *
(2) Are not provided at the following settings:

(i) A nursing facility,
(ii) An institution for mental diseases,
(iii) An intermediate care facility for the mentally retarded, or
(iv) A building that is also a publicly or privately operated facility that provides inpatient institutional treatment or custodial care or a building on the grounds of a public institution, such as an institution for mental diseases or an intermediate care facility for the mentally retarded, that is geographically segregated from the larger community.

ACCSES also recommends that the Interpretative Guidance accompanying the final regulation explain that an individual residing in “a housing complex designed expressly around an individual’s diagnosis or disability” may receive home and community-based services if, and

only if, the housing complex is in full compliance with underlying laws and implementing regulations, including Section 811 of the National Affordable Housing Act of 1990, as amended and implementing regulations (supported housing for persons with disabilities), the Fair Housing Act, and the ADA.

In addition, ACCSES recommends that the Interpretative Guidance accompanying the final regulation explain that home and community-based services included in a state's waiver program will not be considered to have the "qualities of an institutional setting" if it meets the standards prescribing a particular home and community-based service under the Section 1915(c) and the implementing regulations and program guidance. For example, a day habilitation program and/or prevocational services provided in a center-based program would be permissible under the regulation if these programs meet the standards prescribed in the HCBS regulation and guidance applicable to such programs.