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CMCS Informational Bulletin

DATE: August 2, 2019

FROM: Calder Lynch, Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services

SUBJECT: **Heightened Scrutiny Review of Newly Constructed Presumptively Institutional Settings**

CMS issued a series of Frequently Asked Questions (FAQs) on the home and community-based services (HCBS) regulation's heightened scrutiny provisions on March 22, 2019[1]. The Agency is issuing this document in response to follow-up inquiries received on how heightened scrutiny will be applied to newly constructed presumptively institutional settings. Specifically, stakeholders have asked whether the March 2019 guidance impacts CMS's existing guidance on this issue.

With respect to settings under development or new construction, CMS issued guidance in 2016[2] that stated that CMS would only be able to determine whether a setting overcame its institutional presumption after the facility was operational and occupied by Medicaid beneficiaries who were receiving services in the setting. We explained that our determination would consider factors beyond the physical structure of the setting itself to include considerations of how individuals residing or receiving services in the setting actually experience the setting in a manner that promotes independence and community integration. CMS cannot properly consider the factors that go beyond physical structure until the facility is operational and services are actually being provided to individuals.

At this time, CMS is revising the 2016 guidance to allow the state to submit a setting to CMS for a heightened scrutiny review while only non-Medicaid beneficiaries are receiving services in the new setting. CMS encourages states, providers, builders and other stakeholders to thoughtfully consider alternatives to new development of presumptively institutional settings. However, in the event the new construction is considered presumptively institutional, CMS believes that an accurate analysis of a setting's adherence to the regulatory criteria can be performed at the state and federal levels based on the experiences of non-Medicaid beneficiaries. For example, the facility might be able to show that the setting chosen by the private pay individual is integrated in and supports full access of individuals receiving services to the greater community, including opportunities to seek employment and work in competitive integrated settings, and that

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/smd19001.pdf
[2] https://www.medicaid.gov/medicaid/hcbs/downloads/faq-planned-construction.pdf; note that question 2 has been superseded by the document referenced in footnote 1.

individuals engage in community life, control personal resources, and receive services in the community.

Specifically, we are clarifying two issues in this bulletin:

- With respect to newly constructed facilities, CMS can perform a heightened scrutiny review based on how non-Medicaid beneficiaries are receiving services in the new setting at the time a state conducts and submits information for a heightened scrutiny review. For example, private pay individuals not participating in the Medicaid program could be receiving services in the setting, and states could describe how the setting is providing services to these individuals in ways that comply with the federal home and community-based settings criteria. CMS is not establishing a standard for the number of individuals (Medicaid or non-Medicaid) who must be receiving services from the setting in order for a heightened scrutiny review to be performed. The number of individuals, however, should be sufficient so that the state is able to obtain data to demonstrate that the setting adheres to the regulatory criteria and overcomes its institutional presumption. Should the state believe the setting has overcome its institutional presumption and adheres to the regulatory criteria, the state may submit information to CMS for heightened scrutiny review prior to Medicaid beneficiaries receiving services in the setting.

- Should CMS determine that a new presumptively institutional setting overcomes that presumption and adheres to the home and community-based settings criteria, Federal Financial Participation (FFP) for Medicaid-funded HCBS will be available according to the following timelines:

    - For new settings, when CMS agrees that the setting overcomes its institutional presumption without requiring any additional information, or when additional information is needed from the state describing how the setting fully complies with the regulatory criteria without requiring additional remediation, FFP will be available for expenditures associated with dates of service beginning on the date the state determined the setting complied with the regulatory criteria. See Example 1 below.
    - For new settings in which states submit information to CMS for a heightened scrutiny review based on an assessment of how the setting provides services to non-Medicaid beneficiaries, and the state is able to confirm that all Medicaid regulatory requirements either were met or would have been met if the services had been furnished to Medicaid beneficiaries, FFP will be available for expenditures associated with dates of services beginning on the date the setting began providing services to Medicaid beneficiaries. See Example 2 below.
    - For new settings which CMS determines that additional remediation is necessary for the setting to comply with the regulatory criteria, FFP will be available for expenditures associated with dates of service beginning on the date the state confirmed all remediation was completed and that the setting demonstrates compliance with the regulation. See Example 3 below.

- FFP will not be available for Medicaid-funded HCBS provided in presumptively institutional settings that are unable or unwilling to demonstrate compliance with regulatory criteria.
- FFP will only be available for state claims that meet timely filing requirements at section 1132 of the Social Security Act and implementing regulations at 45 CFR part 95.

Example 1: A state submits to CMS a newly constructed setting in the same building as an institution providing inpatient treatment for heightened scrutiny review on July 1, 2019. The setting is furnishing services to a mixture of private-pay individuals and Medicaid beneficiaries. The state submits information to CMS about how the setting overcomes its institutional presumption and adheres to the home and community-based settings criteria based on their assessment conducted on June 1, 2019. CMS reviews the state's submission and agrees that the setting overcomes its institutional presumption. FFP would be available for expenditures for HCBS provided by this setting on or after June 1, 2019.

Example 2: A state submits to CMS a newly constructed setting on the grounds of a public institution for heightened scrutiny review on July 1, 2019. The setting is furnishing services to private-pay individuals, but not yet to Medicaid beneficiaries. The state bases its description of how the setting overcomes its institutional presumption on the experience of those private-pay individuals. Medicaid beneficiaries are accepted into the setting on August 1, 2019. CMS reviews the submitted information and requests additional information of the state on September 15, 2019. That request asks the state to attest[3] that Medicaid beneficiaries receiving services at the setting have person-centered service plans as referenced in the regulation, and are experiencing the setting similarly to non-Medicaid participants consistent with the settings criteria and have access to the broader community to the degree that is outlined in their person-centered service plans. This information was not described in the state's original submission to CMS, as the private-pay individuals receiving services at the setting are not required to have person-centered service plans. The state follows up with the setting on October 1, 2019, and based on a review of person centered plans and/or beneficiary interviews, determines that those regulatory requirements are being met and person-centered plans were in place on the day the setting began providing services to Medicaid beneficiaries. The state submits an attestation to that effect to CMS on October 15, 2019. In that instance, FFP would be available for expenditures for HCBS provided on or after August 1, 2019.

Example 3: In the same scenario described in Example 2, if the state finds that those person-centered planning regulatory requirements are not being met, the setting would be required to implement remediation to comply with those provisions. In this example, the state verifies that the setting completes needed remediation on November 15, 2019, and provides an attestation to CMS on December 1 that the remediation has occurred. FFP would be available for expenditures for HCBS provided by the setting on or after November 15, 2019.

If you have any questions, you can contact Michele MacKenzie, Technical Director, Division of Long Term Services and Supports, at Michele.MacKenzie@cms.hhs.gov.

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[3] CMS reserves the right to ask a state to provide additional information supporting this attestation.