National
MLTSS
Health Plan Association

Home- and Community-Based Settings Rule

Background

Home- and Community-Based Services (HCBS)

State Medicaid programs were originally only required to cover long-term care provided in nursing homes and other institutional settings. A 1999 Supreme Court decision in *Olmstead v. L.C.* ruled that individuals with disabilities have the right to live in the most integrated setting in the community rather than in institutions, and required states to provide home- and community-based services to persons with disabilities when certain conditions were met[1]. The *Olmstead* decision, Medicaid Waivers, and the Affordable Care Act provide the impetus and the means by which states can use Medicaid funding (whether through HCBS waivers or state plan amendments) to provide home- and community-based services (HCBS) for eligible beneficiaries. HCBS have grown dramatically in recent years, today accounting for more than half of all Medicaid spending on long-term services and supports (LTSS). The movement from institutional settings to accessing services and supports in the most integrated and appropriate community settings and homes continues today.

HCBS Settings Rule

In January 2014, the Centers for Medicare and Medicaid Services (CMS) published a final rule[2], to define the characteristics of residential and non-residential settings that meet the requirements to be considered home- and community-based settings and eligible for reimbursement under 1915(c), 1915(i), and 1915(k) authorities[3]. The intent of the rule is to ensure that persons with disabilities receiving HCBS are served in truly integrated settings – that is settings that provide access to the broader community and facilitate relationships with people without disabilities; and ensure that they have control over daily life decisions (e.g., what to eat, when to sleep, who can visit), have choices of services and providers, and have opportunities for competitive integrated employment.

State Implementation

The Rule gives states and providers until March 2019 to implement the new requirements through a transition process that will ensure continuity and minimize disruptions of service or a complete lack of available services and supports in the community. States are required to develop statewide transition plans with public input and submit them to CMS for approval. That process is ongoing now: 51 states/territories have submitted transition plans, one state (TN) has obtained final approval and eleven states have received initial approval (CT, DE, IA, ID, KY, ND, OH, OR, PA, WA, WV).

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[1] The conditions are: the state's treatment professionals determine that such placement is appropriate, the affected persons so not oppose such treatment and the placement can be reasonably accommodated taking into account the resources available to the state and the needs of others

[2] The *Medicaid Program; State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, and Home and Community-Based Setting Requirements for Community First Choice and Home and Community-Based Services (HCBS) Waivers; Final Rule*. 79 Fed.Reg. 2948, 3030-31 9 (January 16, 2014),

[3] The Rule defines covered authorities as 1915(c), 1915(i) and 1915(k); however, CMS indicates that other authorities for providing HCBS, such as 1115 demonstration waivers, are subject to the Rule.

MLTSS Association Position on the Settings Rule

The National MLTSS Health Plan Association welcomes the Rule and supports its intent – to ensure persons with disabilities are served in integrated settings in their homes and communities so that they may remain independent and in control of their daily lives. The Association further supports the specific provisions in the Rule aimed at achieving this result.

The Association appreciates the extensive work that has occurred and is underway in states to plan and implement a transition process toward full implementation of the rule. There is variation, however, from state-to-state in how the Rule is being interpreted and implemented. The Association believes that implementation should accommodate a degree of state variation while ensuring a level of consistency across states where it matters most. The Association also believes that state implementation processes should be carefully designed to uphold the intent of the rule in supporting beneficiary choice of setting in a cost-effective manner and avoids unintended re-institutionalization of individuals.

The Association raises the following areas of concern:

- *Impact of the Rule on Adult Day Care Facilities and Assisted Living Facilities (ALFs)*

  In order for a state to receive federal financial matching funds for HCBS waivers, the waiver services must be provided in a home and community-based setting as defined in the Rule. States vary substantially in the flexibility they allow for what is considered an "integrated setting," and many facility-based programs will have difficulty meeting requirements for coming into compliance with the Rule. The Rule will cause some Adult Day Care Facilities and ALFs to be considered non-HCBS by virtue of being facility-based and in some circumstances located on the same campus as a skilled nursing facility or nursing home. These programs will be submitted under a "heightened scrutiny" process through which states can develop evidence and modify schedules or accommodations to comply with the rule. States and MCOs cannot pay providers for services delivered in non-compliant settings.

- *Impact on Beneficiaries*

  Medicaid Managed LTSS plans will have to discontinue reimbursement to programs and facilities that are unable to comply with the rule, leaving plan members in those programs and facilities without HCBS support unless they move to an "integrated setting." This raises very different concerns for seniors than for individuals under 65 with disabilities.

  For disabled persons under 65, the Settings Rule is intended to correct a civil rights concern: to receive HCBS, people were often required to move into a segregated (disabled only) housing setting. The Settings Rule is intended to support an individual's movement to an integrated setting, but often the lack of accessible, affordable, integrated housing results in a step-down approach, moving first into intermediate congregate housing or an assisted living facility (ALF). If congregate housing and assisted living facilities (ALFs) are considered non-compliant, then many of these beneficiaries will have to return to an institution to retain coverage for their care. A few states have submitted ALFs under the heightened scrutiny process and had them

approved with modifications. However, if this transitional housing option for repatriation is eliminated or reduced by CMS, then there will need to be additional funding for housing or a statutory change that would allow Medicaid managed LTSS plans to pay for community housing.

The Rule for older adults does not address a civil rights concern. Older adults often elect to live in a senior housing unit or senior ALF rather than in integrated housing. Under the Rule, they will be unable to retain their HCBS support if they remain in that unit and will have to move out to retain those services, even if that is the setting of their choice. If integrated housing is not available, the result may be a nursing home placement, which is the opposite of what is intended by the Rule.

Plans will need support from the state in finding alternative solutions for valued programs and facilities that will no longer be covered as a home- or community-based service. A Medicaid demonstration program -- Money Follows the Person (MFP) –successfully supported the transition of individuals from institutions to community-based settings expired in September and should be reauthorized.

- *Variability in State Interpretation and Enforcement*

  States vary in what they consider an "integrated setting," as well as the process they have put in place to assess compliance of programs and facilities with the Rule and to monitor compliance. In states that do not provide Medicaid funding to assisted living facilities (ALFs), they are excluded from the rule. Other states are putting all ALFs through the review process, as they are other provider-controlled settings. Some states that are reviewing all ALFs are putting them all through a "heightened scrutiny" review process while others are placing most of the ALF waiver providers in the "meets with modifications" category. While CMS has been consistent in applying its criteria for what constitutes an "integrated setting" for HCBS, state variation in the organization and funding of services is resulting in wide variation among the states in the application and consequences of the Rule.

- *Delegation of Responsibility for Compliance Assessment and Monitoring to Managed Long-Term Services and Supports (MLTSS) Plans*

  States are ultimately responsible for determining the compliance of providers with requirements for being considered an integrated setting and able to retain HCBS funding. A number of states, though are relying on the MLTSS plans to assess facilities and programs for compliance and to monitor compliance on an ongoing basis. Some states are doing the initial assessments and monitoring compliance during the transition but making ongoing compliance the responsibility of the plans. The responsibility for plans to assess and monitor particular programs or facilities for compliance at any given time and maintain up-to-date lists of compliant and non-compliant settings creates a liability for the plans if they are found subsequently to have reimbursed a setting the state views as non-compliant. This added responsibility may be unnecessary and redundant of the state's existing licensing or credentialing functions and will add administrative costs for the plans, with no added compensation from the state.

Policy Recommendations for State Implementation:

The Final Settings Rule was promulgated in January 2014, and implementation planning for the rule is underway in the majority of states.

The National MLTSS Health Plan Association believes there is a need for additional federal sub-regulatory guidance on aspects of the Rule that may have the unintended consequence of moving beneficiaries to less-integrated settings, and on definitions of key terms and other features of the Rule that permit significant variation among the states in interpretation and application of the Rule.

The U. S. Congress should promptly reauthorize the Money-Follows-the-Person (MFP) program as a critical first step to ensure states have resources to assist beneficiaries adversely affected by the Settings Rule in making the transition to a more integrated setting.

As states continue to interpret the Rule and design its implementation, National MLTSS Health Plan Association member organizations are working with states to strive for greater inter-state consistency in the interpretation and application of the Rule. The Association recommends in general that the states apply a standard set of criteria for what does and does not constitute an "integrated setting."

The Association is particularly concerned that states in the application of the Rule avoid the unintended effect of forcing members who are well-established in settings of their choice to transfer to a less-integrated setting, thus defeating the purpose of the Rule. In order to respect the choices made by beneficiaries and to maintain the continuum of care, we recommend the following:

- States should make every effort to assess residential settings, assisted living facilities, adult day care centers, facility-based day and other habilitation settings that may not initially meet the criteria in the Rule for HCBS, and work with the organizations to accomplish specific steps needed to come into compliance. California, for example, provides grants to facilities to come into compliance.
- States should then fully harness the heightened scrutiny review process to accommodate care settings that overcome their seemingly institutional characteristics and instead have demonstrated that they provide community-based care.
- States should otherwise provide transition assistance for Medicaid beneficiaries whose facilities cannot become compliant to ensure they can transfer to the most-integrated setting of their choosing that is appropriate. States should rebalance, re-resource, and support providers and plans to ensure beneficiaries can make the change. In addition, Congress should reauthorize the Money-Follows-the-Person (MFP) program to ensure that states have these federal resources to aid in the transition.
- States should also work with individuals and their families on understanding and participating in the process throughout development and implementation.

The Association also recommends that MLTSS plans play only a limited role in assessment or monitoring providers for compliance. States are required to conduct initial assessments of settings for compliance with the Rule and oversee and monitor compliance with the Rule. States should maintain current lists available to the plans of compliant and non-compliant providers. MLTSS plans can play a role in monitoring compliance and alerting the state to facilities that are non-compliant, but states have the responsibility for determining non-compliance, providing a corrective action plan, and enforcing the

Rule. To have multiple plans in one facility assessing compliance would be confusing and counterproductive. Plans should not each be conducting their own redundant assessments or certifications of providers. To the extent that plans are engaged in monitoring, they should be additionally compensated for added administrative duties in connection with this activity.

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