
January 10, 2014

**Fact Sheet: Summary of Key Provisions of the Final Rule for 1915(i)
Home and Community-Based Services (HCBS) State Plan Option
(CMS 2249-F/2296-F)**

Background

Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(i) to the Social Security Act (the Act) providing states the option to offer home and community-based services, previously available only through a 1915(c) HCBS waiver, through the state's Medicaid state plan. As originally enacted, states could only serve individuals eligible under the State plan with incomes at or below 150 percent of the Federal poverty level (FPL) or below and could offer some, but not all, HCBS services and supports available through 1915(c) HCBS waivers. In addition, states were not able to target 1915(i) state plan HCBS to particular populations within the state.

The Affordable Care Act expanded coverable services under 1915(i) to include any of the HCBS permitted under section 1915(c) HCBS waivers, certain services for individuals with mental health and substance use disorders and other services requested by a state and approved by the Secretary of Health and Human Services. In addition, the changes support ensuring the quality of HCBS, require states to offer the benefit statewide and enable states to target 1915(i) State Plan HCBS to particular groups of participants but not limit the number of participants who may receive the benefit. CMS published a proposed rule on May 4, 2012 for these 1915(i) provisions. This final rule responds to the public comments received on those proposed rules.

In addition to the above provisions, the final rule also establishes a set of requirements for home and community-based settings under the 1915(i), 1915(c) and 1915(k) Medicaid authorities, and a set of person-centered planning requirements for Medicaid HCBS participants under 1915(c) and 1915(i).

Home and Community-Based Settings

CMS' definition of home and community-based settings has evolved over the past five years, based on experience throughout the country and extensive public feedback about the best way to differentiate between institutional and home and community-based settings. Based on the comments received on the 1915(c) advance notice of proposed rulemaking (ANPRM), the proposed 1915(c) rule, and the comments received on the 1915(i) and 1915(k) proposed rules, CMS is moving away from defining home and community-based settings by "what they are not," and toward defining them by the nature and quality of participants' experiences. The home and community-based setting provisions in this final rule establish a more outcome-oriented definition of home and community-based settings, rather than one based solely on a setting's location, geography, or physical characteristics. The changes related to clarification of home and community-based settings will effectuate the law's intention for Medicaid HCBS to provide alternatives to services provided in institutions and maximize the opportunities for waiver participants to have access to the benefits of

community living, including receiving services in the most integrated setting. For more detail, please refer to the HCBS Settings Fact Sheet available at <http://www.medicaid.gov/HCBS>.

The final rule includes a transition period for states to ensure that their waivers and state plans meet the HCBS settings requirements. New 1915(c) waivers or 1915(i) state plans must meet the new requirements to be approved. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not fully meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. The public will have an opportunity to provide input on states' transition plans. CMS expects states to transition to the new settings requirements in as brief a period as possible and to demonstrate substantial progress during any transition period. CMS will afford states a maximum of a one year period to submit a transition plan for compliance with the home and community-based settings requirements of the final rule, and CMS may approve transition plans for a period of up to five years, as supported by individual state's circumstances, to effectuate full compliance.

States submitting a 1915(c) waiver renewal or waiver amendment within the first year of the effective date of the rule may need to develop a transition plan to ensure that the specific waiver or state plan meets the settings requirements. Within 120 days of the submission of that 1915(c) waiver renewal or waiver amendment, the state needs to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs. CMS will work closely with states as they consider how to best implement these provisions and will be issuing sub-regulatory guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning

In this final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences, including those related to community participation, employment, income and savings, health care and wellness, education and others. The plan should reflect the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct services. This planning process, and the resulting person-centered service plan, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. CMS will provide future guidance regarding the process for operationalizing person-centered planning in order for states to bring their programs into compliance.