COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

JENNIFER S. LEE, M.D.
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

March 1, 2019

MEMORANDUM

TO: The Honorable Thomas K. Norment, Jr.
Co-Chairman, Senate Finance Committee

The Honorable Emmett W. Hanger, Jr.
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

Daniel Timberlake
Director, Department of Planning and Budget

FROM: Jennifer S. Lee, M.D.
Director, Virginia Department of Medical Assistance Services

SUBJECT: Home and Community Based Services Place of Residence in the Commonwealth
Due November 1, 2018

This report is submitted in compliance with Virginia Acts of Assembly – 2018 Session, Chapter 566, S310 which states:

> *"The Department of Medical Assistance Services (Department) shall make recommendations to the General Assembly for legislative, regulatory, or policy changes that provide flexibility to an individual enrolled in a home and community-based waiver to choose his place of residence in the Commonwealth and that ensure such individual's informed choice of place of residence does not reduce, terminate suspend, or deny services for which he is otherwise eligible. The Department shall report such recommendations to the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Finance and Education and Health by November 1, 2018."*

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

JSL/

Enclosure

pc: The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources

Home and Community Based Services Place of Residence in the Commonwealth

A Report to the Virginia General Assembly

Report Mandate:

Virginia Acts of Assembly – 2018 Session, Chapter 566, S310 states: "The Department of Medical Assistance Services (Department) shall make recommendations to the General Assembly for legislative, regulatory, or policy changes that provide flexibility to an individual enrolled in a home and community-based waiver to choose his place of residence in the Commonwealth and that ensure such individual's informed choice of place of residence does not reduce, terminate suspend, or deny services for which he is otherwise eligible. The Department shall *report such recommendations to the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Finance and Education and Health by November 1,*

Background

Virginia's Developmental Disability (DD) Waivers are home and community-based services waivers that operate under section 1915(c) of the Social Security Act. Within broad Federal guidelines, states can develop home and community-based services waivers (HCBS Waivers) to meet the needs of people who prefer to get long-term services and supports in their home or community, rather than in an institutional setting.

On January 14, 2014, the Centers for Medicare & Medicaid Services (CMS) announced the publication of a final rule regarding the home and community-based services (HCBS) provided through Medicaid's 1915(c) HCBS Waiver programs. The rule is intended to enhance the quality of HCBS, provide additional protections to HCBS program participants, and ensure that individuals receiving services through HCBS programs have full access to the benefits of community living. CMS issued an Informational Bulletin on May 9, 2017 indicating that the transition period for compliance with HCBS criteria is extended until March 17, 2022. New settings must be fully compliant prior to receiving Medicaid HCBS funding.

The Department of Medical Assistance Services (DMAS) held a stakeholder meeting on July 20, 2018 to review the report mandate, the HCBS settings rule, and questions and concerns about possible restrictions which might be placed on an individual's choice of residence. This report provides an overview of the CMS HCBS settings requirements, the Statewide Transition Plan process, clarifies settings requirements based on specific circumstances in residential settings, and provides recommendations to promote greater awareness and education on choice for individuals receiving Medicaid HCBS waiver services.

DMAS' mission is to ensure Virginia's Medicaid enrollees receive high-quality and cost-effective health care.

Medicaid plays a critical role in the lives of more than a million Virginians. Medicaid enrollees include children, pregnant women, parents and care takers, older adults and individuals with disabilities. Virginians must meet income thresholds and other eligibility criteria before qualifying to receive Medicaid benefits.

Medicaid covers primary and specialty health care, inpatient care, and behavioral health and addiction and recovery treatment services. Medicaid also covers long-term services and supports, making it possible for thousands of Virginians to remain in their homes or to access residential and nursing home care.

Quick Medicaid facts:

- Covers 1 in 8 Virginians
- Covers 1 in 3 births and 33% of children
- Supports 2 in 3 nursing facility residents

Virginia Medicaid and Children's Health Insurance Program (CHIP) are administered by the Department of Medical Assistance Services (DMAS) and are jointly funded by Virginia and the federal government under the Title XIX and Title XXI of the Social Security Act. Virginia generally receives $1 of federal matching funds for every $1 Virginia spends on Medicaid.

CMS HCBS Settings Requirements

HCBS 1915(c) waiver services are an alternative to an institutional setting. To be eligible for a 1915(c) DD Waiver an individual must meet the eligibility criteria for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) as well as functional eligibility and Medicaid financial requirements. When an individual chooses waiver services, they are choosing home and community-based services and supports versus institutional services and supports.

Per federal HCBS regulations (42 CFR 441.301), individuals enrolled in long-term services and supports waivers are permitted specific rights. In Virginia, for individuals receiving group home, sponsored residential, supported living, group day or group supported employment services in the DD Waivers, all of the following must apply:

- The setting is integrated in and supports full access to the greater community including opportunities to engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- The setting ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- The setting optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- The setting facilitates individual choice regarding services and supports, and who provides them.

In DD Waiver group homes, sponsored residential and supported living settings the following additional conditions must be met:

1. Have “units” which are rented or occupied under a legally enforceable agreement by the individual who has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law, §55.248.2 of the Code of Virginia.
2. Support the individual’s privacy in their sleeping or living unit:
    a. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
    b. Individuals sharing units have a choice of roommates.
    c. Individuals have the freedom to furnish and decorate their sleeping or living units within the terms of their lease.
3. Support the individual’s freedom to control their own schedules and activities, and have access to food at any time.
4. Support individuals to have visitors of their choosing at any time.
5. Be physically accessible to the individual.

Any modification of the requirements specified in items 1 through 4 above, must be individually determined and supported by a specific assessed need and justified in the Person-Centered Individualized Service Plan.

The HCBS settings rule identifies institutional settings in which HCBS services cannot be provided. These include nursing facilities, institutions for mental disease, intermediate care facilities for individuals with intellectual disabilities, and hospitals. The rule also identifies settings that are presumed to have the qualities of an institution:

- Any setting that is located in a building that is also a publicly or privately-operated facility that provides inpatient treatment; or
- Any setting that is located in a building on the grounds of, or immediately adjacent to, a public institution, such as: a Virginia State Training Center, public hospital setting, Virginia State Psychiatric Hospital, Nursing Facility; or
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS. CMS has provided additional guidance on settings that isolate to include: farmstead or disability specific farm communities, gated/secured communities for people with disabilities, residential schools, and multiple settings co-located and operationally related.

A state may only include a presumed institutional setting in its Medicaid HCBS programs if CMS determines through a heightened scrutiny process, based on information presented by the state and input from the public that the setting meets the qualities for being home and community-based and does not have the qualities of an institution.

The HCBS regulations set a new standard for HCBS founded on the characteristics of an integrated community setting with access to the greater community

comparable to that of individuals not receiving Medicaid HCBS. The individual's experience in that setting must reflect HCBS rights and expectations.

Statewide Transition Plan

A state's Statewide Transition Plan (STP) describes to CMS 1) how the state determined its compliance status with the regulation requirements for home and community-based settings, and 2) remediation actions the state will take to transition to full compliance with the new requirements. The STP includes the actions, timeframes and deliverables the state proposes to assure full and on-going compliance with the HCBS settings requirements. CMS reviews and approves a state's STP in a two-step process:

Step 1: Initial STP approval

- Approval of the state's systemic assessment of all relevant rules, regulations, licensing, etc. for compliance with and support of the rule.
- Systemic assessment must include any necessary remediation steps to modify any rules, regulations, licensing requirements, etc.
- Description of the process for site assessment, validation and identifying presumptively institutional settings.

Step 2: Final STP approval

- Approval of the state's site-specific assessments, including the process used for assessments and validation and determinations made about compliance of specific sites.
- Approval of the process for identifying presumptively institutional settings and determining whether the presumption is overcome.
- Approval of remediation steps, including relocation process.

Per 42 CFR 441.301: *"The State's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation."* Virginia received initial approval of its STP on December 9, 2016.

In Virginia, the settings that must be assessed and monitored as part of the STP include licensed group home, sponsored residential, supported living and group day settings as well as group-supported employment settings. CMS allows states to presume that services that occur in an individual's own home, or family home where they reside, comply. For example, if an individual lives in their family home (a non-licensed setting) and receives in-home supports, the state can presume the setting complies with the requirements and does not need to assess that setting. CMS does however affirm its expectation that settings where HCBS services are provided that are congregate in nature, even if they are not licensed by the state, may require assessment and review.

Residential Settings

Stakeholders have expressed questions and concerns about the HCBS settings rule and possible restrictions placed on an individual's choice of residence. The following scenarios are provided to clarify the requirements and how they impact specific situations and settings.

Scenario 1:
The HCBS regulations allow states to presume an individual's own home/family home meet the requirements of the HCBS settings rule. The HCBS settings rule does not prohibit individuals receiving waiver services from living on the same street or block. If an individual lives in their own home/family home, and they live on the same street or neighborhood where 3 or 4 other people who receive waiver services also live, they are not at risk of losing their waiver.

Scenario 2:
The HCBS regulations do not include a restriction on the size of a provider owned/controlled residential setting. Even a very small residential setting may have policies that restrict individual access to things such as food and telephone use that would not be consistent with HCBS requirements, while a setting serving a larger number of individuals may be structured in a manner that comports with the qualities required. Individuals who live in a larger congregate setting, for example with 6 or 8 other people, are not at risk of needing to relocate to a different residence based on the size of the home. Both smaller and larger settings must comply with the settings requirements to continue to receive HCBS funding for services provided to individuals in those settings in accordance with Virginia's STP timeline.

Scenario 3:
An individual lives by himself in an apartment. He holds a lease with a landlord; the landlord does not provide any waiver services or supports. The individual receives in-home supports through the waiver. In this instance,

the setting is considered the individuals own home. It is not a licensed setting, and the setting is presumed to comply with the settings rule.

Scenario 4:
A new provider not yet enrolled with Medicaid is developing a setting that falls under the category of "presumed institutional". This provider cannot be reimbursed for DD waiver group home, sponsored residential or supported living services until the setting overcomes the presumption of institutional in nature through the heightened scrutiny review process. This process cannot occur until individuals are able to experience the setting and CMS determines, based on information presented by the state and input from the public that the setting meets the qualities for being home and community-based and does not have the qualities of an institution. Presumed institutional settings are not prohibited, however they must have the qualities of a home and community-based setting as defined by the HCBS regulations.

Medicaid HCBS must be provided in settings that have the qualities of a home and community-based setting as described in the CMS HCBS regulations and settings requirements. Federal financial participation (FFP) will not be allowable in settings that do not meet the settings requirements in accordance with a state's timeline and remediation activities as detailed in its CMS approved STP for HCBS compliance.

Summary

In conclusion, at the July 20th stakeholder meeting there was consensus that differing understandings of the HCBS settings requirements resulted in concern for an individual's choice of residence and the potential impact of that choice on an individual's waiver services and supports. The settings requirements do not place restrictions on the number of people receiving HCBS services who can live in a neighborhood or the size of a particular setting. The HCBS settings requirements were put in place because of concerns that many states and providers were using federal dollars dedicated to community-based supports to pay for Medicaid waiver services in settings that were still institutional in nature. For this reason, the requirements do require all settings that receive HCBS funding to have the qualities of a home and community-based setting. Settings presumed to have the qualities of an institution, as listed on page 2 of this report, will require heightened scrutiny to ensure they meet the HCBS settings rule.

The timeline to demonstrate compliance is determined by a state's STP, but no later than March 17, 2022. Virginia's updated STP will go out for 30 days public comment in early 2019 with an anticipated submission to CMS in late March 2019. The updated STP will address Virginia's process for ensuring settings transition to compliance.

Recommendations

DMAS makes the following recommendations to the General Assembly in order to support clear and consistent communication and education on the HCBS settings requirements and choice of residence for providers, stakeholders and individuals.

1) DMAS should request from CMS a collaborative webinar/informational session reviewing the HCBS settings requirements and any limitations those requirements may impose on choice of residence.
2) DMAS should make available HCBS compliance information and resources that are consistent and accurate.
3) The Commonwealth should respect the ultimate right of an individual to choose where he/she wants to live while being mindful that HCBS funding is only available for services in settings which comply or are presumed to comply with the provisions outlined above.