



The Final HCBS Rule

Training for Illinois HCBS Providers



HCBS Final Rule

79 FR 2947

- Addresses several sections of Medicaid law under which states may use Federal Medicaid funds to pay for HCBS
- Ensures that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living
- Ensures that individuals receiving services and supports through Medicaid's HCBS programs receive services in the most integrated setting
- Defines and Describes the requirements for Home and Community-Based Settings--*42 CFR 441.301(c)(4)-(c)(5)*
- Defines Person-Centered Planning Requirements--*42 CFR 441.301(c)(1)-(c)(3)*

HCBS Final Rule

Effective date of rule: March 17, 2014

States must demonstrate compliance with the rule by March 17, 2023 for **ALL** existing services. New settings must comply now -- before services are provided in the new setting.

The final rule establishes:

- a) Mandatory requirements for the qualities of Home and Community-Based settings
- b) Settings that are not Home and Community-Based
- c) Settings presumed not to be Home and Community-Based
- d) State compliance and transition requirements



The Foundation of Person-Centered Practices

Historical

- Carl Rogers
- Judith Snow
- John O' Brien,
- Michael Smull,
- Beth Mount,
- Jack Pearpoint,
- Tom Nerney

It is about engaging the person to be recognized as the expert on his/her life and be supported to be in control of his/her life, with the supports needed to do so.

How Do We Describe People?

System-Centered

- Focus on labels
- Emphasize deficits
- See people in the context of human service systems
- Distance people by emphasizing difference

Person-Centered

- See people first
- Emphasize strengths
- See people in the context of their local community
- Bring people together by discovering common experience

Why is all of this so Important?



- For so long, the experiences, needs, desires and contributions of all persons with disabilities have been defined by segregated settings and limiting stereotypes.
- We need to break the cycle of isolation in order for people with disabilities to become participating members in their communities. Having meaningful relationships is essential for one's well-being.
- All individuals have strengths, talents and skills that can be shared and utilized in their community.

How Do You Know It Is Person-Centered?

- **The Person is at the Center**
 - The process is rooted in respect for the person & a commitment to build inclusive communities.
- **Family members & friends are partners**
 - They have important knowledge & can make contributions that cannot be replaced.
- **Listening & Learning Continue**
 - Recognizes that positive possibilities unfold as the people involved learn from experience.
- **Focus on Developing Capacities**
 - Reflects what is important to the person, now & for the future. It insists that the person have real opportunities to contribute to the life of their communities & to benefit from their contributions in turn.
- **Hopeful Action Happens**
 - Action is based on hope that grows from the positive changes that individuals & their allies have already made.

Person-Centered Thinking, Planning and Practice – An Evolution Over the Years

Person-centered thinking helps to establish the means for a person to live a life that they and the people who care about them have good reasons to value.

Person-centered planning is a way to assist people who need HCBS services and supports to construct and describe what they want and need to bring purpose and meaning to their life.

Person-centered practice is the alignment of service resources that give people access to the full benefits of community living and ensure they receive services in a way that may help them achieve **their individual goals**.

Person-Centered Thinking

Basic point of reference is what matters most *to the person, not to you as the professional.*

Everyone has value, and deserves engagement that is dignified and respectful, no matter what their condition.

Underlying belief that the person's life provides the context that must be the basis of planning.

The person is the expert in their own life.

Person-Centered Thinking Leads to a Person-Centered System

Each person involved in delivery support or services to eligible beneficiaries having their own set of **core values** leads to:

The **language** used, which leads to

Decisions made and **actions** taken, which leads to

Results and corresponding **reactions**.

Taken altogether, this becomes a continuous system of thinking and acting in a manner consistent with person-centered thinking.

Person-Centered Service Planning Within Final Rule 42CFR 441.301 (c)(1)

The person-centered planning process is driven by the individual.

It includes people chosen by the individual.

It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible.

It is timely and occurs at times and locations of convenience to the individual.

Perhaps the Most Overlooked Clause Related to Person-Centered Planning:

441.301 (c) (2) *The Person-Centered Service Plan.*

“The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State’s 1915(c) HCBS waiver...”

The Plan Document: Some Key Elements

The Plan identifies:

- the strengths, preferences, needs (clinical and support), and desired outcomes of the individual

The plan also includes risk factors and plans to minimize them.

The plan is signed by all who implement the plan and the person whose plan it is.

The written plan reflects:

That the setting is chosen by the individual and is integrated in, and supports, full access to the greater community;

The opportunities to seek employment and work in competitive integrated settings; and

The opportunity to engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

Both the Person-Centered Plan and the Process to Develop it:

Assist the person in achieving personally-defined outcomes in the most integrated community setting, and it is written to ensure delivery of services in a manner that reflects personal preferences and choices, and

- Contributes to the assurance of health and welfare.
- Reflects cultural considerations
- Uses plain language
- Includes strategies for solving disagreement
- Offers choices to the person regarding services and supports the person receives and from whom
- Provides a method to request updates

A Few Differences About Person-Centered Planning

- Setting and circumstances matter.
- Sequence matters. (Talk about preferences and values FIRST.)
- Building on gifts and talents and natural support is different from fixing what is wrong and starting with the premise that professional support is best.
- The degree of effort invested in planning is equal to the degree of support requested.
- Nothing about me without me, and...
- Friends and families and those who love us and know us best can be equally as important as professional caregivers in the plan development process, but participant selection is confirmed by the person who requires support.

It Begins With Learning How People Want to Live Their Life: What's *Important TO*

What is important to a person includes what results in feeling satisfied, content, comforted, fulfilled, and happy.

1. Relationships (people to be with)
2. Status and control (valued role)
3. Rituals & routines (cultural and personal)
4. Rhythm or pace of life
5. Things to do and places to go (something to look forward to)
6. Things to have

Within That Context, Important FOR is Addressed

What others see as necessary to help the person:

To be valued (social rules, laws)

To be a contributing member of their community (citizenship)

To attend to health issues

To prevent illness

To promote his or her wellness (diet, exercise, sobriety)

To be safe in his or her environment

To have physical and emotional well-being

To be free from fear (threats, abuse)

Person-Centered Planning

The focus is on how the person wants to live, with support necessary to achieve the desired life (their preferences and values)— building on gifts, abilities, and control.

The desired outcomes of the support are identified by the person and their loved ones.

The person and their closest family or friends actively participate in the full development of the plan.

The plan evolves over time, with support and preferences changing as the person changes.

The aim is to achieve a balance between personal preferences and health, safety, and social rules.

Informed Decision-Making:

a process where you support an individual to obtain information and knowledge about a situation or problem and to make a decision.

1. Assist the individual to understand the decision/issue/situation
2. Gather information
3. Explore options and consider outcomes
4. Allow the individual to decide, act, and be empowered
5. Evaluate the decision

Review of Person-Centered Service Plan

** 42 CFR 441.301(c)(3) **

Person-centered service plan must be reviewed and revised:

- Upon reassessment of functional need as required
- At least every 12 months
- When the person's circumstances or needs change significantly
- At the request of the person, or guardian, if applicable

Three Promises of Person-Centered Practice



1. To listen with the intent of understanding and discovering the to/for balance;
2. To supporting action related to what is heard; and
3. To be honest with people without deciding for them what is possible or how they should live.

Source: Section 2402(a) of the ACA – Guidance for Implementing Standards for PCP and Self Direction

HCBS Final Rule

New Settings Requirements

- Any setting wishing to provide HCBS services post March 17, 2014 must comply with the regulations for HCBS settings by the effective date of the program (the start of services).
- Federal Financial Participation (FFP)/funding will not be available for Medicaid-funded HCBS provided in presumptively-institutional settings that are unable or unwilling to demonstrate compliance with the settings regulatory criteria. (Medicaid cannot pay for services that do not comply.)
- FFP/funding for Medicaid-funded HCBS will be available for expenditures associated with the dates of service beginning on the date the State confirmed all remediation was completed and the setting demonstrates compliance with the regulation. (Medicaid may begin paying for services that do comply starting on the date that the State confirms the provider has addressed all issues related to compliance.)

HCBS Final Rule—SETTINGS

The underlying principle of the HCBS Settings Rule and the goal of system transformation is

COMMUNITY INCLUSION

for all Medicaid HCBS participants.

What Is Considered To Be An Institution?

42 CFR 441.301(c)(5)(i)-(iv)

- A nursing facility
- An institution for mental disease—*Choate Mental Health and Developmental Center, McFarland Mental Health Center, etc.*
- An intermediate care facility for individuals with intellectual or developmental disabilities—*ICF/DDs & SODCs*
- A hospital—*all hospitals providing medical, regardless of funding type*

Settings Presumed NOT to be Home and Community-Based

42 CFR 441.301(c)(5)(v)

This applies to both residential and non-residential settings.

Three categories that are presumed to have the qualities of an institution:

1. Settings that are located in a building that is also a publicly or privately-operated facility that provides inpatient institutional treatment;
2. Settings that are in a building located on the grounds of, or immediately adjacent to, a public institution; and
3. Any other settings that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of those not receiving Medicaid HCBS.

Settings Presumed NOT to be Home and Community-Based

CMS intends to take the following factors into account in determining whether a setting may have the effect of isolating individuals receiving Medicaid HCBS from the broader community:

- Due to the design or model of service provision in the setting, individuals have limited, if any, opportunities for interaction in, and with, the broader community;
- The setting restricts beneficiary choice to receive services or to engage in activities outside of the setting; or
- The setting is physically located separate and apart from the broader community and does not facilitate beneficiary opportunity to access the broader community and participate in community services, consistent with a beneficiary's person-centered service plan.

Settings Presumed NOT to be Home and Community-Based (continued)

Rural settings:

- Settings located in rural areas are **NOT** automatically presumed to have qualities of an institution, and more specifically, are not considered by CMS as automatically isolating to HCBS beneficiaries.
- What are some examples?
 - a. A rural Adult Day Service provider with limited access to public transportation
 - b. A rural Supportive Living Provider who lacks the financial capacity to provide their own transportation
 - c. A rural Community Integrated Living Arrangement (CILA) that lacks nearby options for community integration—parks, restaurants, shopping centers, libraries, museums
- We determine whether the setting is isolating by comparing the access that individuals living in the same geographical area (but who are not receiving Medicaid HCBS) have to engage in the community.

How Can Rural Providers overcome isolating features?

The Final Rule dictates customer choice of setting. This includes a customer's right to remain in their rural community. Settings located in rural areas can work to combat isolation through:

- *Emphasizing natural supports to meet transportation needs, i.e., family members.*
- *Linking customers to organizations within the community for transportation assistance.*
- *Partnering with other providers to schedule transportation for activities in the greater community.*

“Facilitating Opportunity”

What Does This Mean?

- The settings provide the resources required (e.g., transportation, activities, funding, support staff, etc.) for participants to access the greater community and participate in community activities.
- The setting provides training and/or support for participants to access resources not provided by the setting (public transportation, how to contact case coordinator or natural supports, budgeting, etc.)

The intention of facilitating opportunity is to ensure that:

- Individuals have the same opportunities that are given to others without disabilities
- Individuals receive the support they require to access these same opportunities to the level they desire

Both Residential and Non-Residential Settings must have the following qualities:

42 CFR 441.301(c)(4)(i)-(v)

- Be integrated in, and support full access to, the community, including:
 - a) Opportunities to seek employment and work in competitive, integrated settings
 - b) Engagement in community life
 - c) Control of personal resources
 - d) Receipt of services in the community
- Be selected by the customer from among settings options including non-disability specific settings; have an option for a private bedroom in a residential setting



**Some of the above criteria may be accommodated by case management staff within the respective Waiver Operating agency, i.e., DRS-HSP Counselor or CCU Case Manager.*

What can this look like?

- The setting is located among other residential buildings, private businesses, retail businesses, restaurants, etc. that facilitates integration with the greater community.
- The setting allows the individual(s) the freedom to move about inside and outside of the setting as opposed to one restricted room or area within the setting and they are allowed to come and go at any time.
- The setting facilitates the opportunity for the individual(s) to have access to, and control of, personal funds.
- The setting provides information about, or training on, how to access and use public transportation, such as buses, taxis, Uber, etc.

Reverse Integration

- Involves bringing people and activities from the broader community into the setting, instead of supporting people in the setting to access the broader community
- Reverse integration activities are not sufficient to meet the true intent and spirit of the HCBS Settings rule.
- Visits by community members have value but cannot replace community access for individuals.

**Under the Final Rule, providers MUST offer opportunities for community integration. However, customers are not required to participate.*



Both Residential and Non-Residential Settings must:

- Ensure an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimize individual initiative, autonomy, and independence in making life choices
- Facilitate individual choice regarding services and supports, and who provides them



What can this look like?

Ensures an individual's....

- Information is kept private.
- The setting staff interact and communicate with the individual(s) respectfully and in a manner in which they would like to be addressed.
- Individual(s) can have a private cell phone, computer, or other personal communication device, or the setting provides access to a device to use for personal communication in private.
- In settings with more than one individual, each individual's supports and plans to address behavioral needs are specific to the individual and are not the same as everyone else in the setting.

What can this look like (continued)?

Optimizes individual initiative....

- The setting offers a secure place for the individual(s) to store personal belongings.
- The setting supports individuals who need assistance with their personal appearance in private.
- The setting affords dignity to the diners (i.e., not required to wear bibs.)
- The setting allows the individual(s) to engage in legal activities (ex. voting when 18 or older or consuming alcohol when 21 or older) in a manner consistent with individuals not receiving Medicaid-funded services and supports.
- The physical environment supports a variety of individual goals and needs (indoor and outdoor gathering spaces, larger group activities as well as solitary activities, and stimulating, as well as calming, activities).

What can this look like (continued)?

Facilitates individual choice....

- The setting does not restrict services, providers, or supports and affords the opportunity for individual(s) to update or change their preferences.
- The setting provides the individual(s) receiving support assistance in developing plans and individualized goals to support their needs and preferences.
- Setting staff are knowledgeable about the capabilities, interests, preferences and needs of the individual.
- Tasks and activities are matched to an individual's skills, abilities and desires.
- Individual(s) sit in any seat in the dining area, can eat privately, if desired, and can request an alternative meal.

Provider-Owned or Controlled Residential Settings

42 CFR 441.301(c)(4)(vi)(A)-(E)



In addition to qualities previously specified, the following additional conditions must be met:

- A. A lease or other legally-enforceable agreement providing similar protections to local and municipal rules and laws
- B. Individual privacy with lockable doors, choice of roommate(s), and freedom to furnish or decorate the unit
- C. Control of own schedule including access to food at any time
- D. Access to visitors at any time
- E. Physically-accessible

** C-E applies to all ADS, TBI Habilitation, and Prevocational Service Providers*

Freedom and Support to Control Schedule and Activities

To comply with this requirement, Providers will ensure:

- People have the freedom to control their own schedule and activities (e.g., They do not have to adhere to a set schedule of waking, bathing, exercising or participating in activities.)
- Support activities are flexible and work around the person's preferred schedule.
- People do not have to follow one "set schedule" for all those living in the setting.
- People have access to food (meals or snacks) and a place to store snacks (e.g., bedroom, kitchen), if desired.

Freedom and Support to Control Schedule and Activities (continued)

To comply with this requirement, Providers will ensure:

- People have choices of when, where and with whom they would like to eat (e.g., no set “mealtimes” or assigned seats; a person can request alternative meals, if desired, etc.)
- People can eat a meal or snack at any time. If they miss a meal due to an activity, they do not have to wait for the next meal to eat; the provider can set aside a plate for them to reheat later or provide an alternate meal when they return.
- People have the right to refuse to participate in activities that the rest of the people in the setting want to experience.

Best practice suggestions



- People are supported in planning their day-to-day activities and schedules (i.e., when to wake up, eat and go to bed.)
- Providers are flexible when planning meetings and other activities so people can coordinate their schedules.
- People can ask for assistance if they would like to schedule appointments for services in the community or arrange for transportation.
- The provider creates an activity calendar each week so people can make decisions about activities in which they would like to participate.
- People can help develop the week's grocery list for the week or activity options.
- People are encouraged to share ideas and make choices about setting activities based on their own personal preferences and interests.
- People who work have access to food through typical workplace rules that all employees follow.

People are able to have visitors of their choosing at any time.

To comply with this requirement, Providers will ensure:

- People can choose their visitors and have no restrictions on visit times;
- People may have overnight guests;
- If the setting has designated visiting areas, people have unrestricted access; and
- People have the right to privacy during visits.

Best practice suggestions

- The policy and procedures for visits should include the person's right to:
 - i. Have visitors of their choosing at any time; and
 - ii. Request privacy during the visit.
- The person's right to have visitors of their choosing at any time must be contained in the resident rights document, the Resident Handbook or the Lease/Residency Agreement.
- The provider directly addresses health and safety concerns with the person and shares them with the person's case manager. If an agency implements visit modifications, the case manager must be involved and said modifications must be included in the personal plan. The modifications are documented and implemented in collaboration with the person and the provider.



The setting is physically accessible to the person.

To comply with this requirement, Providers will ensure:

- A person's physical environment meets his or her needs. For example, people must be able to use common areas in the home, such as the kitchen, dining area, laundry area and shared-living space, to the extent they desire.
- People must have the right to move about the setting and not be confined to any one defined area. They should have unobstructed access to all areas of the common living space that they wish to access. **this would not include "staff only" areas for paid support providers*
- Licensed programs must also refer to their applicable licensing/registration requirements regarding accessibility.

Best practice suggestions

- Have a conversation with a person about accessibility needs upon move-in.
- Ensure the physical environment meets the needs of the people who live in the setting (e.g., People can use common areas in the home such as the kitchen, dining area, laundry and shared living areas to the extent desired.)
- People are notified that they may request a reasonable accommodation, and the provider explains how to make such a request.
- Staff and residents regularly check for fall or trip hazards (loose rugs, uneven surfaces, etc.)
- As needed, the provider installs grab bars, ramps, adapted furniture, etc., to ensure access to desired areas and household items.



Any modifications of additional conditions A-D must be supported by a specific, assessed need and justified in the person-centered service plan

42 CFR 441.301(c)(4)(vi)(F)



What must be documented?

- A specific and individualized, assessed need
- Positive interventions and supports used prior to any modifications
- Less-intrusive methods of meeting the need that had been tried, but did not work
- Clear description of the condition that is directly proportionate to the specific assessed need
- Regular collection and review of data to measure ongoing effectiveness of the modification
- Established time limits for periodic reviews to determine if modification is still needed or can be terminated
- Informed consent of the person or guardian, if applicable
- Assurance that interventions and supports will cause no harm to the person—*the benefits outweigh the risks*

Supported by a Specific Need:

- Restricting independence or access to resources is appropriate only to reduce specific risks.
- Controls on personal freedoms and access to the community cannot be imposed on a class or group of individuals.
- Restrictions or modifications cannot be implemented as “house rules” in any setting, regardless of the population served and must not be used for the convenience of staff.

An individualized rights restriction used for an individual cannot affect another individual in the same setting, to the greatest extent possible.

- For those restrictions that affect other individuals in the setting, there must be a way for them to circumvent the restriction.

For example,

- If an individual requires a food restriction that results in the refrigerator being locked, there must be a way for other individuals to access that food (e.g., access to key, code, etc.)
- If an individual requires a media restriction of any media PG13 or above, there needs to be a way for other individuals to access that type of media (e.g., watching on personal devices, having an agreed upon media schedule, etc.)

Unsafe Wandering or Exit-Seeking Behavior:

- Settings with controlled-egress should be able to demonstrate how they can make individual determinations of unsafe exit-seeking risk and make individual accommodations for those who are not at risk.
- Should a person choose a setting with controlled-egress, the setting must develop person-centered care plans that honor autonomy as well as minimize safety risks for each person, consistent with his or her plan goals.
- Technological solutions, such as unobtrusive electronic pendants that alert staff when an individual is exiting, may be used for those at risk, but may not be necessary for others who have not shown a risk of unsafe, exit-seeking behavior.

For example, spouses or partners who are not at risk for exit-seeking and who reside in the same setting should have the ability to come and go by having the code to an electronically-controlled exit.

Balancing Safety With *The Dignity of Risk*



Dignity of risk means allowing individuals the right to take reasonable risks, as it is essential for their dignity and self-esteem and should not be stopped by overly-cautious team members.

Positive risk-taking:

- Improves autonomy
- Improves social interaction
- Improves health
- Allows one to live independently
- Constructs their lives in accordance to their values and personality
- Promotes self-determination and feelings of worth

Over-protection:

- Patronizes
- Smothers the person
- Removes hope
- Diminishes the person
- Prevents individuals from reaching their potential

Promising Practices for Providers: Community Integration

- Developing partnerships and building relationships with businesses or organizations in the community in which people of all abilities can be active
- Participating in an advisory group that consists of members of the community, family members, and others to increase individualized community-based service offerings



Promising Practices for Providers: Natural Supports:

- Utilizing a variety of public transportation options (including ride shares, taxi services, virtual transportation services, etc.) to promote optimal individualization of scheduling and activities
- Fostering access to technology and other innovations as a way to supplement natural supports
- Offering activities and programs that encourage families and friends to participate regularly and that promote greater independence and autonomy



Modernizing HCBS Settings

Former Practices

- Provide services at the setting (e.g., church, salon)
- Bring in visiting artists/classes
- Group planning
- Provider creates the program schedule
- Over-protection
- Limited choice

**Some former practices such as services/visiting artists at the setting still have value and may be offered in addition to community activities.*

New Practices

- Identify and attend services in the community
- Locate community classes
- Suggest activities based upon an individual's interests
- Individuals create their own schedule
- Positive risk-taking
- Informed decision-making

Resources on Federal Settings

CQL's HCBSACT Project: <https://www.c-q-l.org/resources/projects/the-hcbs-act-project/>

CQL's HCBS Training Videos: https://youtube.com/playlist?list=PL_6PLdSIhcvNW7TI77a-DdTGvSp_H1gBl

Medicaid HCB Settings Requirement Compliance Toolkit:

<https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-settings-requirements-compliance-toolkit/index.html>

ASAN HCBS Settings Tool -Kit: <https://autisticadvocacy.org/policy/toolkits/hcbsrule/>

Resources on Federal Settings

HCBS Advocacy Coalition: <https://hcbsadvocacy.org/>

HCBS Final Rule: https://www.ecfr.gov/cgi-bin/text-idx?node=se42.4.441_1301&rgn=div8

NCAPPS Person-Centered Planning Resources: <https://ncapps.acl.gov/resources.html>

