Frequently Asked Questions (FAQ) on HCBS Settings Requirements, Living Choices Waiver Providers

What is (Home and Community-Based Services) HCBS Settings Rule?

In March 2014, the Centers for Medicare & Medicaid Services (CMS) issued new federal regulations collectively known as the HCBS Settings Rule. These regulations added specific requirements for settings where Medicaid-funded Home and Community-Based Services (HCBS) are provided. The primary goal is to ensure that individuals receive HCBS in settings fully integrated into the community. States are required to bring all Medicaid HCBS programs into compliance with the rule.

The HCBS Settings Rule was created to guarantee that individuals receiving long-term services and supports through Medicaid-funded HCBS have full access to community life and can receive person-centered care in the most integrated settings that meet their needs and aspirations.

It outlines standards for all HCBS settings, including additional requirements for provider-owned or controlled environments.

The HCBS Settings Rule requires that all HCBS settings meet the following criteria:

- The setting is integrated in and supports full access to the greater community;
- The setting is selected by the individual from setting options;
- The setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- The setting optimizes autonomy and independence in making life choices; and
- The setting facilitates choice regarding services and who provides them.

Additionally, the HCBS Settings Rule requires HCBS setting of a residential setting to meet the following requirements:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- The individual has privacy in his or her unit, including lockable doors, choice of roommate and freedom to furnish or decorate their unit;
- The individual controls his or her own schedule;

- The individual has access to food at any time;
- The individual can have visitors at any time (no "visiting hours"); and
- The setting is physically accessible to the individual.

Who is Affected by HCBS Settings?

All Level II Assisted Living Facilities (ALF II) enrolled in Medicaid are affected. Although ALF IIs are classified as long-term care facilities under the Arkansas law, those receiving Medicaid reimbursement are also certified to provide services through the Arkansas Living Choices Assisted Living Waiver Program. This program is a Home and Community-Based Services (HCBS) and must therefore comply with the HCBS Settings Rule.

What is Heightened Scrutiny?

Under the HCBS Settings Rule, Medicaid-funded Home and Community-Based Services can only be provided in settings that are integrated in the community, not in institutional environments. CMS presumes that certain settings have institutional or isolating characteristics. These "presumptively institutional settings" must go through a process called *heightened scrutiny* to demonstrate they meet all HCBS requirements. To receive Medicaid HCBS waiver funding through the Arkansas Living Choices Assisted Living Waiver Program, these settings must provide evidence that they can overcome the institutional presumption and fully comply with the rule.

What is a "Heightened Scrutiny" review?

As an initial step, states must identify settings that exhibit institutional characteristics- such as size/capacity, institutional practices, or physical connections to institutional facilities. If a state believes that setting can and should meet the HCBS standards with changes, it may submit evidence to CMS through a process called "heightened scrutiny." CMS then evaluates whether the setting has addressed its institutional qualities and now meets the criteria for being considered community-based.

If a setting initially presumed to isolate individuals corrects all issues and the state confirms it now complies with HCBS standards, it may avoid a full heightened scrutiny review; however, states must still include all settings in the State Transition Plan.

To guide this process, CMS developed a set of "Exploratory Questions" to help states assess compliance. While states conduct the initial assessments, CMS makes the final determination based on the evidence provided. This evidence should focus on how the setting supports individuals receiving Medicaid HCBS in engaging with and accessing the broader community, rather than on the nature or severity of the individuals' disabilities.

Who is Affected by Heightened Scrutiny?

CMS considers a setting *presumptively institutional* if **any** of the following conditions apply:

- It is located in a building that is also a public or private institution (e.g., a nursing home, hospital or human development center).
- It is on the same grounds as, or adjacent to, a public institution.
- It isolates individuals from the broader community.

Settings may be considered isolating if they have the following characteristics:

- The physical design or service model limits opportunities for interaction with the broader community (i.e., gated communities, farmsteads, campus-style arrangements, etc.).
- Individuals have limited choice in receiving services or participating in activities outside the setting.
- The setting is physically separate from the broader community and does not facilitate access to it (i.e., a remote or rural location with no transportation or support to access to the community).
    - *Note: Rural locations are not automatically considered isolating. The state will assess whether residents have the same opportunities for community involvement as individuals live outside the setting.*

Additional Considerations:

CMS allows states to identify other characteristics they consider isolating, as long as these are clearly communicated to stakeholders.

In Arkansas, if the Department of Human Services (DHS) identifies settings that exhibit isolating or institutional traits, it may submit those settings to CMS for *heightened scrutiny* review. Currently, DHS includes the following additional criterion for heightened scrutiny:

- Settings with multiple provider-owned or operated homes clustered together.

When Will Providers Be Reviewed for HCBS Settings Rule?

DPSQA conducted initial compliance reviews in late 2022 and early 2023, followed by Heightened Scrutiny assessments in 2024Based on these results, CMS has instructed DHS to do a more in-depth review of Heightened Scrutiny providers. Additionally, since the review is to be conducted at least every three (3) years, DHS will review all providers based on CMS requirements. Accordingly, **each ALF II provider will undergo an individualized HCBS Settings Review**.

Providers will then be reviewed for HCBS Settings Rules on a continuous basis- this means during annual licensing reviews and complaint investigations, if applicable.

What Happens if a Provider is Out of Compliance with HCBS Settings Rule?

If a provider is found to be out of compliance with any aspect of the HCBS Settings Rule, a Plan of Correction will be required to address the identified issues. To continue to receiving Medicaid funding, the provider must complete the corrective actions, which will be must be completed verified through a follow-up visit. DPSQA will support providers by monitoring progress and assisting with any challenges that arise.

Providers that remain out of compliance- or return to a non-compliance- risk losing Medicaid funding. If a provider continues to violate any of the Settings Rule requirements, the state will no longer be able to fund the facility through the Living Choices Waiver.

While DHS acknowledges that such situations may occur, it believes all providers can achieve compliance if they are committed and willing to make the necessary changes.

How do HCBS Settings Requirements impact Assisted Living Facilities?

According to CMS's FAQ, the HCBS Settings requirements outlined in the final rule apply to all settings where individuals receive HCBS, including assisted living facilities. In Arkansas, every Level II Assisted Living Facility is also certified as a Medicaid provider to offer HCBS waiver services through the state's Living Choices Program.

Is an ALF provider required to install locks on a Medicaid recipient's unit or apartment door?

Yes, an ALF II provider must ensure that a Medicaid recipient can lock the door to their unit or apartment, unless the recipient's Medicaid service plan- known as the Person Centered Care Plan (PCSP)- specifies otherwise. The HCBS Settings Rule (42 CFR §441.301(c)(4)(vi)(B)(1) states: "Each individual has privacy in their sleeping or living unit: (1) Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors as needed. Any modifications […] must be supported by a specific assessed need and justified in the Medicaid person-centered service plan."

Is an ALF provider in compliance with the HCBS Settings Rule for door locks if only the memory care (ASCU) unit's main door is lockable, but not each individual apartment or unit?

No, this setting would not be considered compliant with the HCBS Settings Rule. A diagnosis related to memory care needs (e.g., dementia or Alzheimer's) should not automatically assume that an individual cannot carry their own apartment key. Everyone must be individually assessed through their person-centered plan to determine if they can carry a key or if alternate options can

support their independence. Alternatives should be explored and attempted before restricting key access, which should be a last resort.

ALF II providers must ensure that a Medicaid recipient's door is lockable unless restrictions are specified in the PCSP. Providers must also ensure door locks comply with relevant policies and Life Safety Code standards. Additionally, ALF II facilities must follow the applicable occupancy and general chapters of the NFPA 101 Life Safety Code, including requirements regarding the type of locks permitted on the doors.

How can an ALF II provider comply with HCBS Settings Rule requirements for door locks while serving Medicaid recipients who may wander or exit-seek unsafely, such as individuals in a memory care (ASCU) unit?

An ALF II provider can meet the HCBS Settings Rule requirement for bedroom door locks through the Medicaid person-centered planning process. Person-centered planning, along with staff training and individualized care, are essential components that help providers address unsafe wandering and exit-seeking behavior while complying with HCBS standards.

As noted, an ALF II must ensure that a Medicaid recipient's bedroom door is lockable by the individual, unless otherwise specified in their person-centered plan. The Living Choices PCSP process is led by the Living Choices Waiver Nurse and an interdisciplinary team assembled for each recipient. ALF II staff may participate in this team if requested by the recipient. The provider is responsible for implementing any modifications outlined in the PCSP.

The HCBS Settings Rule requires that any modification to the lockable door requirement be based on a specific assessed need and justified in the Medicaid recipient's service plan [42 CFR §441.301(c)(4)(vi)(F)]. This includes ensuring that the apartment and unit doors are lockable by the recipient, with appropriate staff having keys as necessary.

DHS recommends that ALF II providers develop internal policies regarding door locks and establish assessment procedures to determine when a door lock is appropriate for a Medicaid recipient.

If an individual is unable to use a key, will this need to be written as a restriction in the person-centered plan and service plan?

If an individual wants a key but cannot physically manipulate it due to their disability, providers should consider alternative options such as a keypad or swipe card. Physical accommodations must be made to enable the person to be able to access their space. This is not a restriction but an effort the provider must continue to pursue on the individual's behalf.

The HCBS Settings Rule requires that the option to lock their door must be available to individuals. If an individual chooses not to have a key, there is no requirement to provide one; however, this preference should be documented in their person-centered plan.

Is it appropriate for an ALF II provider to assess door lock safety on an ongoing basis for Medicaid recipients, and to address changes in condition over time?

Yes, DHS encourages Living Choices Waiver staff and ALF II providers to conduct regular, ongoing assessments to determine whether a door lock is appropriate for a Medicaid recipient residing in an ALF II.

The HCBS Settings Rule requires that any modification to the rule's conditions must be based on specific assessed need and justified in the Medicaid recipient's service plan [42 CFR §441.301(c)(4)(vi)(F)]. This includes the requirement that apartment and unit doors have an entrance lockable by the Medicaid recipient, with only appropriate staff having keys when appropriate.

DHS recommends that ALF II providers develop internal policies regarding door locks and assessment processes for determining whether a door lock may or may not be appropriate for a Medicaid recipient.

Who would be considered "appropriate staff" to have access to a Medicaid recipient's door key?

The designation of appropriate staff should be jointly determined by the resident and the provider, and documented in writing (e.g., in the person-centered plan or residency/occupancy agreement). Simply stating "appropriate staff" is not sufficient to meet the standard.

Are ALF II providers required to allow Medicaid recipients to have visitors at any time?

Yes, an ALF II must ensure Medicaid recipients can have visitors at any time, unless otherwise specified in the recipient's PCSP and agreed to by the recipient. The HCBS Settings Rule (42 CFR §441.301(c)(4)(vi)(C)) states: "Individuals are able to have visitors of their choosing at any time."

Any modification to this requirement must be supported by a specific assessed need and justified in the recipient's service plan [42 CFR §441.301(c)(4)(vi)(F)].

Visitation Policy Expectations:

According to ALF II regulations, visitors shall be permitted at all times, except when visitation disrupts services to other residents or threatens the health, safety, or welfare of residents (*20 CAR §411-501(1)(A)(B)*).

Providers must have policies that uphold Medicaid recipients' right to visitors as they choose. Visitors must be allowed at any time, unless restrictions are based on health and safety risks documented in the recipient's person-centered service plan. Providers are not responsible for lodging, meals, and/or care of visitors.

Providers should notify Medicaid recipients in writing if visitor restrictions apply. Visitation policies must be available to recipients and guests and include:

- Any limits on visit duration, fees for lodging or meals, and roommate consent for overnight visitors;
- Conditions under which visitors are prohibited or restricted due to a health or safety risks;
- Visitor sign-in requirements;
- Restrictions on visitors who cause disturbances or pose safety risks.

Can an ALF II provider enforce a curfew for Medicaid recipients who reside in the facility, including the memory care (ASCU) unit?

The HCBS Settings Rule requires that individuals have the freedom to control their own schedules and activities. Therefore, a setting-wide curfew cannot be imposed as a general "house rule" or restriction in an ALF II. Providers may encourage or recommend that Medicaid recipients return by a certain time, but they cannot require it.

In an ALF II provider responsible for making appliances, such as washer and dryer, accessible to Medicaid recipients?

The HCBS Settings Rule does not specifically require ALFs to provide particular appliances, like washers and dryers, but it **does** require that individuals receiving Medicaid-funded Home and Community-Based Services (HCBS) have **the same level of access to everyday life as people not receiving HCBS** – including access to typical household amenities, independence in daily activities, and autonomy in their living environment.

While the rule does not mandate a washer and dryer in every unit or room, the spirit of the rule supports:

- **Reasonable access** to household appliances (like laundry facilities),
- **The ability to do laundry independently** or with support as needed,
- **The right to privacy** when doing personal tasks like laundry, and
- **No unnecessary restrictions** placed on when or how individuals access those appliances.

If a facility provides laundry services **only at restricted times** or **does not allow individuals to do their own laundry** when they are capable of doing so (or could do with support), that could be considered noncompliant with the HCBS Settings Rule.

Best practices for compliance:

- Ensure washers and dryers are accessible to residents (physically and procedurally).
- Support individuals in using them **independently** if they wish, with assistance only as needed.
- Avoid **blanket policies** that prevent individuals from accessing laundry facilities based on diagnosis or setting norms.

What is an ALF II provider's responsibility for supporting Medicaid recipient's access to employment?

Under the HCBS Settings Rule, an residential setting such as an assisted living facility that services Medicaid recipients has a clear responsibility to support individuals' right to **seek, obtain, and maintain employment** in the **most integrated setting** appropriate to their needs and preferences.

The rule requires that individual receiving HCBS:

- **Have opportunities to seek employment and work** in competitive integrated settings,
- **Are supported in pursuing employment goals** outlined in their person-centered plan,
- **Are not subject to facility rules or schedules** that restrict their ability to work (such as curfews or limited access to transportation), and
- **Receive support to explore employment options,** including job development, training, or transportation assistance.

An ALF must actively support Medicaid recipients' rights to pursue employment as part of a community-integrated life. This includes removing barriers, providing flexibility, and coordinating supports to help individuals work in competitive, integrated settings, if they choose to do so.

Why is reverse integration considered insufficient?

CMS has made it clear that reverse integration- bringing individuals from the broader community into the facility- does not satisfy the community integration requirement of the HCBS Settings rule. The rule is intended to ensure that Medicaid waiver funding supports individuals in accessing and participating in the broader community outside of the facility.

To demonstrate compliance, providers must show how they support individuals in engaging with the community beyond the facility's walls- not simply by hosting outside guests or activities on-

site. While encouraging volunteers or community members to participate in on-site activities is allowed and beneficial, it does not fulfill the requirement for true community integration.

What is an ALF II providers responsibility to provide transportation or arranging transportation for Medicaid recipients to access the community or employment away from the facility?

Under the HCBS Settings Rule, providers must ensure Medicaid recipients have access to the community, including transportation for employment, service, and activities.

With an assisted living facility is not required to provide transportation directly, they must arrange or facilitate access to reliable options- such as public transit, non-emergency medical transportation (NEMT) such as doctor visits, ride-shares, or help from their PASSEs. Providers must also assist residents in using these options to ensure that facility policies (like curfews or staff availability) do not restrict access to the community.

Transportation must not be a barrier to a resident's independence, employment, or full community participation.

As an ALF, we have scheduled outings for our residents three (3) times a month to places like the grocery store or Wal-Mart. Does this satisfy transportation and community integration requirements?

No, offering only three scheduled outings per month (e.g., to Walmart or the grocery store) does not fully meet the HCBS Settings Rule requirements for transportation and community integration. Access to the community must be **frequent, flexible, and person-centered-** not limited to a preset schedule. Limited outings:

- Restrict resident choice and autonomy,
- Do not reflect individualized needs or preferences, and
- Risk appearing institutional.

Providers should support residents in accessing the community **when and where they choose**. This includes **providing or helping arrange individualized transportation**, rather than relying solely on group outings. Community access needs should be clearly documented in each resident's person-centered plan.

What if an ALF II provider needs to make exceptions to the HCBS Settings Rule requirements for a resident's health and welfare?

The HCBS Settings Rule requires Home and Community Based Settings to meet certain "qualities." However, these requirements may be modified on an individual basis if there is a specific assessed need, and the modification is justified in the person's service plan.

How will providers be affected if lack of staff is a barrier to meeting some of the Settings Rule requirements?

DHS recognizes the ongoing challenges in attracting and retaining staff- a concern shared by many states. Arkansas is not alone in this struggle, and CMS acknowledged these staffing challenges and the last impact of the COVID-19 pandemic in 2021. However, CMS has not indicated any changes to HCBS compliance requirements. As a result, providers must have appropriate policies and practices in place to ensure compliance, including working collaboratively with individuals and their interdisciplinary teams to support their needs and preferences.

What are person-centered practices and what do they address?

Person-centered practices focus on planning supports and services based on an individual's goals, preferences, and desired lifestyle- not on professional opinion or available provider options. Planning is guided by what the person needs to live the life they want, with input from their support team. Together, they identify the services and supports that will help the person live, work (if they choose), and participate in their preferred community on their own terms.

These practices are flexible, adaptable, and promote informed choice and creativity. Ultimately, person-centered approaches enhance an individual's quality of life and support them in creating or maintaining a meaningful life in the community.

How can we be more person-centered?

Providers can adopt a more person-centered approach by seeing each individual as a whole person, recognizing their unique strengths and contributions, and keeping focus on their preferences and goals. A core principle of person-centered thinking is balancing what is *important to* the person (such as what brings them joy) with what is *important for* the person (such as their health and safety).

While the freedom to explore new experiences is essential, providers play a key role in supporting individuals to thoughtfully consider the risks and benefits of their choices.

What does it mean for a person to have informed choice?

Informed choice means making decisions based on accurate, complete information. It is supported through ongoing person-centered conversations and activities. A person exercising informed choice understands the options, along with the associated risks and benefits. This process values and actively explores community resources and supports.

How can providers make sure individuals have informed choice?

The HCBS Settings Rule affirms individuals' right to make informed choices and determine what is important *to* and *for* them. Providers can support informed choice by:

- Providing or helping individuals access the information needed to make informed decisions when developing individualized plans- this includes selecting outcomes, providers, supports and services, and the most integrated settings for receiving those services.
- Establishing policies that ensure services and supports are delivered in ways that offer individuals meaningful choices.
- Communicating opportunities to exercise informed choice using appropriate methods, and offering assistance to those who need support in making decisions.
- Actively supporting individuals in the process of making informed decisions.

How can we better learn about individual's preferences and needs?

There are many effective techniques providers can use to better understand an individual's preferences and needs. To make these efforts more meaningful and productive, consider the following approaches:

- **Ask open-ended questions** about choice, independence, rights, and community access. Examples include:
    - "What types of opportunities do you have to spend time in the community with other community members?"
    - "What kinds of interactions do you typically have with community members?"
    - "What do you like about your work, home, or services?"
    - "What would you change about them, if anything?"
    - "Have you felt you weren't treated fairly? If so, can you describe the situation?"
- **Listen carefully** to the person's response and follow up with additional questions or examples. Ask for details about how their services have supported- or limited- their community involvement or independence.
- **Observe non-verbal cues** such as body language and tone of voice to assess whether the person's words reflect their true feelings. Reassure them that their feedback is confidential and will be used only to improve services.

- **Use visual aids or assistive technology** for individuals who have limited verbal and communication. For instance, show photos of different community activities and ask the person to point to what they like or identify someone they'd like to go with.
- **Try new experiences** and observe the person's level of engagement. Their actions can reveal preferences. Speaking with staff who work closely with the individual can also offer insights.
- **Hold structured conversations** during intake, annual reviews, team meetings, and one-on-one interactions to explore changing preferences and needs over time.
- **Engage individuals in a formal planning process** during quarterly, semi-annual or annual meetings. Discuss what the person wants to achieve in the coming year and beyond. After the meeting, staff can share the individual's goals, interests, and preferences with other team members who support them.

Based on HCBS Settings Rule standards, who should be signing the residency agreement/occupancy agreement?

Whenever possible, the individual should sign the residency agreement, even if a guardian is also required to sign. It is the provider's responsibility to meet with the individual to explain the agreement, including rights it contains, and to take as much time as needed to answer questions and ensure understanding. Even if the individual may not fully comprehend all aspects of the agreement, the provider should make every effort to involve and engage the person in the process.

Based on HCBS Settings Rule standards, do residency/occupancy agreements have to be renewed every year? What happens if a waiver participant lapses in signing the lease renewal? Does that mean they would need to leave?

The residency/occupancy agreement must be renewed annually. If an individual has not signed the agreement, they should be asked whether they wish to continue living in the setting. If they say yes, they should be encouraged to sign the agreement, and any requested modifications should be documented. If the does not wish to remain in the setting, the PASSE and the DAABH Waiver Nurse should be contacted to either assist with signing of the lease/agreement or begin helping the individual transition to a new setting.

Are we required to train all of our staff on the HCBS Settings Rule?

Yes, all staff at an assisted living facility serving Medicaid recipients must be trained on HCBS Settings Rule. Every staff member- direct care, administrative, and support staff- plays a role in ensuring compliance and protecting residents' rights.

The Centers for Medicare and Medicaid Services (CMS) expects that all HCBS providers ensure their setting meet the federal standards outlined in the HCBS Settings Rule. This includes:

- **Promoting individual rights** (privacy, dignity, freedom, choice)
- **Supporting access to the community,** employment, and social services
- **Avoiding institutional practices,** like rigid schedules or limited visitor access

At a minimum, training should include:

- Direct care staff (e.g., CNAs, personal care aides)
- Supervisors and managers
- Activity coordinators
- Dietary, housekeeping, and maintenance staff
- Administrative staff involved in admissions, service planning, or compliance.

Even staff who don't provide direct care impact the daily environment and must understand how to support residents' rights under the rule.

Training should be included in new employee orientation, ongoing in-service or annual training, and policy updates.

How do we go about training our staff around the HCBS Settings Rule?

To effectively train staff on the HCBS Settings Rule, facilities should provide clear, ongoing, and practical training to ensure staff understand both the **intent of the rule** and their **role in implementing it.**

Each HCBS Settings Rule criteria should be documented in training. At a minimum, training should cover:

- An overview of the HCBS Settings Rule and its purpose
- Resident rights (privacy, autonomy, choice, access to community, etc.)
- Person-centered practices
- How to identify and avoid institutional or non-compliant practices
- Staff responsibilities for documentation and service delivery