

# Home and Community-Based Services Settings Rule: Community Integration Options and Resident Choice Are Key in Assessment of Co-Located Assisted Living Communities and Inpatient Facilities

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The federal Center for Medicaid and Medicare Services (CMS) promulgated regulations in 2014 which established standards for the settings in which Medicaid-reimbursed home and community-based services (HCBS) may be provided (42 C.F.R. § 441.301). These regulations also pertain to the settings in which individuals who receive HCBS may reside, even if the Medicaid HCBS are provided in a different setting. ***The federal regulations focus on community integration, individual choice and privacy, and other factors that relate to an individual's experience of the setting as being home-like and not institution-like.*** These regulations set a floor for Medicaid reimbursement, but states may elect to set more stringent requirements. States have been charged with developing a transition plan to ensure that state Medicaid programs come into compliance with the new HCBS expectations by March 2022. As of November 2017, seven states (Arkansas, Delaware, Kentucky, Oklahoma, Tennessee, Washington, and the District of Columbia) have received final CMS approval of their Transition Plans.

## **Co-located settings (in the same building) are presumed to have the qualities of an institution, and so the setting must demonstrate HCBS qualities to overcome this presumption.**

The federal regulatory approach to ensure that the settings of care for HCBS are non-institutional in nature has largely focused on how the individual experiences the setting (a focus on policies and operation more than physical plant). However, the new regulations also list specific physical characteristics that cause a setting to be presumed to have “the qualities of an institution” and therefore not to be acceptable settings for Medicaid-reimbursed HCBS, without additional federal review. This list includes HCBS settings which are co-located with a publicly- or privately-operated facility that provides inpatient institutional treatment (e.g., a nursing home, an ICF-IDD, an Institution for Mental Disease, or a hospital). Co-location refers to sharing the same building with the institution.

### **CMS differentiates adjacent and co-located.**

**Adjacent:** HCBS settings adjacent to *publicly (government)-* owned and operated institutional settings must overcome the same federal presumption. In contrast, CMS does not apply this presumption to HCBS settings adjacent to *privately-* owned institutions. States may impose additional state review on HCBS settings adjacent to any institution.

**Co-located:** Any HCBS setting co-located with an institution is subject to the presumption and must undergo CMS heightened scrutiny review to remain an HCBS Medicaid provider.

Publicly-owned means government-owned, and does not refer to for-profit or not-for-profit status.

## Whether an assisted living (AL) community can be considered non-institutional is determined by: (1) the purpose, design, and programmatic features of the setting; (2) the degree of physical, financial, and programmatic interconnectedness of the setting and the institution; and (3) the resident's experience.

### CMS Guidance

CMS emphasizes that individuals who are receiving HCBS should have the opportunity to engage in the broader community in the same manner as individuals not receiving Medicaid funded HCBS services, and that the setting should promote autonomy in life decisions and daily activities.<sup>1</sup> AL communities should ensure that residents reliant upon Medicaid are not segregated from other assisted living residents, and that all residents (regardless of payer) have equal access to the broader community. CMS has also made clear that “reverse integration” strategies, in which external community members or organizations establish a presence in the facility or on the campus and engage with residents without leaving the setting, are insufficient to demonstrate community integration.

CMS assumes that the more closely tied the HCBS setting operation is to the institutional operation (e.g., shared dining room or activity space, shared staffing, and shared administrative oversight), the more likely it is that the institutional licensure and certification requirements, institutional program implementation, and even public perception of the setting will dictate the experience for the HCBS resident. CMS is particularly concerned that shared staff and shared administrators are unlikely to appropriately distinguish between the settings and will fail to adequately support the level of resident choice, privacy, decision-making, schedule flexibility, and community engagement that is expected in HCBS settings.<sup>2</sup>

### CMS Heightened Scrutiny Review

Each state must identify HCBS settings which are presumed to have the qualities of an institution, including all co-located HCBS settings. However, the state can submit evidence to CMS, through the federal heightened scrutiny process, that a setting which is presumed to have the qualities of an institution is in fact not institutional in nature and does have the qualities of home and community-based settings (42 CFR 441.301 (c) (5)(v)). States must be able to demonstrate that persons receiving services are not isolated from the broader community. Unless the state can make a case (on a setting-by-setting basis) for inclusion under the CMS heightened scrutiny process, co-located settings and settings adjacent to a public institution will be excluded from HCBS participation (by 2022).

**Adjacency:** The regulations also specify that any HCBS settings adjacent to or on the campus of a publicly-owned or operated institution are presumed to have the qualities of an institution and must go through heightened scrutiny review to remain in the program. Settings adjacent to a privately-owned or operated institution may only be subject to additional state review and decision-making.

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<sup>1</sup> Exploratory Questions to Assist States in Assessment of Residential Settings, pg. 3 <https://www.medicare.gov/medicaid/hcbs/downloads/exploratory-questions-re-settings-characteristics.pdf>, accessed 11/29/2017

<sup>2</sup> Ibid.

## AL communities must have a clearly defined approach to supporting community integration and resident choice.

The fact that CMS considers co-location an indicator of possible isolation for residents suggests that an AL community should have a clearly defined approach to supporting community integration and resident choice. This could include strategies to promote the ability of individuals to participate in community activities to the extent desired.<sup>3</sup> Assisted living providers can facilitate access to these activities through providing residents with information, coordinating scheduling, identifying and communicating transportation options, and/or working with the HCBS care manager to ensure the person-centered plans reflect necessary supports and services.

In Home and Community-Based Setting Requirements guidance issued June 26, 2015, CMS provides examples of potential ways a state can demonstrate that settings located in a facility that also provides inpatient treatment, or those adjacent to public institutional settings, can meet the requirements for HCBS participation.<sup>4</sup> This might include documentation that:

- There is minimal or no interconnectedness in administration and financial operations.
- If institutional facility staff are assigned or used as back up for the HCBS setting, it is only on a limited basis. Staff should be cross-trained to meet the same qualifications as the HCBS staff and have a clear understanding of HCBS requirements.
- Participants living in the HCBS setting do not have to rely solely on the institutional facility for any category of services, including meals and transportation.
- Individuals in the HCBS setting have opportunities to engage in “typical life activities” outside of the setting, in the broader community, and have relationships with community members unaffiliated with the setting.

CMS is looking for evidence that there is a meaningful distinction between the HCBS setting and the co-located or adjacent institutional facility and that they are not “operationally interrelated.”

## States with CMS-approved transition plans that include co-located settings focus on the evidence of community integration options for residents.

They also highlight physical and programmatic differences between the AL community and nursing facility.

Arkansas identified five AL communities co-located with nursing facilities.<sup>5</sup> To review the settings, they developed a series of criteria for the heightened scrutiny process. These include evidence and documentation related to the physical structure of the building or buildings, policies, programs, and staffing, such as:

- Evidence residents are involved outside the setting;
- Description of nearby community activities and the proximity of transit;
- Campus/map diagrams that distinguish one setting from another;

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<sup>3</sup> For example, residents should be supported to participate in their preferred religious services, to get their hair styled in a retail establishment outside of the AL community, to access health care elsewhere, or to purchase food in the local grocery store.

<sup>4</sup> <https://www.medicaid.gov/medicaid/hcbs/downloads/home-and-community-based-setting-requirements.pdf>

<sup>5</sup> Arkansas Department of Human Services, Home and Community-Based Services (HCBS) Statewide Settings Transition Plan, pg. 23, <https://www.medicaid.gov/medicaid/hcbs/downloads/ar/ar-approved-plan.pdf>, accessed 11/29/2017.

- Descriptions of how the AL community is or is not physically connected to the nursing facility;
- Descriptions of how the AL community is or is not administratively connected to the nursing facility, including through shared staff or finances;
- Descriptions of any shared resources, such as transportation or eating facilities;
- Copies of current policies and procedures for both settings; and
- Staff qualifications, including any cross-training that occurs to allow staff to serve both settings, and training for staff in the ALF that is consistent with the HCBS Settings regulation.

Washington identified 12 AL communities co-located with institutions.<sup>6</sup> The compliance strategy focused more on community access and less on physical plant or administration. For example, the state required one Spokane AL community that is attached to a nursing facility (as well as independent living apartments) to develop a plan with the following outcomes:

- Full access to community resources and services, including assistance with accessing transportation. This included providing information on community resources, services, and transportation options to each resident. Education is provided at monthly resident council meetings. A list of transportation providers is given to each resident upon admission.
- Opportunities to participate in community activities, both facility-sponsored and independent. Resident activity preferences are requested during admission, and at monthly resident council meetings. Residents receive monthly activity schedules, including on- and off-campus activities. Residents may attend any activity at the AL community, nursing facility, or independent living apartment section of the campus.
- Regular solicitation and incorporation of input from residents about preferred on-site and off-site activities. Solicitation occurs at admission and during monthly resident council meetings. Copies of meeting minutes identifying activities are available for ongoing compliance monitoring.<sup>7</sup>

Tennessee found 72 AL communities with potentially isolating characteristics, including those adjacent to an inpatient treatment setting.<sup>8</sup> The state reviewed each physical site, the providers' promotional materials, the organizational policy and procedure documentation, a sampling of resident care plans, consumer experience data and other evidence to determine compliance.

## **Compliance strategies for AL communities co-located with institutional facilities should focus on documenting HCBS-compliant residential services and minimizing reliance on use of shared institutional resources.**

Strategies Include:

- Ensure that all other conditions of the federal rule for provider-controlled settings are met for HCBS assisted living residents, including program elements such as tenant rights, privacy requirements, scheduling choice and control, access to food and visitors at any time, and physical accessibility. Any restrictions of individual resident rights occur

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<sup>6</sup> Washington State's Revised Statewide Transition Plan for New HCBS Rules – Posted for Public Comment on January 15, 2016, pg. 213, <https://www.dshs.wa.gov/sites/default/files/ALISA/stakeholders/documents/HCBS/Washington%20State--Transition%20Plan%20for%20New%20HCBS%20Rules--Revised%201-14-15.pdf>, accessed 11/29/2017.

<sup>7</sup> Ibid., pg. 241-242.

<sup>8</sup> State of Tennessee Statewide Transition Plan and Heightened Scrutiny Milestone Tracking, Quarterly Report, April 2017, <http://www.tn.gov/assets/entities/tenncare/attachments/StatewideTransitionPlanQuarterlyStatusReportApril2017.pdf> Pg. 16

only when properly documented and regularly reviewed.

- Implement procedures to support community integration for all assisted living residents equally, regardless of payment source. Provide information about community resources, transportation, and internal and external activity options, and facilitate choice and access to these broader community opportunities for all residents.
- Collaborate with local and state HCBS care managers/service coordinators in the development of person-centered plans that provide for appropriate supports (paid and unpaid) for community integration consistent with individual preferences.
- Ensure that any AL community internal plans of care are aligned with the HCBS requirements, and are consistent with the HCBS person-centered service plans of residents.
- Ensure that financial and programmatic operations are clearly delineated; maintain clear distinctions in rules, records, policies and procedures when sharing resources.
- If categories of services (e.g., transportation, meals) are provided through the institutional facility, ensure that HCBS residents have additional choices and options.
- Train all staff, and align staff qualifications, for any staff or administrator who may work with HCBS residents or programs (including those primarily assigned to institutional facilities) to meet the state and federal HCBS staff qualification requirements.

## **AL communities should develop documentation strategies to provide evidence that a co-located community is a home and community-based setting.**

Strategies include:

- Develop documented policies and procedures for the HCBS setting distinct from the co-located or adjacent institutional setting (including staff training) that address each of the federal and state implementation requirements related to the characteristics of the setting and resident experiences as specifically as possible, including policies and procedures that facilitate opportunities for broader community participation.
- Revise internal and external informational materials - including disclosure documents, marketing, resident agreements, websites – for consistency with policies and procedures reflecting rule requirements. For example, resident agreement information about activities and services may help demonstrate how the setting supports HCBS residents to engage in community life, maintain privacy, exercise autonomy and independence in making decisions, and make choices about activities and daily living.
- Help validate compliance through reliable surveys or tools able to capture the experience and perspectives of HCBS residents consistent with HCBS regulatory requirements, such as National Core Indicators, CQL Personal Outcome Measures, interRAI Quality of Life Survey, CAHPS HCBS Consumer Experience or other instruments cross-walked with HCBS compliance requirements.
- Collect data and develop reporting mechanisms related to resident options, choices and community activities. For example, document information shared with residents related to transportation or local events, as well as provider efforts to facilitate access and resident participation rates.