Health Advocate

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Home & Community-Based Services: State Transition Plans & Implementation Updates

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Key Resources

NHeLP Q&A: Home and Community-Based Services - Final Rules

NHeLP Q&A: HCBS – Transition Plan Advocacy: Identifying the Issues

NHeLP Summary of CMS Response Letters

Health Advocate: HCBS State Transition Plans after One Year (May 2015)

CMS Home and Community-Based Services

HCBS Advocacy

Coming in April's *Health Advocate*:

1332 Authority

In January 2014, the Centers for Medicare & Medicaid Services (CMS) finalized regulations defining a Medicaid "community-based" setting. But that was far from the end of the road. Now, two years into the transition planning process to implement that definition, we have made progress on the longer journey toward a more participant-focused, community-integrated home and community-based services (HCBS) delivery system. The transition planning process has increasingly underscored that the strength of implementation, as much as the definition itself, will shape the landscape of HCBS settings for years to come. Many states are now at a critical juncture in this process as they post revised transition plans and assessments of settings for public comment.

Background

Many older adults and people with disabilities depend on Medicaid-funded HCBS to live and thrive in their communities. HCBS help individuals maintain social networks and actively engage with their communities through services, such as personal care and supported employment. HCBS settings range widely from individuals' homes to non-residential day facilities to assisted living facilities and group homes. For decades, no single definition for a Medicaid "community-based" setting existed, and some purportedly HCBS settings hardly differed from institutions with regulated schedules, limited privacy, and policies that isolated participants from the surrounding community.

After years of advocacy and rulemaking, the definition of a community-based setting now correctly centers on participant experience. To satisfy the new standard, a setting must show it optimizes individuals' autonomy and choice, promotes their full access to community living, and ensures their rights of privacy, dignity, and respect. The regulations lay out additional requirements for provider-owned or controlled settings, such as having lockable bedroom doors and allowing visitors at any time, to protect HCBS recipients and inhibit institutional practices. Certain other settings are presumed institutional under the rule and would require heightened scrutiny review that shows they are actually community-based to qualify for Medicaid HCBS funding.

The final regulations require states to develop transition plans to bring their current HCBS infrastructure into compliance with the new definition before March 17, 2019.

Each plan details how the state will:

(1) assess its state standards and policies for compliance with federal standards,

(2) evaluate all HCBS settings for compliance,
(3) develop remediation plans to implement needed changes for both settings and HCBS policies,
(4) implement a smooth transfer process for any HCBS participants who will move to a more integrated setting, and
(5) design systems to conduct ongoing monitoring and oversight of HCBS settings.

The first drafts, submitted to CMS in spring 2015, were often disjointed and skeletal and did not provide robust mechanisms for ensuring compliance with the new regulations.

CMS responded to these initial plans with strong critiques. Most states are currently engaged in a second round of public comments as they revise and improve their transition plans. This offers advocates another opportunity to push for the strongest possible implementation of the new HCBS settings definition and ensure that older adults and individuals with disabilities receive the support they need to access the full benefits of community living.

Themes in CMS Response Letters to States

CMS's consistently strong responses to states' initial submissions reflected a number of key themes state and national disability and aging advocates had been raising. CMS also published helpful guidance clarifying the requirements for heightened scrutiny and strengthening the assessment process that supports many advocates' prior recommendations. Key themes include:

- **Transparent public engagement throughout the transition period.** CMS reiterated that states must release plans for public comment after any substantial change, including posting assessment results for public comment and providing adequate notice. CMS cited examples of notice that failed to satisfy regulatory requirements and advised many states to summarize stakeholder comments clearly and provide specific responses, not simply acknowledge the commenter's point. Notice and transparency remain problematic in many states, but have improved in the second round.

- **Evaluation of all settings and proper verification of provider self-assessments.** CMS required states to evaluate every HCBS setting during the transition period and encouraged a multi-pronged assessment process with sound methodology. Most states relied primarily or exclusively on provider self-assessments. CMS's responses require states to ensure all providers respond (or have an alternative assessment), that providers separately assess each of the setting they operate, and that states develop a validation process to account for potential bias in provider responses. This could include independent on-site reviews, beneficiary survey tools, or other approaches. Advocates remain concerned that revised plans include poorly vetted assessment tools with serious methodological flaws. Major concerns include leading questions, inadequate education about the purpose of the surveys, questionnaires that do not address all components of the federal rule, and inappropriate "assistance" filling out surveys. One pilot study in Michigan found a large proportion of beneficiary surveys had been completed by case managers without direct input from beneficiaries themselves.

- **Substantial participant input in settings assessments.** A number of states have developed beneficiary survey tools to validate provider self-assessments and use as part of ongoing monitoring of setting compliance. For example, Idaho's plan includes face-to-face interviews of a representative sample of HCBS recipients conducted by a third party to determine a setting's current compliance level, and then a repeat of the process in 2017 to ensure needed changes have actually been made. Iowa's beneficiary survey has been adapted to address specific situations where a participant requires assistance to complete the survey.

- **A stronger heightened scrutiny process.** Every CMS response letter requested more detail on how states would identify settings presumed to be institutional. Most state plans identified only settings co-located with or on the grounds of an institution, but did not address other settings likely to have the effect of isolating individuals, as required in CMS regulations and guidance. Such other settings would include clustered settings, settings geographically isolated from community centers, and sites that may be located in a community but isolate participants through limited access or other programmatic features. Many revised state plans remain weak on this issue. States must list all presumed institutional settings in their plan, along with substantial evidence to prove that a setting presumed institutional is actually community-based, to allow stakeholders the opportunity to comment on those settings.

Building Better HCBS: Improving Options

Beyond evaluating their current HCBS programs, the transition planning process encourages states to create new infrastructure that reflects contemporary community integration standards consistent with the new HCBS regulations, the Americans with Disabilities Act (ADA), and the Supreme Court's decision in *Olmstead v. L.C.* Specifically, three facets of the transition planning process relate directly to creating new, more integrated HCBS capacity:

- **States must offer each HCBS participant an option of a non-disability specific setting.** Lack of infrastructure limits some individuals' choices to disability or aging-specific congregate settings, particularly for people living in rural areas, but federal law requires that individuals have a choice of a non-disability specific setting. A number of transition plans have attempted to skirt this requirement by promising participants a choice among "available options." Even if current capacity falls short, advocates should push their states to assess where individuals lack adequate choice and develop a capacity-building plan to modernize the HCBS system, improve community integration, and ensure the state meets this regulatory standard by the end of the transition period.

- **States may implement tiered standards.** CMS requires all settings to meet the minimum federal standards by 2019 but allows states to implement tiered standards for new providers or new enrollment. For example, a state with a 6-person limit for group homes could continue to fund existing compliant homes while requiring new facilities to have no more than 3 residents. This promising approach can minimize disruptions in current settings while shifting enrollment toward a more integrated and ADA-compliant HCBS system. Several states, including Massachusetts, Washington, and New Jersey, have opted to implement tiered community integration standards to phase out sheltered workshops or to limit the size of new group homes.

- **CMS discourages new construction that reflects outmoded setting designs.** Despite the new regulations, developers in several states continue to propose building new settings that do not represent contemporary expectations for promoting full access to the community. These range from group homes on the grounds of institutions to large, congregate settings for people with disabilities in industrial-zoned areas. Such settings would be presumed institutional under the new regulations. Just as no state would permit a new building based on construction codes from the 1970s, no state should allow new construction of HCBS settings that reflect outdated understandings about community integration. Moreover, new construction involves evaluating a *proposed* service delivery plan. There are no residents to interview, no actual event logs, person-centered plans or event calendars to review, and no rooms to observe. Evidence for heightened scrutiny review should center upon participant experience, but that is not possible when there are not yet any participants. This difficulty producing appropriate evidence, which CMS has acknowledged, raises serious questions about how CMS would approve new construction that would be presumed institutional (and require heightened scrutiny review). New construction should always reflect the community integration standards embodied in the new regulations, the ADA, and the principles of *Olmstead*.

Conclusion

We are entering a critical phase of the HCBS transition planning when states begin to post results from site-specific assessments, including identifying presumed institutional settings, and submitting those results to CMS for approval. Several states' plans are currently out for comment.[1] A full list of pending states, along with resources to help advocates review and comment on plans, is available at www.hcbsadvocacy.org. Strongly implemented, the new definition can help modernize the whole HCBS infrastructure over time. But serious headwinds, including pressure from existing providers and other special interests, could result in watered-down implementation that simply reinforces the status quo. Now is a critical moment to ensure the regulations are implemented to their fullest potential, so all individuals who rely on Medicaid HCBS receive services in settings that offer them full access to the benefits of community living.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. NHeLP advocates, educates and litigates at the federal and state level.

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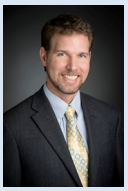

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[1] Those states include North Dakota (3/20), D.C. (3/21), Delaware (3/22), South Carolina (3/25), Alabama (3/30), Indiana (4/6), and Virginia (4/7). For links to revised plans and directions for submitting comments, see www.hcbsadvocacy.org.