PUBLICATION

Home and Community-Based Services: Seven Things You Need to Know

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July 21, 2015

Few people have a strong understanding of home and community-based services (HCBS), how they work, how they came about and why they are important. There are a number of reasons why HCBS experts are few and far between. Put simply, administration of HCBS and its relation to Medicaid or Medicaid waiver funding is a convoluted area of the law. This article wades through the muddy waters in an attempt to explain some of the finer points of HCBS. Though just the tip of the iceberg, these are the seven things you need to know about HCBS.

1. HCBS serve a broad range of individuals with varying needs.

The HCBS programs target three groups – individuals who are aged and disabled or both, individuals with intellectual disabilities or developmental disabilities or both, and individuals with mental illnesses. HCBS programs allow individuals within these three target populations to receive a mix of services in their own home or community rather than in the traditional, institutional setting. Some of the services that HCBS individuals are able to receive are case management; habilitation which may include certain pre-vocational, supportive employment and certain special educational services; personal care and respite services; adult day care and adult day health services; day treatment or other partial hospitalization services; psychosocial rehabilitation services and clinic services for individuals with chronic mental illness; home delivered meals; home health aides; and homemaker services. Respiratory care is also a service available for ventilator-dependent individuals. States also have the option to provide other services approved by the Centers for Medicare & Medicaid Services (CMS) which are "effective and necessary to avoid institutionalization."

2. HCBS programs operate under one of three Medicaid or Medicaid waiver options.

There are three Medicaid authorities for HCBS: the 1915(c) HCBS Medicaid waiver program; the 1915(i) State Plan HCBS benefit option; and the 1915(k) Community First Choice (CFC) HCBS State Plan benefit option. The HCBS Medicaid waiver program became an option to State Medicaid agencies in 1983 when Congress approved section 1915(c) to the Social Security Act (SSA). This amendment to the SSA gave states the option to receive a waiver of Medicaid rules governing institutional care, and opened the door for individuals to receive treatment in the comfort of their own homes under the umbrella of Medicaid coverage. Today, section 1915(c) waivers are the largest Medicaid HCBS-related expenditures, with 47 states and the District of Columbia each operating at least one 1915(c) waiver. The section 1915(i) HCBS State Plan benefit option was added by Section 6086 of the Deficit Reduction Act of 2005 (DRA). The Affordable Care Act added the HCBS 1915(k) Community First Choice (CFC) State Plan benefit option and made amendments to the requirements defining and describing the State Plan Section 1915(i) HCBS benefit option.

3. There is a trend away from institutional care and to HCBS.

Not surprisingly, many individuals need and want to receive care in the comfort of their own home or community rather than in an institutional setting. Enrollment in HCBS programs is growing, resulting in an increase in HCBS-related Medicaid expenditures. In 2002, HCBS accounted for 32 percent of Medicaid Long Term Services and Supports (LTSS) expenditures, totaling $25.1 billion. By 2011, that figure had grown to 45

percent, totaling $55.4 billion. This HCBS growth necessarily resulted in a 13 percent reduction in Medicaid LTSS expenditures on institution-based services over the same time, and growth in HCBS enrollment and expenditures does not appear to be slowing down soon.

4. HCBS are guided by the Americans with Disabilities Act (ADA) and the *Olmstead* decision.

Inclusion is the overarching theme behind the administration of HCBS, as evidenced by the adoption of the ADA in 1990 and subsequent Supreme Court decision in *Olmstead v. L.C.* in 1999. In passing the ADA, the federal government barred discrimination on the basis of disability in public services provided by state and local governments and by private entities. Nine years later in *Olmstead,* the Supreme Court held that "under Title II of the ADA, States are required to provide community-based treatment for persons with mental disabilities when the State's treatment professionals determine that such placement is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated." In reaching its holding, the Supreme Court illuminated the exclusion concerns found in the ADA, dictating that "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life." Furthermore, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

5. The Centers for Medicare and Medicaid Services (CMS) recently changed the requirements of HCBS programs.

In 2014, CMS issued a final rule which, among other things, amended certain of the 1915(i) requirements and revised certain of the 1915(c) regulation requirements including providing States the option to combine target populations within one 1915(c) waiver, established requirements to enhance the quality of HCBS, included changes to the requirements for person-centered plans and processes, provided additional protections to participants and established what constitutes a home and community-based setting. The final rule requires CFCs to comply with the HCBS setting requirements. All home and community-based settings must meet the following qualifications: "the setting is integrated in and supports full access to the greater community; is selected by the individual from among setting options; ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint; optimizes autonomy and independence in making life choices; and facilitates choice regarding services and who provides them; provides opportunities to seek employment and work in competitive integrated settings, and ensures the individual receives services in the community to the same degree of access as an individual not receiving HCBS." In regard to provider-owned or controlled home and community-based residential settings, the requirements include: "the individual has a lease or other legally enforceable agreement providing similar protections; the individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit; the individual controls his/her own schedule including access to food at any time; the individual can have visitors at any time; and the setting is physically accessible to the individual." In order to receive future Medicaid reimbursements for the administration of HCBS, States must align their existing and future HCBS programs with the final rule. CMS has required States to submit Transition Plans detailing how and when they expect to bring their 1915(c) HCBS waiver programs and 1915(i) HCBS State Plan benefit option into compliance with the final rule and modify service rates.

6. The Affordable Care Act (ACA) introduced a new State Plan Benefit option and the Innovation Center to encourage alternative payment and service delivery models while improving quality and outcomes.

The ACA established the Community First Choice (CFC) State Plan benefit option to provide home- and community-based attendant care and personal care services and supports to individuals with disabilities and

chronic conditions in conjunction with existing State plans. CFC gives States a six-percentage point increase in federal matching payments for service expenditures under this option. The CMS final HCBS rule published last year also requires CFC to comply with the HCBS setting requirements. The ACA also created the Innovation Center, a body charged with creating and testing new payment and service delivery models that reduce HCBS expenditures without detracting from the quality of services. CMS projects that by the end of the fiscal year 2015, the cumulative obligations of the Innovation Center will approach $5 billion, further highlighting the growing importance of HCBS and the need to discover cost-saving measures. The CMS final HCBS rule provides a five year approval and renewal period for certain of these Medicaid waivers and demonstration projects that serve dually eligible Medicare and Medicaid individuals.

7. The Medicaid expansion debate is incredibly important to the future of HCBS.

States are finding it difficult to meet the growing demand for HCBS. While States do have separately-funded HCBS programs, Medicaid remains the primary payer for LTSS in the United States. The State Medicaid expansion option offered under the ACA could become an increasingly attractive option for States looking to supplement their LTSS programs. As qualified individuals remain on waiting lists for HCBS, States continue to juggle policy implications connected to Medicaid expansion. HCBS remain in limbo in many States, and there is no doubting that States accepting Medicaid expansion will see their already-growing HCBS enrollment continue to surge.