HOME AND COMMUNITY BASED SERVICES (HCBS) FINAL RULE
FREQUENTLY ASKED QUESTIONS

Question	Answer
I have heard that there are new federal regulations that may impact some Medicaid providers, can you explain?	Yes, there are new federal rules that will affect certified family home providers, Residential Assisted Living Facility providers and any non-residential service providers who are reimbursed by Medicaid to provide home and community based services to a Medicaid participant. The goal of the new rules is to enhance the overall quality of home and community-based services (HCBS) and to ensure that individuals receive these services in settings that are integrated in, and support full access to, the greater community. These federal rules became effective on March 17, 2014 and require all state Medicaid programs to ensure they are followed by providers in each state. Idaho has been conducting educational web-ex meetings which are posted with other updated information on this webpage if you would like to learn more.
Who does this rule impact?	This new CMS HCBS rule impacts participants receiving HCBS services, as well as Medicaid providers who furnish HCBS. These providers may include those involved in developing HCBS service plans and those delivering HCBS in non-residential and residential settings.
Where can I see a copy of these new regulations?	A link to the federal legislation can be found on this webpage under "Resources." Follow the link to "Federal Regulation." A summary of the rules can also be found on this webpage under "Resources". Follow the link to "Home and Community Based Setting Qualities."
When are we expected to be in compliance with the new regulations?	Idaho Medicaid has informed CMS (the Centers for Medicare and Medicaid Services) that Idaho Medicaid will be proposing state Medicaid rule changes during the 2016 legislative session to support the new federal requirements. Once the proposed rules are approved by the Legislature, providers will have six months to come into compliance in order to continue to be reimbursed by Medicaid to provide services to Medicaid funded participants. Provider compliance is expected by January 1, 2017 when Idaho Medicaid will begin assessment of setting compliance.
Will this impact my Medicaid reimbursement?	Reimbursement rates are not being impacted by the federal or state HCBS rules. In order to continue to receive Medicaid reimbursement, certified family home providers, Residential Assisted Living Facility (RALF) providers and non-

Question	Answer
	residential service providers who furnish home and community-based services to a Medicaid participant must follow these regulations by January 1, 2017. Any such provider, who is unable or unwilling to comply with the new rules discussed above, can no longer be reimbursed to provide Medicaid services. If it is determined that a setting does not meet the new HCBS setting requirements, participants will be notified and, provided with assistance in finding alternative care and/or housing.
How can providers obtain more information and learn how to come into compliance with these new setting regulations?	Medicaid will continue to host WebEx meetings over the next year and a half to help providers understand the new expectations. These meetings will be announced on this webpage and via email. To ensure you are on the email list for these announcements, please send your email address to the program at HCBSsettings@dhw.idaho.gov or follow the "Email the Program" link found on this webpage under "Ask The Program". Medicaid will also develop a tool kit for providers, which will be available in early 2016 to help you assess your compliance with the new federal rules. The tool kit will include a checklist that identifies HCBS setting requirements for the different types of Medicaid reimbursed providers. The tool kit will be posted to this webpage once it is ready.
How can I best stay informed?	Information and updates will continue to be posted on this webpage. It is our primary means of communication so please check it frequently for new information and resources. We also are sending alerts to providers via email. To enroll on the HCBS email list, please send your email address along with the type of services you offer to HCBSsettings@dhw.idaho.gov or just follow the "Email the Program" link found on this webpage under "Ask The Program".
States have until March 2019 to submit plans to the federal agency. Why is Idaho establishing a target date of January 2017 for compliance?"	The regulation requires states to submit their statewide transition plans to CMS by March 17, 2015. It further states that all home and community-based settings must be fully compliant with the HCBS setting regulations by March of 2019. To reach compliance in Idaho, the following will occur: • The transition plan was submitted to CMS in March of 2015 • Rules will be promulgated during the 2016 legislative session • Those rules will become effective in July, 2016 • Providers will be given until December of 2016 to reach full compliance

Question	Answer
	• The state will take one year to complete its initial assessment of home and community-based settings, January 2017 through December 2017 • Corrective action plans will be issued as needed. A corrective action plan initiated in December 2017 could take until March of 2018 to resolve • Participants will be notified of any setting that is not or will not be HCBS compliant and they will be provided assistance in finding an alternate HCBS compliant setting • All settings where a participant is residing or receiving services that are funded with HCBS dollars will be compliant by March of 2019 Medicaid believes it is important to complete the assessment process of setting compliance in this time frame so that participants have a reasonable amount of time to transition if needed. Assessment will take a full year. Assessment cannot begin before rule is promulgated and providers have time to comply.
If these rules have been in effect since March of 2014, when does Medicaid expect providers to make changes to meet them?	Although the federal legislation was passed in March of 2014, CMS has given states some flexibility in the timeline for coming into compliance. Idaho expects providers to be fully compliant by December of 2016. The state will continue to work with providers to help them understand what the regulations require and how they can complete a self-evaluation. Medicaid will begin completing assessments of settings in January of 2017 and expects this work will take a full year.
How will Idaho ensure that all providers can access information about this project?	In addition to all electronic communications including this webpage, a variety of activities are occurring. They include phone meetings, communications via professional organizations, work with advocacy groups, a notice regarding this project on the remittance advice sent to providers and handouts to be distributed to certified family home providers. The state is currently encouraging people to spread the word through their professional communities and provider networks to engage as much of the interested population as is possible and feasible.
Which requirements apply to all settings and which apply only to	<u>All settings must demonstrate the following qualities:</u> 1. The setting is integrated in, and facilitates the individual's full access to, the

Question	Answer
residential settings?	greater community to the same degree of access as individuals not receiving Medicaid HCBS. 2. The setting includes opportunities to seek employment and work in competitive, integrated settings to the same degree of access as individuals not receiving Medicaid HCBS. 3. The setting includes opportunities to engage in community life to the same degree of access as individuals not receiving Medicaid HCBS. 4. The setting includes opportunities to control personal resources to the same degree of access as individuals not receiving Medicaid HCBS. 5. The setting includes opportunities to receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. 6. The setting is included as an option to be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The chosen setting options are identified and documented in the person-centered service plan and based on the individual's needs; preferences; and, for residential settings, resources available for room and board. 7. An individual's essential personal rights of privacy, dignity, respect, and freedom from coercion and restraint are protected. 8. Individual initiative, autonomy, and independence in making life choices, including but not limited to daily activities, physical environment, and with whom to interact are optimized and not regimented. 9. Individual choice regarding services and supports, and who provides them, is facilitated. <u>Provider owned and controlled residential settings must **also** have these qualities:</u> 1. The unit or room is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the

Question	Answer
	landlord tenant law of the State, county, city or other designated entity; For settings in which landlord tenant laws do not apply, the State must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law 2. Each individual has privacy in their sleeping or living unit: Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors. 3. Individuals sharing units have a choice of roommates in that setting. 4. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement. 5. Individuals have the freedom and support to control their own schedules and activities 6. Individuals have access to food at any time. 7. Individuals are able to have visitors of their choosing at any time. 8. The setting is physically accessible to the individual.
When can we modify the rule?	Only the provider owned and controlled residential setting qualities listed in the question above ("Which requirements apply to all settings and which apply only to residential settings?") may be modified. The process to do that is outlined in the rule and summarized here: Any modification of the requirements must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: 1. Identify a specific and individualized assessed need. 2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan. 3. Document less intrusive methods of meeting the need that have been tried but did not work.

Question	Answer
	4. Include a clear description of the condition that is directly proportionate to the specific assessed need. 5. Include regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Include the informed consent of the individual. Include an assurance that interventions and supports will cause no harm to the individual.
Will Idaho Medicaid hold any public forums for providers to discuss this project?	Medicaid has offered several public forums where stakeholder input has been solicited. These began in July with a series of five WebEx meetings. During those meetings the new rule was reviewed, results of Idaho's analysis of current compliance were presented, and feedback from stakeholders was solicited. The PowerPoint presentation along with the audio of those meetings can be found on this webpage. Additionally phone conferences have been held and continue to be offered to various provider groups. It is fully expected that phone conferences and WebEx meetings will continue as we move through this process. Stakeholder input is critical to the success of this work. It is Medicaid's goal to keep this process very transparent and to engage stakeholders at every step. Please watch the webpage for upcoming events.
Will these new regulations impact providers or participants of the Medicare-Medicaid Coordinated Plan (MMCP)?	Yes, the new federal requirements apply to all home and community-based services, including those furnished under MMCP. (Administered by Blue Cross of Idaho.) All Medicaid-funded home and community-based services (HCBS) must comply, whether they are furnished directly by the state Medicaid agency or by a Medicaid managed care program.
Do these rules apply to certified family homes?	Yes, these new rules apply to all settings where home- and community-based services (HCBS) are furnished. The additional residential rules apply to provider-controlled residential settings where people receiving HCBS funds live. In Idaho, this includes certified family homes (CFHs) and residential assisted living facilities (RALFs). Please refer to WebEx #2 at www.HCBS.dhw.idaho.gov for details.

Question	Answer
Has Idaho Medicaid considered the health and safety issues regarding 24-hour access to food? For example, what if a resident cannot safely operate a microwave? What if a resident is on a medically required restricted diet?	There are a variety of ways that a provider can ensure 24-hour access to food, including allowing a resident to have food or snacks available in their room, by giving individuals control in selecting the foods that they eat, and deciding when to eat. This does not necessarily mean that every individual must have a microwave in their room. If it is not safe for a participant to operate a microwave, there are likely other ways that this requirement can be met. An individual should not be presented with narrow options decided by someone else, without input from the individual. It is also recognized that in some cases, if someone's individualized assessed needs indicate that a modification is necessary there might be a need to have pantries and the refrigerator locked as there is clear evidence that an individual needing modifications will seek out food and that other positive approaches to safeguarding have not been successful. This type of modification affects everyone in the household. In these cases, there must be arrangements made so that other individuals can have the right to access to food at any time. These arrangements might include the ability to ask staff to open the pantry at any time, and/or the person having a locked pantry in their own room for storage of their own food. The expectation is that reasonable approaches are taken to support the people who are impacted by the restriction that is in place to maintain the level of control that is appropriate for them, through mitigating activities that are person-centered.
I am concerned about the requirement that residents of certified family homes and residential assisted living facilities must have access to food 24/7. Is it sufficient to have a vending machine available?	After further discussions with CMS it is Medicaid's interpretation of the new federal requirements that residents should have access to food in the same way you or I have access to food in our own homes. Thus simply installing a vending machine would not suffice to fully meet the requirement.
What type of data will Idaho Medicaid be collecting for monitoring purposes?	Please refer to the current Transition Plan posted on this webpage for details about assessment and monitoring the residential settings. Idaho Medicaid is currently analyzing how we will monitor compliance with these requirements in the non-residential settings. We will include our progress on this portion of our

Question	Answer
	work in the next publication of the transition plan which is likely to occur in Spring or early summer, 2015.
Has the state considered the funding required for providers to come into compliance? Can providers expect an increase in reimbursement?	Idaho Medicaid pays for the residential services provided by the CFH or RALF. Room and board are not covered under the Medicaid state plan and payments for these services are expressly prohibited. Services are not changing, only the settings in which they are offered. Medicaid is not currently considering changes to reimbursement for services.
The requirement says that settings must be physically accessible to the individual. What does physically accessible mean?	Physically accessible means that for residents with mobility or sensory impairments, the provider or facility must provide a physical environment which meets the needs of the person for independent mobility and use of appliances, bathroom facilities, and living areas. This is a criterion that is already reviewed by the Division of Licensing and Certification. For example, it would be expected that the doorways and halls in the residence be wide enough to accommodate a participant who requires a wheelchair.
Where can a provider obtain Idaho's landlord tenant laws?	Idaho's landlord tenant laws are described in Idaho Statute, Title 6, Chapter 3.
Why is Medicaid doing this work and not Licensing and Certification staff?	The Center for Medicare and Medicaid Services (CMS) has directed Medicaid to complete the assessment of the new federal regulations since Medicaid is the entity responsible for payments to providers for HCBS. Medicaid has been working closely with Licensing and Certification staff as we look at how to determine which settings meet or do not meet the requirements of a home and community-based setting. This is a collaborative effort between Medicaid and Licensing and Certification.
What changes can we expect to see in licensing and certification requirements?	It is not anticipated that this project will result in any changes to licensing and certification requirements (please click the hyperlinks for existing licensing and certification requirements: CFHs and RALFs). The draft transition plan has a projected time frame for implementing changes to Idaho Medicaid requirements.
Are congregate, center-based service delivery settings still a viable option for HCBS assuming they meet the setting	CMS's Response: "Yes, congregate, facility-based settings are options for individuals receiving HCBS when the setting meets HCBS requirements as specified within the regulations and the service definition within the approved waiver application."

Question	Answer
requirements?	Idaho will develop standards for congregate, facility-based settings (such as developmental disability agencies and adult day health centers) where HCBS services occur, as well as a toolkit with further guidance for providers.
The new requirement is that participants are given the option to integrate or engage in community activities, not that they are required to participate, correct?	That is true. Any setting where someone is receiving HCBS services must provide opportunities for integration into the community. Some participants may prefer not to go out into the community as often as others. In general, the less experience a person has with life in the community, the more likely he/she is to need support and opportunities to try different activities. Each participant should be encouraged and supported to have full access to the community based opportunities related to his or her interests, preferences, and priorities for meaningful activities to the same degree as others in the community. Information about the person's choices for meaningful community inclusion and integration activities, desired frequency and duration of these activities, and the supports needed to participate should be documented in the person's service plan.
Is there a conflict with the new HCBS Rules when the provider is assigned as the payee?	CMS Response: "No. The assignment of a representative payee is under the purview of the Social Security Administration. This rule does not supersede or negate that authority."
The new HCBS regulations say that in a residential setting people must be permitted to select their own roommates. Would you please clarify?	Participants' preferences in deciding where they live, and with whom they live, are a priority. The individual's choice of roommate must be documented in the person-centered plan. The person-centered plan must document how choice was provided to and exercised by the individual. Conflicts should be addressed if they occur and mediation strategies should be available to address concerns.
The requirements states that each individual must have privacy in their sleeping or living unit. Does the term "living unit" mean that the individual should have a key to the residence as well as his or her bedroom?	CMS response: "Yes. It is expected that individuals would have keys to the residences in which they live. If there are circumstances that would prevent an individual from having a key to the residence, these should be discussed during the person-centered planning process and described and documented in the person-centered plan. If, as indicated in the person-centered plan, an individual will not have a key to the residence, the individual should still have full access to the residence and methods to make this possible should be included in the plan."

Question	Answer
Does staff having keys to residents' rooms for safety reasons violate the requirement for privacy?	The staff person(s) allowed to have keys to an individual's room should be determined by the provider and participant and should be documented in the person-centered plan. The provision of keys to anyone other than the residents of the setting should be limited to those individuals and circumstances identified and for the purposes described in the person-centered planning process.
How will rural communities meet the requirement to provide participants opportunities to engage in the community when there are fewer options to support community integration?	Individuals receiving Medicaid HCBS in rural communities must have the same opportunity for community integration as do individuals not receiving Medicaid HCBS in that community. Access must be comparable to that of others in that rural area. A very rural setting may preclude the person from frequenting their local communities in the same manner as people living in an urban setting, but this is also true for the public at large. It is important that individuals who reside in very rural settings also understand that they have a choice of where they live and can ask to move to a more urban setting if they feel isolated from the greater community.
Visitors allowed 24/7 will be difficult. Our residents can have visitors, but we like to know who is coming in the facility. We have many vulnerable adults at our facility. We have to watch out for their best interest. If a resident brings a highly volatile person into the facility it could endanger the whole house, not just the one resident, including staff. How can we accommodate this requirement while ensuring the safety of our residents?	If an individual's rights, including but not limited to roommates, visitors, or with whom to interact, are to be restricted in any way, it must be supported by a specific assessed need and justified in the person-centered plan. Providers are still able to take precautionary measures such as locked doors, use of doorbells for visitors, visitor sign in sheets, etc. However, procedures should not unnecessarily restrict visitors for the convenience of staff and/or to restrict the person from freedom of association with whomever they choose. It is understood that in a shared living situation, the needs of other residents must also be respected. But there should be an effort to communicate and coordinate between the affected parties, rather than having blanket house rules restricting when and how a person can receive visitors. Any restrictions on individual choice must be focused on the health and welfare of the individual and the consideration of risk mitigation strategies. The restriction, if it is determined necessary and appropriate in accordance with CMS's guidelines, must be documented in the person-centered plan, and the individual must provide informed consent for the restriction. Please see the

Question	Answer
	question above, "When can we modify the rule?"
If a restriction to one of these requirements is placed on the provider residency agreement and the resident thus agrees to that restriction, is that sufficient?	No, CMS has been very clear that any restrictions placed must follow the process outlined in rule. Please see the question above, "When can we modify the rule?"
Having the state ensure that participants are aware of options for a private unit is very disconcerting. Does this require facilities to give all Medicaid clients the option of a single room?	The rule does not require every provider to have a private room option. Instead, it requires the state to ensure that there are private room options available within a state's HCBS program. The Centers for Medicare and Medicaid Services (CMS) has made it clear in their FAQs, found at www.HCBS.dhw.idaho.gov, that the resident must have the OPTION of a private unit in a residential setting. The regulatory requirement acknowledges that an individual may need to share a room due to the financial means available to pay for room and board or may choose to share a room for other reasons. However, when a room is shared, the individual should have a choice in arranging for a roommate.
How does a facility maintain the safety of the resident with Alzheimer's or dementia and still meet the requirements of this rule?	Certainly all safety needs should be addressed in the person-centered plan and risks to health and safety mitigated there.
The requirement is that the participant is free from coercion and restraint. What if the person engages in self-injurious behavior or destruction of property, restraint may be the only way to afford them protection from themselves?	In a provider-owned or controlled residential setting, states must ensure that any necessary modification to the rights of individuals receiving services is based on individually assessed need and such justification is documented in the person-centered plan. In other settings, the individual must be afforded the rights of privacy, dignity and respect, and freedom from coercion and restraint. The person-centered plan must reflect risk factors and the measures in place to minimize them, including individualized back-up plans and strategies.