

Joint State Advisory 16-20: CMS Answers Common Questions on Requirements for Home-and Community-Based Settings

July 6, 2016

CMS has issued another [guidance](#) document addressing implementation of the home-and community-based services (HCBS) regulations that were published in 2014. This guidance is the latest in a series of bulletins CMS has issued since it published these regulations in 2014. See Advisory 14-4: CMS Finalizes New Standards for Home-and Community-Based Settings (Jan. 23, 2014); Advisory 14-50: CMS Issues Additional Guidance on New Home-and Community-Based Setting Standards (Dec. 29, 2014); Advisory 15-36: CMS Issues Guidance Clarifying Requirements for Home-and Community-Based Service Settings (July 31, 2015).

The guidance is styled as a series of questions and answers that clarifies HCBS regulations relating to “heightened scrutiny” review of presumed institutional settings, and modifications to required characteristics in a provider-owned or controlled setting.

Settings Under Construction Subject to Heightened Scrutiny to Overcome Presumption of Institutional Setting

Under CMS regulations, Medicaid funding is not available for HCBS for individuals living in locations that have the “qualities” of an institutional setting. 42 C.F.R. § 441.301(c)(5)(v). Settings will be presumed to be institutional if they are located within, or adjacent to, a public institution or private facility providing inpatient institutional treatment, or if they “have the effect of isolating individuals from the broader community of individuals not receiving HCBS.”

States may overcome a setting’s presumed institutional nature by securing CMS approval of the setting as compliant with HCBS regulations. States must submit documentation demonstrating the steps taken to bring a setting into compliance with HCBS regulations, which CMS reviews under a “heightened scrutiny” standard. Settings that are presumed institutional but which do not receive CMS approval through this process will not be eligible for federal matching funds. For settings that were added to an HCBS waiver or the state plan HCBS on or after March 17, 2014, States must obtain CMS approval through the heightened review process before the setting can be included as part of an HCBS program. Such settings must be in compliance with the HCBS regulations by the time the State submits a claim for Federal reimbursement.

In the guidance issued last month, CMS states that settings currently under construction or development cannot obtain “pre-approval” of compliance with HCBS standards. CMS will not

solely rely on proposed plans and physical design descriptions in determining whether a setting is compliant with HCBS requirements. CMS explains that it needs to examine how the proposed plans are implemented, and whether individuals in the setting actually have contact with the broader community, which CMS may not be able to assess until the setting is operational and occupied. As a result, investors in new or developing settings bear the financial risk, in the event that the setting is not approved as compliant with HCBS regulations after its completion. Nonetheless, CMS encourages states to maintain communication with CMS during the planning stages of the proposed development, so as to discuss any risk that the setting may not meet the heightened scrutiny requirements, and to establish policies and strategies to mitigate that risk.

The guidance also clarifies that new settings that come online after March 17, 2014 (the effective date of the regulations) cannot take advantage of the five-year transition period that other settings are provided to come into compliance with the new setting requirements. Rather, new facilities must be compliant with the regulations by the time the State submits a claim for FFP for HCBS delivered to individuals in the setting.

Modifications in a Provider-Owned or Controlled Residential Setting

The regulations set forth five qualities that a home-and community-based setting must possess, based on the needs of the individual recorded in their person-centered service plan. 42 C.F.R. §§441.710(a)(1); 441.530(a)(1). Provider-owned or controlled residential settings must meet additional requirements geared towards ensuring that individuals in controlled settings still retain privacy and independence. 42 C.F.R. §§441.710(a)(1)(vi); 441.530(a)(1)(vi). For example, provider-owned or controlled residential settings must allow individuals to have visitors of their choosing at any time, and must have the freedom to support and control their own schedules and activities, among other requirements. *Id.*

States provide HCBS to individuals with a wide variety of needs, however, and restrictions may be permitted for individuals with complex health and behavioral goals, who often require increased structure and control in their setting. For example, many States provide services to individuals with severe pica behavior, where the individual compulsively eats non-food items, requiring staff to provide increased observation and strict supervision to control and prevent the behavior. Some restrictions may similarly be necessary for individuals who are likely to wander, who have a history of physically harming themselves or others, who have a history of sexual predation, or who experience some dementia. For this reason, CMS allows States and providers to make modifications to an individual's person-centered plan and impose restrictions on the freedom and movement of specific individuals living in that setting, if necessary for the health and safety of those individuals. 42 C.F.R. §§ 441.301(c)(2)(xiii), 441.710(a)(1)(vi)(F), 441.530(a)(1)(vi)(F).

Because such modifications may curtail an individual's freedom of movement, or may be contrary to the individual's preference, CMS requires that modifications are narrowly tailored to the specific needs of the individual, and imposed only after positive interventions and other less-intrusive methods have failed to meet the needs and goals of the individual. States seeking to impose such modifications must also provide a description of how the modification is directly

proportional to the individual's specific assessed need, and how the State plans to periodically review and collect data on the efficacy and necessity of the restrictions.

The guidance emphasizes that any restrictions imposed in this manner must be highly individualized, and cannot be imposed on a class or group of individuals. Modifications cannot be implemented as “house rules” of any setting, regardless of the homogeneity of the population served, or the inconvenience that a mismatch of restrictions may cause for the setting’s staff. Instead, modifications must be included in an individual’s person-centered service plan, and must be reviewed periodically to ensure that the modification is consistent with the individual’s current health and safety needs, and does not unnecessarily discount the individual’s preferences in his or her care and treatment.

CMS envisions that States will create an audit and oversight system to ensure that modifications meet HCBS requirements. The guidance suggests that States use a variety of strategies in the oversight process, such as establishing frequent periodic reviews to ensure the continued need for the restriction, conducting periodic audits of individual person-centered service plans, creating state-wide training systems for case managers and providers in writing person-centered service plans that include modifications, and establishing data collection protocols to ensure ongoing monitoring and review of modifications. States may take advantage of the five year transition period to address these modification requirements, and may include a process for addressing modifications in the Statewide Transition Plan.

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