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

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Assisted Living Overview

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Assisted Living Overview

- National View
- Origin Story
- Trends
- Medicaid

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Assisted Living: National View

Significant State Variation

- Definition & licensure[1]
- 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

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Assisted Living: National View

Housing	Supportive Services	Assistance with ADLs & IADLs	(some degree of) Health Care

- Resident right to make choices and receive services to promote the resident's dignity, autonomy, independence, and quality of life

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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

Brown Wilson, Keren. "Historical Evolution of Assisted Living in the United States, 1979 to the Present." *The Gerontologist*. Vol 47, Issue Suppl_1, (Dec 1, 2007): pages 8-22

Truven Health Analytics. *Improving the Balance: The Evolution of Medicaid Expenditures for Long-Term Services and Supports, FY 1981-2014*. (June 3, 2016)

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Assisted Living: Trends

Rising Acuity	Majority Private Pay
Growth	Quality

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Assisted Living: Licensure Trends

Training/ Staffing	Memory Care	Resident Rights	Quality

NCAL Resources

- AL Annual Licensure Regulatory Review[1]
- Case studies of New Jersey, Wisconsin, and Oregons' innovative collaborations to embrace quality efforts[2]

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

2 National Center for Assisted Living. *Assisted Living Communities: States Embrace Unique Collaborative Quality Efforts*. 2018. https://www.ahcancal.org/ncal/advocacy/regs/Documents/NCAL%20AL%20Case%20Studies.pdf

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Assisted Living: Medicaid Participation

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

National Center for Health Statistics[1]	Government Accountability Office[2]
• 47% ALFs participate in Medicaid • 16% of AL residents rely on Medicaid to pay for services (NCAL estimates 130,000 residents)	• States report 260,000 Medicaid beneficiaries receiving services provided by AL

1. Centers for Disease Control, National Center for Health Statistics. *National Survey of Residential Care Facilities.* https://www.cdc.gov/nchs/nsrcf/index.htm

2. Government Accountability Office. *MEDICAID ASSISTED LIVING SERVICES: Improved Federal Oversight of Beneficiary Health and Welfare is Needed. GAO-18-179.* (Jan. 5, 2018)

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Assisted Living: Medicaid Variation

Medicaid Authority	• 1915(c), 1115, state plan options
Breadth of Medicaid AL Coverage	• Tailored eligibility • Caps and waitlists • Rate adequacy
Participation of AL Providers	• Admitting Medicaid resident vs existing resident who spent down assets

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HEALTH MANAGEMENT ASSOCIATES

Assisted Living: HCBS Compliance

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August 29, 2018

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

HCBS SETTINGS COMPLIANCE

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

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

DOCUMENTING PRIVACY AND CHOICE

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 ro review policy and practice

Avoid “house rules”

Individualized modifications

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?

MEMORY CARE UNITS

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MEMORY CARE UNITS

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 over-utilization 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

Co-located settings (where inpatient care is also provided) are presumed to have the characteristics of an institution

- Hospitals
- Nursing Facilities
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Institutions for Mental Disease

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

COMMON AREAS OF DISCREPANCY

STAFFING

LEVEL OF CARE & DISCHARGE

SPECIAL UNITS

PERSON-CENTERED PLANNING

STATE LICENSING CONFLICTS

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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HEALTH MANAGEMENT ASSOCIATES

Transforming Lives

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

Presentation to HCBS Conference

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Importance of Assisted Living Facilities

Licensed Assisted Living in Washington State

All Licensed as Assisted Living

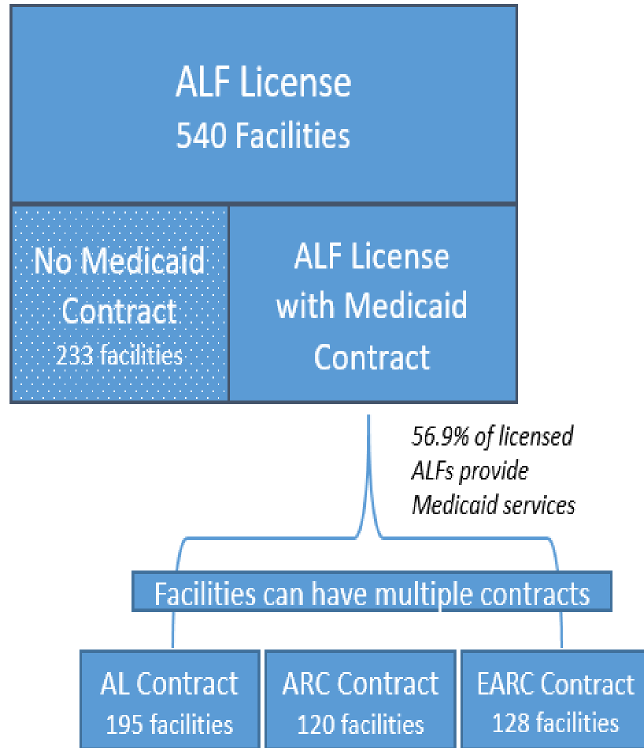
Medicaid Contract Types:

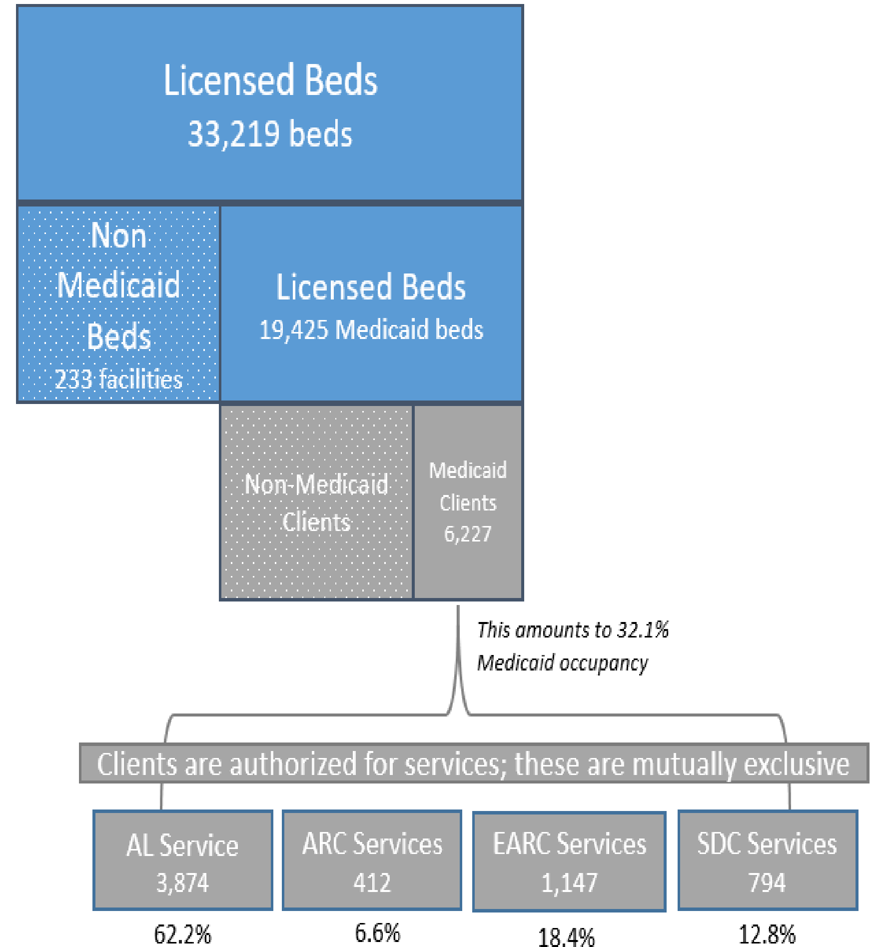
1. Adult Residential
2. Enhanced Adult Residential
3. Assisted Living

Specialty Contract Types:

1. Specialized Dementia Care
2. Expanded Community Supports

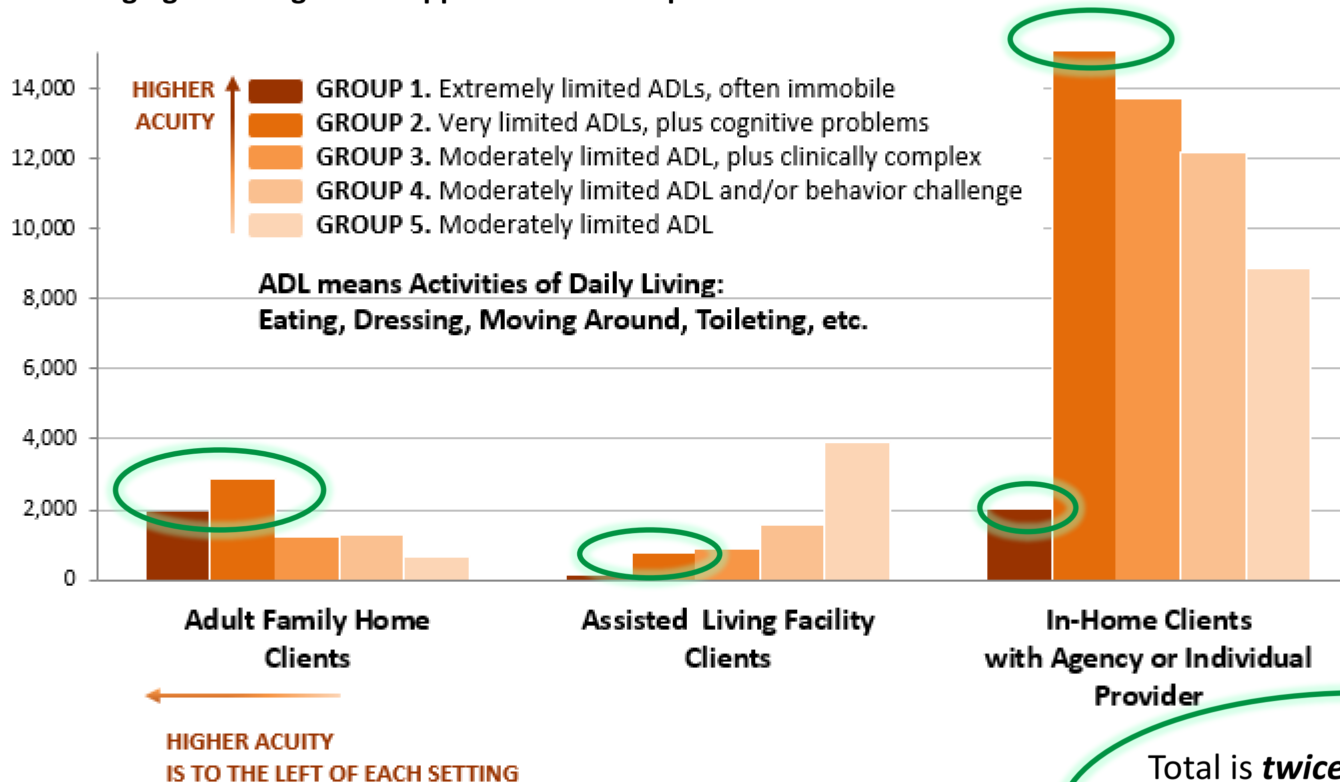
Licensing, Contracts, and Medicaid Occupancy





Source and notes:
Data provided by the Office of Rates | SP127 & SP121 | May 2018. Data pulled June 2018.

All need levels, including high level
are served in home or community-based settings

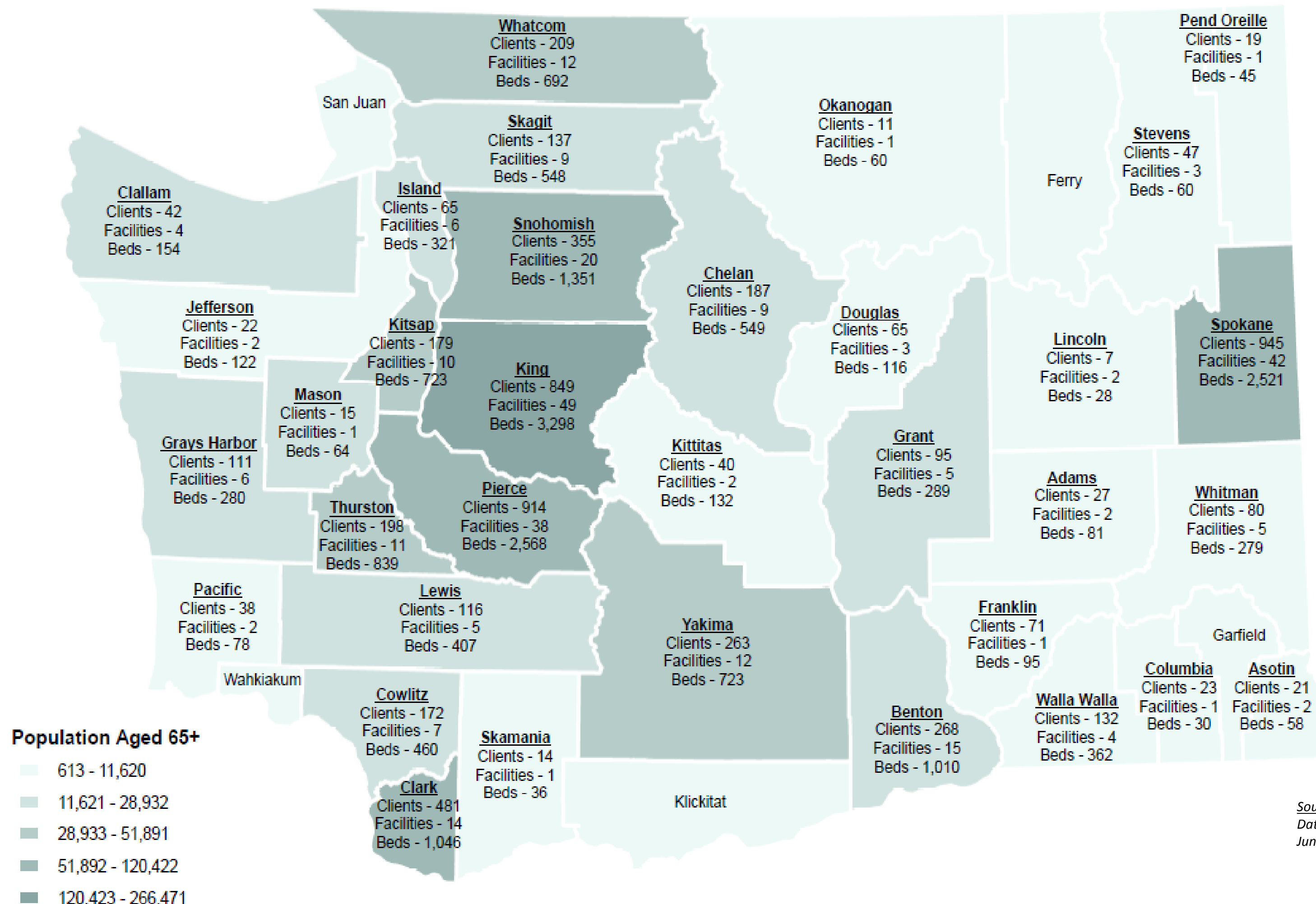


Source: CARE data as of June 30, 2015 snapshot, combined clients of ALTSA and DDA.

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

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 June 2018. Data pulled May 2018.

ALF Medicaid Utilization

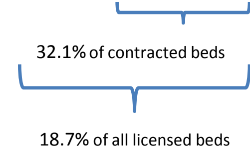
Percent of total licensed beds utilized by ALF clients

*ALF clients are those receiving AL, ARC, EARC, or SDC services.

Whatcom 19%
San Juan
Skagit 16%
Okanogan 18%
Ferry 56%
Stevens 40%
Pend Oreille 42%
Clallam 8%
Island 16%
Snohomish 12%
Chelan 31%
Douglas 25%
Lincoln 25%
Spokane 31%
Jefferson 14%
Kitsap 14%
King 9%
Mason 8%
Grays Harbor 40%
Kittitas 24%
Grant 26%
Adams 33%
Whitman 24%
Thurston 18%
Pierce 25%
Pacific 49%
Lewis 35%
Yakima 28%
Franklin 75%
Garfield
Wahkiakum
Columbia 77%
Asotin 36%
Walla Walla 25%
Benton 20%
Cowlitz 26%
Skamania 39%
Clark 20%
Klickitat

Medicaid_Utilization
No ALF Service
1% - 15%
16% - 23%
24% - 31%
32% - 46%
47% - 77%

	Total Licensed Beds	ALF Contracted Beds	Clients
Statewide	33,219	19,425	6,227



Source and notes:
Data provided by the Office of Rates | SP121 June 2018. Data pulled May 2018.

Heighted 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

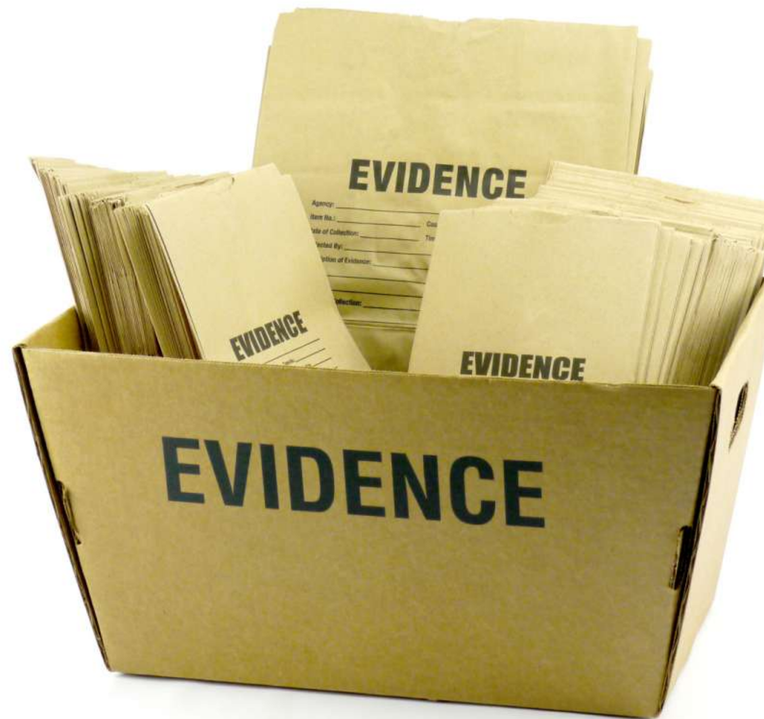
Heightened Scrutiny

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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