

## **Appendix M: Protocol for Review of West Virginia Home and Community Settings**

Section 1. *Purpose:* The purpose of this protocol is to manage provider identification and compliance with setting requirements in accordance with the Home and Community Based Services settings rule 42 *CFR 441.301(c)(4)(i-v)/441.710(a)(1)(i-v)/441.530(a)(1)(i-v)*

The actions in Sections 4 through 9 are repeated as necessary to assure that all applicable HCBS settings remain in compliance with the Integrated Services Rule.

### *Section 2. Member and Provider data analysis*

Analysis of the data collected from the 2015 Member and Provider surveys was completed to identify the following key indicators of non-compliance and to prioritize settings reviews:

Key Indicator: Providers that self-identify as being in compliance, but Member responses indicate otherwise.

Key Indicator: Member responses indicate provider compliance, but Provider response indicates otherwise.

Key Indicator: Provider responses that self-identify gross non-compliance among the five requirements of 42 *CFR 441.301(c)(4)(i-v)/441.710(a)(1)(i-v)/441.530(a)(1)(i-v)*. These providers are scored as 0, 3 or 4 on the assessment instrument. (Appendices K and N of State Transition Plan).

Key Indicator: Analysis of provider respondents to identify those with licensed (owned or leased settings) which did not respond as instructed.

Key Indicator: Any provider setting for which BMS has received a complaint alleging non-compliance.

These Key Indicators translate into Scores based as follows:

Score of 1 No indication of an Institutional Setting AND

No indication of Isolating Effects AND

Score of less than 10% for Conditions that Restrict Choice or Rights (Compliance)

Score of 2 No indication of an Institutional Setting AND

Score of 1-49% for Isolating Effects AND

Score of 10-49% for conditions that Restrict Choice or Rights

Score of 3 No indication of an Institutional Setting AND

Score of 1-49% for Isolating Effects AND

Score of 50% or higher for conditions that Restrict Choice or Rights

Score of 4 Any indication of an institutional setting AND

Score of 50% or higher for Isolating Effects

(Gross Non-Compliance)

Providers with identified Key Indicators are considered Priority I.

Providers without identified Key Indicators and scoring 1 or 2 on the self - assessment instrument are considered Priority II.

The relation of score to priority is as follows:

Score	0 (no answers)	Priority I
	1	Priority II
	2	Priority II
	3	Priority I
	4	Priority I

No providers were found, based on the self - survey, to be totally compliant. Priority II (Score 1 or 2) providers had self-surveyed to indicate substantive compliance.

Section 3. *Validation Process for Provider Responses and Key Indicators*

All providers not initially responding to the surveys were notified by email, phone and letter that the lack of response signifies that they are not in compliance and are under intense BMS scrutiny.

Direct communication with each non-respondent provider ascertained if the provider wished to come into compliance. All providers ultimately expressed the intention to come into compliance and completed the survey.

#### Section 4. *Setting/Site visits and Revisits*

Site visits were conducted to validate provider responses using the following criteria (Priority I): (completion date 1/12/2018)

Providers who did not self-identify, but member responses indicate non-compliance.

Providers who did not respond but should have responded.

Providers who self-identify non-compliance.

Site visits were conducted for **all** Facility Based Day Habilitation and Supported Employment settings. (Completion date 1/5/2018)

Site visits were conducted for **all** residential settings housing 4 or more individuals. (Completion date 1/12/2018)

Site visits were conducted for 50% of all 1-3 bed settings. All Priority I 1-3 bed settings were reviewed. A random sample of Priority II settings identified additional 1-3 bed settings with the sample skewed to assure that all providers have at least one setting reviewed. It was recognized that the percentage of site visits conducted for Priority II settings exceeded the 50% target in order to assure that all providers had at least one setting review. (Completion date was 1/12/2018).

Follow up visits were conducted for all settings not found in compliance. The timelines were based on Plan of Compliance Dates.

Annual reviews (and follow-ups if necessary) will be conducted for all settings in subsequent years.

As new providers or settings falling under the Integrated Services Rule (settings owned or leased by provider) are created, these settings shall receive an initial State Transition Plan review prior to beginning services at the setting. This review would include technical assistance and general compliance determination. Then when the setting is fully operational, BMS would conduct a full review as they have for all other provider settings, following the procedures in **Appendix M**.

Should any site visit result in the setting falling under the designation CMS Heightened Scrutiny, CMS will be notified.

#### *Section 5. Setting/Site Visits Procedure*

Initial provider contacts are announced. Multiple sites owned or leased by one provider may or may not be reviewed sequentially.

Follow up and annual setting visits will be unannounced. When conducted by KEPRO, 48 hour notice shall be given. KEPRO reviews will include a verification of all settings, and census and services provided for each under the State Transition Plan.

Portions of the review process may be conducted off the setting grounds. (For example: Policy review at the provider main office).

Reviewer should be familiar with Attachment 6, Guidance for Reviewers, prior to entrance. Reviewer conducts entrance meeting, introduces self and purpose of the setting review. Reviewer acquires a list of all persons receiving Waiver services at the setting and the total number of persons being served or living at the setting. Type(s) of transportation used and available to members is also obtained. Types of services, including but not limited to Facility Based Day Habilitation, Supported Employment, Skilled Nursing services and Electronic Monitoring, will be identified.

Reviewer completes the Setting Assessment instrument (Non-Residential Site Review -Attachment 1, Residential Site Review – Attachment 2 and Site Review/Records – Attachment 3 as applicable) for each setting.

Observations include meals when possible.

Reviewer obtains verification documentation for non-compliance issues as found. This documentation may include photographs, copies of documents (including copies of policy or procedures), interview responses and/or observations made by the reviewer.

Reviewer interviews up to 20% of individuals and/or guardians. Interviews may be by phone.

Reviewer reviews charts of individuals, as well as others as necessary.

Reviewer should note NA for 'not applicable' if the question or prompt doesn't apply to the setting.

At the conclusion of the setting review, the reviewer will meet briefly with setting personnel designated by the provider. Reviewer will provide a brief synopsis of the review findings and inform the provider that there will be a written review report (SAVE, Attachment 4/KEPRO Provider Review Tool) given to the provider. The provider will be informed that additional off-site record review (Attachment 3) and/or interviews may also be referenced in the reports. Providers will also be informed that any non-compliance found will require a plan to bring the setting into compliance. The timeline for the receipt of the SAVE report should not exceed 30 days from the date of the exit. This will depend on the receipt of additional off-site record reviews and interviews that need to be completed before the report is finalized.

#### Section 6. *Plan of Compliance*

Each setting review will result in a Setting Assessment Visit and Evaluation report (SAVE, Attachment 4/KEPRO Provider Review Tool). This report will specify each assessment criterion not met.

Each setting review will result in a Plan of Compliance report (Attachment 5). This form will be completed by the provider and will include the Action Steps for each criterion cited in the setting review and a date for completion.

BMS or KEPRO will review and approve or disapprove the Plan of Compliance submitted for each setting where deficiencies are found.

Should BMS not approve the Plan of Compliance, the provider will be notified that the provider has signified that it has no approved plan to come into compliance. BMS will work with the provider to assure transition plans to other facilities or settings for members currently served by that provider and the Disenrollment of the Provider's setting from the program.

Should BMS approve the Plan of Compliance and completion dates, BMS or KEPRO will conduct a return setting visit, after the completion date designated by the provider. The purpose of this visit is to determine that non-compliant findings have been corrected.

This process will be repeated annually.

#### *Section 7. Review of Assessment Results and Follow Up*

As each report is finalized and a Plan of Compliance approved, the findings of non-compliance will be entered in a database for each provider and each finding. At the conclusion of the first cycle of reviews, this information was analyzed to identify trends, needs for provider training, and statistical probability for each finding across all providers, by type of provider and by region/county (see **Appendix N**).

This analysis will be repeated annually or more frequently as needed. When issues or needs for training are identified, these will be addressed by BMS.

The report will include the names and number of settings compliant with the HCBS settings criteria; the names and number of settings that are moving towards compliance (have deficiencies but there is a plan of compliance); the names and number of settings that cannot/will not comply with the HCBS settings criteria; the names and number of settings that are presumptively institutional in nature. This information will be disseminated as described in Section 11.

#### *Section 8. Heightened Scrutiny if Necessary*

There may be times that a provider meets the criteria of a "Presumptively non-HCBS setting" that is presumed to have the qualities of an institution. This could occur even when the BMS review has found otherwise. BMS will submit evidence to CMS regarding this provider if the state determines, through its assessments,

that the setting does have qualities that are home and community-based in nature and does not have the qualities of an institution. This evidence will include State and other stakeholder evidence.

BMS will cooperate with CMS as CMS determines whether the setting is a non-HCBS Setting. BMS will act on the CMS determination.

### Section 9. *Transition of Members to Integrated Settings*

There may be times that a provider cannot comply or refuses to come into compliance with the Home and Community Based Services Rule. This provider/setting is then deemed a non-HCBS setting and BMS will begin the Relocation of Beneficiaries process found in this section. In the event that a provider cannot comply or refuses to come into compliance with the Home and Community Based Services Rule, the provider will be informed that the setting found non-compliant will be dis-enrolled from the Medicaid program.

1. This notification will be by certified mail as well as electronically.
2. The Provider will have 10 calendar days from the date of its notification of disenrollment to notify all member participants of the disenrollment and actions the provider will take to ensure person centered planning. Within 30 working days of the date of the notification, the provider will submit to BMS an Agency Transition Plan. This plan will list 1) setting location which is non-compliant; 2) the member(s) by name and Medicaid Number; 3) the service(s) provided to each listed member; 4) the date for the Critical Juncture transition meeting for each listed member; 5) The result of the meeting including setting/location of services that do comply with the rule; 6) The date of the change of provider/setting.
3. BMS will be copied on all provider to member correspondence.
4. KEPRO will notify the affected members as well.
5. The provider will have 90 calendar days from the date of the notification to transition individuals to other services and/or settings that do comply with the Rule.
6. Individual face to face team meetings for transition will be held and the individual and their legal representative (if applicable) will make

the final choice from available settings that comply with the rule. This team should include all the participants of the member's team, including the member, family members, legal representatives, advocates, representatives of all agencies serving the member or which may begin serving the member, the service coordinator, plus any other persons the member wishes to attend.

7. Provider disenrollment will occur at the end of the 90 days or when all members are successfully transitioned.
8. For each member, all IPP services delivered by the dis-enrolled provider/setting to the member must be replaced services from an enrolled provider/setting to ensure continuity of care.
9. In no instance will there be a disruption of services to the individual member. Person centered planning by the individual's team meeting must insure that transition is to services that comply with the rule.

AGENCY TRANSITION PLAN: Public notification

The provider agency in conjunction with BMS must hold a general informational meeting for all members, legal representatives and other interested parties. BMS will attend this meeting to answer any questions. Members will also be encouraged to call BMS should they have any questions. Requests should be made through phone, email or letter with BMS contact information made available to all affected members at Critical Juncture meetings and on the BMS website.

AGENCY TRANSITION PLAN: BMS monitoring reports

The provider will submit updates to the Agency's Transition plan weekly to BMS, completing items 4-6 of item 3 above as these events occur. The plan update will be provided to BMS until all member transitions are complete.

Should an individual member request assistance beyond that given by the provider, BMS will assist the member in the timely transition to another provider and/or setting. In isolated instances, BMS may extend the 90-day transition period for an individual member due to imminent harm concerns.

STATE MONITORING AFTER TRANSITION:

Monitoring of members in the new settings will be conducted by the Service Coordinator of the individual member.

1. Within the first 3 business days after the transition, the service coordinator will do a physical face to face visit to the new setting, using the review tool for Service Coordinators (**Appendix O**).
2. A second face to face physical visit will be conducted within 30 days of the first visit by the Service Coordinator.
3. A third face to face physical visit will be conducted within 60 days of the second visit by the Service Coordinator.
4. Subsequently Service Coordinators will resume the normal 30 day residential reviews and/or the 60 day non-residential reviews.
5. In the event that there are any problems found at any time, the service coordinator should notify BMS, State Transition Plan Program Manager I at 304-356-4869 and also notify his/her immediate supervisor. The service coordinator monitors but does not enforce.

#### PROVIDER DUE PROCESS:

In the event that the provider disputes the BMS finding that the provider setting(s) is not HCBS Rule compliant, the provider is instructed to follow the same procedure as that for disputation of any statement of deficiencies. This information would be included with the statement of deficiencies sent to the provider with the notice of non-compliance.

#### Section 10. *Ongoing Monitoring*

Settings are reviewed as a part of the ASO (KEPRO) review process after the initial setting reviews and return setting visits, following the protocol and assessment instruments outlined above. All settings are reviewed yearly. Follow up visits will be conducted at all settings not found to be in full compliance.

In addition, The West Virginia Office of Health Facility Licensure and Certification conducts provider reviews, including site visits for all licensed sites.

These occur at least every two years and may occur more frequently if problems are found which result in a license for a lesser period of time.

### Section 11. *Ongoing Reports*

There will be an omnibus report of the analysis of the data provided to BMS on an annual basis. This report is described in Section 7.

Setting review updates, identifying best practices, systemic problems, number of reviews completed and numbers of reviews to be completed will be reported to:

Providers during quarterly provider meetings

QA/QI councils during quarterly meetings

IDDW Waiver Contract Management Meetings held monthly.