

Residential: Integration

Federal Register / Vol. 79, No. 11 / Thursday, January 16, 2014 / Rules and Regulations

§ 441.530 Home and Community-Based Setting.

(a) States must make available attendant services and supports in a home and community-based setting consistent with both paragraphs (a)(1) and (a)(2) of this section.

(1) Home and community-based settings must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

- (i). The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid
- (iv). Optimizes but does not regiment individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Comments and CMS Responses regarding Residential Integration

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Choice:

Comment: One commenter stated that the proposed regulation would eliminate or at least severely restrict client and family choice of program options and opportunities and that consumers and families need more options, not fewer during these difficult times. Several other commenters expressed serious concern that the proposed regulation will eliminate instead of enhance choice for individuals with significant disabilities.

Response: We disagree. **We are not eliminating the choice of institutional options. We are specifying the qualities necessary for settings to be considered home and community-based settings.**

Comment: Several commenters supported the language as written, stating appreciation that **CMS as clarified that the term “community” refers to the greater community and not solely a community of one’s peers and, that integration also means more than integration in a community of peers. They further stated that focusing on the purpose of HCBS helps define its characteristics.** A few commenters agreed that a home and community setting should facilitate individuals’ full access to the greater community as they choose, including in the areas noted. However, the commenters noted that individuals may vary in their choices as they seek full access to and participation in the greater community, and a home and community-based setting should facilitate such full access consistent with an individual’s choices and preferences. The commenters recommended adding the following language related to access “based on the individual’s needs and preferences.” Another commenter stated the belief that the language is very broad and ambiguous and should be defined along with “the greater community.” Another commenter requested that we define “community” and suggested the language

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parallel the language used under the section pertaining to person-centered service plan, stressing that individuals should be given the right to obtain services “from the provider and the community of his or her choice.”

Response: We support individual choice and agree that individuals may vary in their choices as they seek full access and participation in the greater community. However, in order to receive approval of a State plan under which it will receive Medicaid funding for HCBS, a state must ensure that the choices available to individuals meet the requirements for community integration at § 441.710 of the final rule.

“Greater Community”:

Comment: Some commenters expressed concern with the requirement as proposed at § 441.530(a)(1)(i) that the setting must permit access to the greater community “in the same manner as individuals without disabilities.” One commenter stated that it would be more appropriate to require access “to the same extent” and that this language will give HCBS providers reasonable flexibility in regards to making accommodations for disabilities and to avoid disputes and possible litigation on the exact manner in which such accommodation must be provided. Other commenters indicated that this requirement is not measurable and may reduce choice for rural populations.

Response: After significant consideration, we have removed from § 441.530(a)(1)(i) “in the same manner as” from this requirement, and replaced it with “to the same degree of access as,” to best describe our intent to ensure access to the greater community that includes individuals with and without disabilities.

Rural Communities:

Comment: One commenter stated that licensed facilities may be located in both urban and rural settings resulting in variation with the amount of “integration” available. The settings are chosen with this in mind, and one that seems to be less integrated to CMS may be preferred by some over living where it appears participation in community activities is greater.

Response: We agree that there is a large degree of variance regarding the geographical settings where licensed homes are located. We agree that an individual should be able to exercise choice in regard to these settings. We do not express preference in regard to the proximity of activities to where an individual lives; the emphasis is on access to those chosen activities and whether the individual has the same degree of access to such activities as individuals not receiving Medicaid HCBS.

Person Centered Service Plan vs Setting:

Comment: One commenter suggested that CMS make the person-centered process the critical identification for what is determined to be community based not where the site is located or what it looks like. Another commenter states that the person-centered planning meeting should be where the needs and preferences are matched with compatible and appropriate services/ living arrangements and where modifications to existing services and acceptable compromises are determined. They state that maintaining a full continuum of services and settings is a better plan than limiting options or making them harder to access because some people might find them objectionable. One commenter states that specific restrictions on living arrangements should not supersede supports and services identified through the person-centered planning process.

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Response: We believe that our regulations need to address the issue of what constitutes home and community based settings. **While the person-centered service plan can and does assist individuals with integration into the community, it is not the vehicle to determine whether a setting meets the requirements for being home and community-based.**

Locked Doors:

Comment: A few commenters disagreed with the proposed language requiring that units have lockable doors. The commenters believe that this requirement poses a safety risk in the event of an emergency and added that clarification is also needed on a unit owned by the resident who may not want to provide the appropriate staff with keys to his/her door. The commenters pointed out that in some apartment buildings the entrance door is the unit's door and asked if the resident owns the unit whether he/she will be required to provide appropriate staff with keys.

Response: We disagree that the recommended change is necessary. However, **the requirement for a lockable entrance door may be modified if supported by a specific assessed need and justified and agreed to in the person-centered service plan.** Additionally, the state must ensure adherence to requirements set forth at § 441.530(a)(1)(vi)(F) and § 441.710(a)(1)(vi)(F). **We would like to clarify that this regulation does not require individuals to provide keys to anyone. The language is meant to curtail the issuing of resident keys to all employees or staff regardless of the employee's responsibilities, thus granting employees unlimited access to an individual's room.** This provision indicates that only appropriate individuals should have access to an individual's room. For example, it may be appropriate for the property manager to have keys, but it might not be appropriate for the individual working at a reception area.

GUIDANCE ON SETTINGS THAT HAVE THE EFFECT OF ISOLATING INDIVIDUALS RECEIVING HCBS FROM THE BROADER COMMUNITY

The purpose of this guidance is to provide more information to states and other stakeholders about settings that have the effect of isolating individuals receiving HCBS from the broader community.

The final rule identifies settings that are presumed to have institutional qualities and do not meet the rule's requirements for home and community-based settings. These settings include those in a publicly or privately-owned facility that provide inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS. A state may only include such a setting in its Medicaid HCBS programs if CMS determines through a heightened scrutiny process, based on information presented by the state and input from the public that the state has demonstrated that the setting meets the qualities for being home and community-based and does not have the qualities of an institution. (For more information about the heightened scrutiny process, see Section 441.301(c)(5)(v) Home and Community-Based Setting).

Settings that have the following two characteristics alone might, but will not necessarily, meet the criteria for having the effect of isolating individuals:

- The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.

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- The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.

Settings that isolate people receiving HCBS from the broader community may have any of the following characteristics:

- The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
- People in the setting have limited, if any, interaction with the broader community.
- Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).

The following is a non-exhaustive list of examples of residential settings that typically have the effect of isolating people receiving HCBS from the broader community. CMS will be issuing separate guidance regarding non-residential settings.

- **Farmstead or disability-specific farm community:** These settings are often in rural areas on large parcels of land, with little ability to access the broader community outside the farm. Individuals who live at the farm typically interact primarily with people with disabilities and staff who work with those individuals. Individuals typically live in homes only with other people with disabilities and/or staff. Their neighbors are other individuals with disabilities or staff who work with those individuals. Daily activities are typically designed to take place on-site so that an individual generally does not leave the farm to access HCB services or participate in community activities. For example, these settings will often provide on-site a place to receive clinical (medical and/or behavioral health) services, day services, places to shop and attend church services, as well as social activities where individuals on the farm engage with others on the farm, all of whom are receiving Medicaid HCBS. While sometimes people from the broader community may come on-site, people from the farm do not go out into the broader community as part of their daily life. Thus, the setting does not facilitate individuals integrating into the greater community and has characteristics that isolate individuals receiving Medicaid HCBS from individuals not receiving Medicaid HCBS.
- **Gated/secured “community” for people with disabilities:** Gated communities typically consist primarily of people with disabilities and the staff that work with them. Often, these locations will provide residential, behavioral health, day services, social and recreational activities, and long term services and supports all within the gated community. Individuals receiving HCBS in this type of setting often do not leave the grounds of the gated community in order to access activities or services in the broader community. Thus, the setting typically does not afford individuals the opportunity to fully engage in community life and choose activities, services and providers that will optimize integration into the broader community.
- **Residential schools:** These settings incorporate both the educational program and the residential program in the same building or in buildings in close proximity to each other (e.g. two buildings side by side). Individuals do not travel into the broader community to live or to attend school. Individuals served in these settings typically interact only with other residents of the home and the residential and educational staff. Additional individuals with disabilities from the community at large may attend the educational program. Activities such as religious services may be held on-site as opposed

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to facilitating individuals attending places of worship in the community. These settings may be in urban areas as well as suburban and rural areas. Individuals experience in the broader community may be limited to large group activities on “bus field trips.” The setting therefore comprises the individual’s access to experience in the greater community at a level that isolates individuals receiving Medicaid HCBS from individuals not receiving Medicaid HCBS.

- Multiple settings co-located and operationally related (i.e., operated and controlled by the same provider) that congregate a large number of people with disabilities together and provide for significant shared programming and staff, such that people’s ability to interact with the broader community is limited. Depending on the program design, this could include, for example, group homes on the grounds of a private ICF or numerous group homes co-located on a single site or close proximity (multiple units on the same street or a court, for example). In CMS’ experience, most Continuing Care Retirement Communities (CCRCs), which are designed to allow aging couples with different levels of need to remain together or close by, do not raise the same concerns around isolation as the examples above, particularly since CCRCs typically include residents who live independently in addition to those who receive HCBS.

FAQs concerning Medicaid Beneficiaries in Home and Community-Based Settings who Exhibit Unsafe Wandering or Exit-Seeking Behavior December 15, 2016

Q4: How can residential and adult day settings promote community integration for people who are at risk of unsafe wandering or exit-seeking? What are some examples of promising practices for implementing the community integration requirements of the regulations defining home and community-based settings and simultaneously assuring the safety of individuals who exhibit these behaviors?

A4: All settings must facilitate and optimize Medicaid beneficiaries to live according to their daily routines and rituals, pursue their interests, and maximize opportunities for their engagement with the broader community in a self-determined manner, as outlined in the individual’s person-centered service plan. The plan must reflect clinical and support needs as identified through an assessment of functional need, and document the individual’s preferences for community integration and how these preferences will be addressed in the setting they have chosen.

Settings can support community integration, in accordance with each individual’s person-centered plan by strategies and practices such as:

- Finding out during initial assessments what individuals desire in terms of community engagement and educate them about how the setting’s capabilities will meet the individual’s needs and preferences. This should be done before the individual makes a decision about services and settings to allow the best fit between the person and place.
- Documenting the factors the person identifies as important in a community such as proximity to and involvement of family, connections to communities of faith, specific cultural resources and activities, and others.
- Recording individual preferences for community integration in the person-centered plan and how the setting will support those preferences (e.g., participating in their faith community, attending a

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favorite club, Sunday breakfast at the local diner, interests in volunteering or in working, etc.) as well as the transportation needed to achieve desired outcomes, recognizing that many of these activities are leveraged through natural supports and thus would not require Medicaid-funded resources.

- Providing individuals with opportunities to engage others in their settings through activities, outings, and socialization opportunities.
- Providing sufficient staff and transportation to enable individuals' participation in their activities of choice in the broader community. These could include opportunities for work, cultural enjoyment, worship, or volunteering. The person-centered service plan may also include provider-facilitated opportunities to engage in desired activities in the broader community.
- Ensuring that visitors are not restricted, and individuals can connect to their virtual communities of choice through social media noting that this alone does not substitute for community activities and integration.
- Ensuring that individuals have opportunities to visit with and go out with family members and friends, when they want this. Providing an inviting environment and flexible schedules and service times (e.g., meals, medication administration) can encourage family and friends' participation in the life of the residential setting and support their efforts to maintain individuals' connections to the external community.
- Reviewing at least annually whether any parts of the person-centered plan need change. It is important to note that the modifications requirement within the regulations defining home and community-based settings also applies to anyone in a residential or nonresidential setting, and thus the person-centered plan needs to document what services and supports should be made available to allow people to live where they want and do what they want during the day to assure maximum integration with the broader community. For more information on the HCBS rule requirements on person-centered planning, please refer to CMS' previous FAQs on this topic.

All settings, including those in rural communities and those in low density suburban areas, are encouraged to provide adequate transportation opportunities to meet beneficiaries' desires for meaningful community engagement and participation in typical community activities.

Note that visits by community members have value but do not substitute for community access for Medicaid beneficiaries receiving services in residential and adult day settings.