CMS has released regulations to expand access to home and community-based long-term care services (HCBS); HCBS waivers will be granted for five years initially, and the state plan benefit has been expanded. The final rule implements provisions of the Deficit Reduction Act (DRA) (P.L. 109-171) and the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) that give states more flexibility to design and implement HCBS through a waiver, a state plan amendment, or both (Final rule, 79 FR 2947, January 16, 2014).

**Definition of HCBS.** Long-term care in an individual’s home or in a community setting includes assistance with activities of daily living, such as personal care, administration of medications, and maintaining a clean and safe environment. The statute explicitly excludes nursing facilities, intermediate care facilities, and institutions for mental diseases from the definition of HCBS. The final rule defines “home and community” as a setting that affords maximum integration into the community, in which an individual can work, participate in outside activities, and interact with people who are not disabled. The setting must be freely chosen by the individual. CMS also adopted requirements that a provider must meet to qualify its services as HCBS. Included are ensuring the rights of privacy, dignity, freedom from restraint, and autonomy. Individuals must be permitted to choose their activities and with whom they will interact.

In a residential setting controlled by the provider, the individual must have the rights of a tenant, for example, locking doors from the inside, limiting access to appropriate staff, privacy in the sleeping area or unit, freedom to decorate the unit as he or she chooses, within the limits of a residential lease. The residence may not restrict the individuals’ activities; they must have the freedom to have visitors any time and to come and go at will and to have access to food at all times.

**Target populations.** The rule permits states to target their HCBS waivers to specific populations, including individuals who are elderly or disabled, or both and who have intellectual disabilities or mental illness. The state may combine its waivers but must assure that the needs of each individual may be met.

**Duration of waivers.** Typically, initial HCBS waivers were for three years, and renewal waivers lasted five years. Under this rule, however, HCBS waivers may be authorized for five years at the beginning.

**HCBS under a state plan.** States may add HCBS as an optional benefit under the state plan; if they do so, the limits on duration and need for renewal do not apply. Eligibility must depend on needs-based criteria; in other words, the functional limitations and the medical necessity of services determine who may receive benefits. An independent evaluation must be conducted to determine the individual’s needs and strengths. The agent who performs the evaluation must be a qualified professional who is not affiliated with a provider of HCBS.

**Person-centered service plans.** The plan of care must be based on the independent evaluation. The state or agency developing the care plan must consult with the individual or, if necessary, the individual’s representative. Each service or intervention included must address a specific need identified in the evaluation.

The individual beneficiaries must be allowed to choose their service providers from the available qualified providers and to set their own goals and desired outcomes. They must also be allowed to choose their residence, and a setting not targeted to individuals with disabilities must be among the options offered. The plan of care also must include documentation to show that less restrictive alternatives have been considered. If the
plan includes a residential setting, the plan must document the alternatives considered and the reasons they were rejected. Similarly, when the plan of care is modified, the reasons must be documented.

**Beneficiary protections.** If eligibility is denied based on the independent evaluation, the applicant has the right to appeal as with any other denial. The state must develop standards defining and preventing conflict of interests. At a minimum, the functions of evaluation agent and provider of services must be separated. The person who performs the independent evaluation, the assessment of needs and/or develops the care plan may not be: (1) related by blood or marriage to the beneficiary or to any paid caregiver; (2) financially responsible for the beneficiary; (3) have authority to make medical or financial decisions for the beneficiary; or (4) the owner of, employed by, or financially interested in any entity that is paid to care for the beneficiary. The last restriction may be waived if the state demonstrates that there are no other professionals available.

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