Request for CMS Action on Implementation of Federal Regulations for HCBS Settings

States Must Give Public a Meaningful Opportunity to Comment on Draft Transition Plans

Public Comment Requirement Should Include Services Transferred From HCBS Waivers to 1915(k) Programs

Provider-Controlled Settings Should Not Discriminate Based on Source of Payment

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The Centers for Medicare and Medicaid Services (CMS) should take action to ensure the proper implementation of the new federal regulations on home and community-based services (HCBS) settings. This document addresses three issues: 1) the inadequate public comment processes being proposed by some states, 2) the need for public comment for HCBS provided through 1915(k) programs, and 3) the inappropriateness of payment-source discrimination in provider-controlled settings.

Contrary to the Federal Regulations, Some States Are Not Providing a Meaningful Opportunity for the Public to Comment on Draft Transition Plans.

The new federal Medicaid regulations set standards for the settings in which HCBS are provided.[1] The requirements are extensive, requiring states both to adjust their standards, and to develop or modify procedures to ensure compliance with those standards.

Given the many changes that states will need to make, public comment is vital to states' development of their revised standards and procedures. The federal regulations provide for public comment procedures in which a state must do all of the following:

- Make a draft transition plan available to the public for comment. The transition plan must detail how the state will operate its HCBS programs in accordance with the new regulations.
- Provide a notice-and-comment period of at least 30 days.
- Consider and modify the transition plan, as the state deems appropriate, to account for public comment.

[1] *See* 79 Fed. Reg. 2,948 (Jan. 16, 2014).

- Submit a summary of the comments to CMS with a proposed transition plan, including a list of changes made in response to the comments, and an explanation of why other comments did not lead to changes.[2]

A small number of states already have begun taking steps to develop a transition plan. Unfortunately, in some states, the public will not be able to comment on a transition plan's substance. In Wyoming, for example, a 30-day notice-and-comment period ran from April 18, 2014 to May 22, 2014, and allowed for comments only on the state's *process to develop* its transition plan.[3] The transition plan itself will be drafted by the state between December 1, 2014, and January 15, 2015, evidently with no opportunity for public comment on a draft.

Similarly, Iowa made a draft transition plan available for public comment during May 2014, but that plan discusses only the state's decision-making processes, and not the state's standards or enforcement mechanisms.[4] For example, the draft transition plan says that the state from August 2014 through July 2015 "will work to revise programmatic rules to reflect final [federal] regulations on HCBS setting requirements," with no discussion of what those revisions might be.

We understand that states are operating under regulatory timeliness, but those timelines should be implemented in a way that maintains meaningful public comment. The regulations require that "a transition plan detail[] how the State will operate all section 1915(c) HCBS waivers and any section 1915(i) State plan benefit"; thus, public comment cannot be limited to merely the state's process in developing a plan. We urge CMS to take action to ensure that states offer the public comment opportunities as required by law.

The Public Comment Requirement Should Include Services Transferred From HCBS Waivers to 1915(k) Programs.

We request that CMS require a transition plan for HCBS provided through 1915(k) programs. The situation in Oregon demonstrates the need for this requirement. Oregon has transferred virtually all HCBS from 1915(c) waivers to a 1915(k) program, but the 1915(k) plan was adopted before CMS issued the final regulations for HCBS settings.[5] Since the new regulations apply both to 1915(c) waivers and 1915(k) programs, Oregon should be required to submit a transition plan (with opportunity for public comment) that addresses how Oregon's 1915(k) HCBS will be brought into conformity with the new standards. The public input process could incorporate existing mechanisms within Oregon's 1915(k) program, including the Development and Implementation Council, and the consumer feedback process within the state's quality assurance program.[6] It would be a disservice to Oregon consumers for the state instead to exclude 1915(k) services from its transition planning.

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[2] 42 U.S.C. §§ 441.301(c)(6)(iii) (HCBS waivers); 441.710(a)(3)(iii) (HCBS state-plan services).
[3] Wyoming Dep't of Health, State Plan for Assessing HCBS Settings Compliance (April 18, 2014), *available at* www.health.wyo.gov/healthcarefin/medicaid/homecareservices.html.
[4] Iowa Dep't of Human Services, Informational Letter No. 1383 (April 30, 2014); Iowa Department of Human Services, HCBS Settings, State Home and Community Based Services (HCBS) Setting Transition Plan Due 7/31/2014. Each of these documents is available at dhs.iowa.gov/ime/about/initiatives/HCBS.
[5] *See* Oregon State Plan, Transmittal #12-14, Attachment 3.1-K, pp. 25-31; 42 C.F.R. § 441.530.
[6] 42 C.F.R. §§ 441.575, 441.585(c).

Provider-Controlled Settings Should Not Discriminate Based on Source of Payment.

CMS should be clear in its forthcoming guidance that provider-owned or controlled residential settings should not limit rights based on a resident's source of payment. A contrary interpretation would condone payment-source discrimination that would be contrary to both the letter and the spirit of the new regulations.

The new federal regulations are based on an important principle. It is not enough that an HCBS setting is not classified as an institution. For services to be properly considered home and community-based, the setting must be non-institutional in character.

In short, consumers must be treated fairly and humanely, and the setting must be home-like.

Payment-Source Discrimination Is an Institution-Like Practice That Is Antithetical to a Community-Based Setting.

Consistent application of the regulatory standards is essential for provider-owned or controlled settings to truly be non-institutional. These settings generally are licensed facilities — assisted living facilities, for example, or adult residential facilities for persons with disabilities — and the risk is great that they operate in ways that are institutional. Because of that risk, the new HCBS regulations apply additional requirements to those settings. Those regulations must apply to all residents, regardless of payment source, if the facility truly is to be considered non-institutional and thus eligible for reimbursement as a community-based setting.

It is instructive to consider the ramification of a contrary interpretation. In general, the regulations establish five standards specifically for provider-owned or controlled settings:

1. A legal right to a specific physical place, with protection against eviction.
2. Privacy, including lockable doors and the right to choose a roommate.
3. Control of schedules and activities, with access to food at any time.
4. Access to visitors at any time.
5. Physical accessibility.

If these protections were applied to Medicaid beneficiaries, but denied to other residents, the result would be an institutional environment. Imagine, for example, visitors being allowed for Medicaid beneficiaries but not for other facility residents. This type of payment-source discrimination clearly would be contrary to the goal of a home-like environment and thus harmful to Medicaid beneficiaries.

The Language of the Regulations Indicates that Payment-Source Discrimination Should Not Be Allowed.

Consistent with these principles, the regulations for provider-owned or controlled residential settings generally refer broadly to all residents of the setting — specifically, to "individuals" or

to "each individual."[7] Importantly, the regulations generally do not make a distinction based on a resident's payment source, indicating that the standards set by the regulations should apply to all of the setting's residents.

An exception is seen in one specific provision, requiring that a State ensure that a written lease or similar agreement is in place for "each HCBS participant."[8] The limited use of this more restrictive term reinforces the understanding that the term "individual" should include setting residents regardless of their payment source. If the term "individual" instead were interpreted to refer only to persons with Medicaid HCBS reimbursement for services, there would be no need to make a specific reference to an "HCBS participant."

This understanding is consistent with a standard rule of statutory interpretation – when specific language is included in one section of a statute, but omitted in another, it is assumed that the omission is intentional.[9] Here, the specific, limited reference to "HCBS participant" indicates that the broader use of the term "individual" should not be limited to persons with Medicaid HCBS coverage.

For these reasons, it is vital that CMS guidance clearly state that the standards for provider-owned or controlled setting be applied regardless of an individual's reimbursement source. Payment-source discrimination is an institution-like practice that should not be tolerated in a home or community-based setting.

[7] 42 C.F.R. §§ 441.301(b)(4)(vi), 441.530(a)(1(vi), 441.710(a)(1)(vi) (HCBS waivers, Community First Choice option, and HCBS state-plan services, respectively).
[8] 42 C.F.R. §§ 441.301(b)(4)(vi)(A), 441.530(a)(1(vi)(A), 441.710(a)(1)(vi)(A). In the case of the Community First Choice option, the regulation refers to "each participant" rather than "each HCBS participant."
[9] *See, e.g.*, Keene Corp. v. U.S., 508 U.S. 200, 208 (1993).