Assisted Living in Medicaid HCBS Settings: Strategies to Ensure Compliance and Quality

August 29, 2018

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Assisted Living Overview

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Assisted Living Overview

- National View
- Origin Story
- Trends
- Medicaid
Assisted Living: National View

Significant State Variation

- Definition & licensure
- Role of AL in LTSS and housing spectrums
- Medicaid coverage

1 For more on each state’s assisted living licensure requirements, see NCAL’s annual assisted living licensure review: https://www.ahcancal.org/ncal/advocacy/regs/Pages/AssistedLivingRegulations.aspx
Assisted Living: National View

- Resident right to make choices and receive services to promote the resident's dignity, autonomy, independence, and quality of life
Assisted Living: Origin Story & Medicaid Intersection

1965-1980
- Medicaid nursing facility coverage
- Nursing facilities and residential care split

1980s
- 1915(c) waiver authority & rebalancing
- Beginning of “assisted living”

1990s
- Olmstead & rebalancing
- Significant AL growth

2000s-present
- Settings Rule & rebalancing
- Significant AL growth
- AL licensure activity


Assisted Living: Trends

- Rising Acuity
- Majority Private Pay
- Growth
- Quality
Assisted Living: Licensure Trends

NCAL Resources
• AL Annual Licensure Regulatory Review¹
• Case studies of New Jersey, Wisconsin, and Oregon's innovative collaborations to embrace quality efforts²

¹ National Center for Assisted Living. 2017 Assisted Living Regulatory Review. https://www.ahcancal.org/ncal/advocacy/regs/Pages/AssistedLivingRegulations.aspx
Assisted Living: Medicaid Participation

- Medicaid-enrolled AL providers (not Medicaid beneficiaries living in AL who can receive other Medicaid-covered services)


### Assisted Living: Medicaid Variation

<table>
<thead>
<tr>
<th>Medicaid Authority</th>
<th>1915(c), 1115, state plan options</th>
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<tbody>
<tr>
<td>Breadth of Medicaid AL Coverage</td>
<td>Tailored eligibility</td>
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<td>Caps and waitlists</td>
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<td>Rate adequacy</td>
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<td>Participation of AL Providers</td>
<td>Admitting Medicaid resident vs</td>
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<td>existing resident who spent down</td>
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Assisted Living: HCBS Compliance

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August 29, 2018
HCBS SETTINGS COMPLIANCE: ASSISTED LIVING

Medicaid-Enrolled Assisted Living Communities

SPECIFIC COMPLIANCE AREAS:

- Ensuring Individual Choice and Privacy
- Memory Care Units: The Importance of Person-Centered Planning
- Co-Located Settings: Ensuring Community Integration Options and Resident Choice
- Differences Between State Licensure Requirements and HCBS Settings Rule
The federal HCBS 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.

The federal HCBS regulations set a floor for Medicaid reimbursement, but states may elect to set more stringent requirements.
ASSISTED LIVING

ENSURING CHOICE AND PRIVACY

Health Management Associates
**CHOICE & PRIVACY REQUIREMENTS**

**SETTINGS CHARACTERISTICS**
- Selected by the individual
- Rights of privacy, dignity, and respect, and freedom from coercion and restraint
- Optimizes, but does not regiment individual initiative, autonomy, and independence
- Facilitates individual choice regarding services and supports, and who provides them

**PROVIDER-CONTROLLED**
- Freedom and support to control their own schedules activities, and have access to food at any time;
- Privacy in their sleeping or living unit; and
- Visitors at any time.

**UNIT REQUIREMENTS**
- Units have entrance doors that individuals can lock
- Individuals sharing units have choice of roommates
- Individuals have freedom to furnish or decorate

**INDIVIDUAL MODIFICATIONS**
- Supported by a specific assessed need; documented in the person-centered plan
- Document the positive interventions and less intrusive methods tried
- Proportionate response, collect and review data, measure effectiveness
- Time limits and periodic review
- Informed consent
- No harm
States to facilitate consumer choice, which must be documented in the PCP:
- Who provides services
- Access to a private room option
- Non-disability specific setting

Providers to demonstrate that policy, procedure and practice support privacy and choice for residents
- Resident agreements/tenancy agreements
- Feedback from residents
- Consumer experience surveys

Resident Councils/Advisories to review policy and practice
- Avoid “house rules”
- Individualized modifications

DOCUMENTING PRIVACY AND CHOICE
STATE COMPLIANCE STRATEGIES

OKLAHOMA
- Community access and consumer experience the same across all residents
- Residents have food preparation and access options beyond set dining hours
- Phone access in every unit
- Exceptions to visiting hours; allowance for overnight guests

ARKANSAS
- Lockable bathroom doors
- Staff knock/ring doorbell for access to resident units
- Setting arranged for privacy during personal care
- Residents can do their own laundry

TENNESSEE
- Review of provider mission and vision for community integration
- Does training align with rule requirements?
- Does provider have policy and procedure that reflects the rule?
CMS guidance does not support restrictions that are automatically applied based on diagnosis or setting, nor those applied to a class or group of individuals. **No state has been approved for a diagnosis-based approach, nor for any exemption of a category or type of provider settings, from the HCBS settings requirements.**

- Restrictions must be supported by a specific assessed need, justified in the person-centered plan, require informed consent, must meet other requirements
- Memory care with controlled egress should include access options for other residents, visitors, staff and residents as needs change
- Coordinated HCBS person-centered care planning, including providers, is critical for both positive outcomes for residents and provider compliance
Adopting best practices can help providers meet compliance requirements

+ **Proper nutrition and hydration**, including culturally appropriate meals and enjoyable and flexible meal times and snacks

+ **Pain management**, including avoidance of overutilization of psychotropic medications, treating pain as a vital sign, and tailoring pain management to the individual

+ **Social engagement**, including opportunities for fun, community, and meaningful interactions

+ **Communication support for people unable to express preferences using words**, including recognizing, documenting, interpreting and responding to behavior as a form of communication
ASSISTED LIVING

CO-LOCATED SETTINGS

HEALTH MANAGEMENT ASSOCIATES
Co-located settings (where inpatient care is also provided) are presumed to have the characteristics of an institution must demonstrate HCBS qualities -- including design, operational and programmatic features and beneficiary experiences – in order to overcome this presumption.
CO-LOCATION: HCBS COMPLIANCE

FOCUS ON COMMUNITY INTEGRATION AND AVOID SHARED INSITUTIONAL RESOURCES

+ Ensure compliance with all HCBS characteristics such as tenant rights, privacy requirements, scheduling control, access to food and visitors, physical accessibility

+ Support community integration by facilitating choice and access to community resources, transportation, and internal and external activity options

+ Develop person-centered plans that provide for appropriate supports (paid and unpaid) for community integration consistent with individual preferences

+ Ensure financial and programmatic operations are clearly delineated, and if certain services (e.g., transportation, meals) are provided through the institutional facility, ensure that HCBS residents have additional choices

+ Staff training and alignment of qualifications, including those primarily assigned to co-located institutional facilities, in understanding HCBS requirements
AL communities should develop documentation strategies to provide evidence that a co-located community is truly a home and community-based setting

- **Develop documented policies, procedures and practices** for the HCBS setting distinct from the co-located or adjacent institutional setting, including staff training.

- **Revise internal and external informational materials** – including disclosure documents, marketing, resident agreements, websites – for consistency with policies and procedures reflecting rule requirements.

- **Validate compliance through reliable surveys or tools** able to capture the experience and perspectives of HCBS residents consistent with HCBS regulatory requirements.

- **Collect data and develop reporting mechanisms** related to resident options, choices and community activities.
ASSISTED LIVING

STATE LICENSURE ALIGNMENT

HEALTH MANAGEMENT ASSOCIATES
COMMON AREAS OF DISCREPANCY

STAFFING

LEVEL OF CARE & DISCHARGE

SPECIAL UNITS

PERSON-CENTERED PLANNING
States have taken multiple approaches when faced with licensing requirements, statutes or regulations that contradict or are silent on the requirements in the HCBS Settings rule.

- Incorporation of federal requirements into state regulations
- No change to silent or incongruous state regulations, with additional information provided through the provider manual and official provider communication.
- Promise in the transition plan to update and align state regulations in the future.
QUESTIONS?

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Assisted Living in HCBS Settings:
A State Example:
Washington State

Presentation to HCBS Conference
Bea Rector, Director
Home and Community Services Division
Importance of Assisted Living Facilities
Licensed Assisted Living in Washington State

All Licensed as Assisted Living

Medicaid Contract Types:
1. Adult Residential
2. Enhanced Adult Residential
3. Assisted Living

Specialty Contract Types:
1. Specialized Dementia Care
2. Expanded Community Supports
Washington State Department of Social and Health Services

Licensing, Contracts, and Medicaid Occupancy

ALF License
540 Facilities

No Medicaid Contract
233 facilities

ALF License with Medicaid Contract

Facilities can have multiple contracts
AL Contract 195 facilities
ARC Contract 120 facilities
EARC Contract 128 facilities

56.9% of licensed ALFs provide Medicaid services

Licensed Beds
33,219 beds

Licensed Beds
19,425 Medicaid beds

Non-Medicaid Beds
233 facilities
Non-Medicaid Clients
Medicaid Clients 6,227

This amounts to 32.1% Medicaid occupancy

Clients are authorized for services; these are mutually exclusive
AL Service 3,874
ARC Services 412
EARC Services 1,147
SDC Services 794

62.2% 6.6% 18.4% 12.8%

Source and notes:
Data provided by the Office of Rates / SP127 & SP111 / May 2018. Data pulled June 2018.
All need levels, including high level are served in home or community-based settings.

Number of Home and Community Clients by CARE Acuity Grouping
Aging and Long-Term Supports and Developmental Disabilities Administration

Total is twice as much as the entire nursing home caseload for all acuity levels.

Source: CARE data as of June 30, 2015 snapshot, combined clients of ALTSA and DDA.
County Distribution of ALF Services
Clients, Facilities, and Beds

These are the numbers of clients authorized for ALF services, the number of Medicaid contracted ALFs, and the number of licensed beds for these contracted ALFs.

Source and notes:
Data provided by the Office of Rates | SP121
ALF Medicaid Utilization

Percent of total licensed beds utilized by ALF clients

<table>
<thead>
<tr>
<th>Statewide</th>
<th>Total Licensed Beds</th>
<th>ALF Contracted Beds</th>
<th>Clients</th>
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<tbody>
<tr>
<td></td>
<td>33,219</td>
<td>19,425</td>
<td>6,227</td>
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32.1% of contracted beds
18.7% of all licensed beds

Source and notes:
Data provided by the Office of Rates | SP121
Heightened Scrutiny: Ongoing Compliance

Washington fully supports community integration and has long standing process for monitoring:

- Law- Quality of Life-Rights (RCW 70.129)
- Residential Care Services inspections
- Complaint Resolution Unit investigations
Heightened Scrutiny

Consider information from:

- Medicaid residents, families
- On-site observations
- Advocates, Long-Term Care Ombudsman, Disability Rights of Washington
- Case managers
- Facility staff
- Review policies
Heightened Scrutiny
Evidence Package
Heightened Scrutiny

Washington does not move a setting forward for Heightened Scrutiny when the facilities design, policies, or practices:

• Do not isolate participants, even when there are individual instances of isolation
• Isolate participants and the facility is unwilling or unable to make changes
Additional Thoughts

• Understanding of modifications

• Partnering with Provider Associations

• Communication
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