In January 2014, the Centers for Medicare & Medicaid Services promulgated a final federal rule (2014 Home and Community Based Services Final Rule. CMS-2249-F and CMS 2296-F) to ensure that individuals receiving long term services and supports (LTSS) through home and community-based services (HCBS) programs under 1915(c) and 1915(i) have full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal finances and receive services in the community to the same degree as individuals not receiving Medicaid HCBS.

The WV Home and Community Based Services Statewide Settings Transition Plan is a document that is several years in the making and is WV's response to how WV will meet the standards in the final federal rule. Over the past 8 years, WV has put this document out for public comment seven times, adding to the plan each time and making revisions. This final plan is divided into four sections – Phase I is Planning, Phase II is Initial Research and Discovery, Phase III is Analysis of Research and Phase IV is Steps Going Forward. In an effort to make the document less voluminous much of the research, analysis and public comments have been moved to the webpage for WV's STP which may be found at this link: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/WVSWTP/Pages/default.aspx

The West Virginia Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of West Virginia Code. The Bureau for Medical Services (BMS) in the West Virginia Department of Health and Human Resources (DHHR) is the single State agency responsible for administering the Program. This program, therefore, must also function within federally defined parameters.

West Virginia underwent the process of developing a transition plan pursuant to 42 CFR 441.301(c)(6) that contained the actions the State took to bring all West Virginia waivers into compliance with requirements set forth in 42 CFR 441.301(c)(4-5). West Virginia has three HCBS waivers that are affected by this Rule: Aged and Disabled Waiver (ADW), Intellectual and/or Developmental Disabilities Waiver (IDDW), and Traumatic Brain Injury Waiver (TBIW). The Children with Severe Emotional Disorders Waiver (CSEDW) provides services in foster and natural homes and these settings must be compliant before any services can be provided in these settings.

All members and settings for all of the Waiver programs will be reviewed annually using the following protocols.

Member-Controlled Settings

Member-controlled settings are defined as home or apartments owned or leased by a HCBS member or by one of their family members. 92% of the members on all three Waiver programs own or lease their own homes. Individual, privately-owned homes (privately-owned or rented homes and apartments in which the individual receiving Medicaid-funded home and community-based services live independently or with family members, friends, or roommates) are presumed to be in compliance with the regulatory criteria of a home and community-based setting. The state includes private residences as part of the overall quality assurance framework when implementing

monitoring processes for ongoing compliance with the settings criteria, as well as any oversight provisions in the approved HCBS waivers or State Plan Amendments.

The member's case manager must assess the setting annually, up to 90 days prior to the member's anchor date, to ascertain that the member continues to reside in a setting with the characteristics of a member-controlled setting and that the setting continues to meet the standards as described below:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, 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. 42 CFR 441.301(c)(4)(i)/441.710(a)(1)(i)/441.530(a)(1)(i)

2. The setting is selected by the individual from among setting options including non-disability specific settings. The settings options are identified and documented in the person-centered plan and are based on the individual's needs, preferences 42 CFR 441.301(c)(4)(ii)/ 441.710(a)(1)(ii)/441.530(a)(1)(ii)

3. The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint. 42 CFR 441.301(c)(4)(iii)/ 441.710(a)(1)(iii)/441.530(a)(1)(iii)

4. 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. 42 CFR 441.301(c)(4)(iv)/ 441.710(a)(1)(iv)/441.530(a)(1)(iv)

5. The setting facilitates individual choice regarding services and supports, and who provides them. 42 CFR 441.301(c)(4)(v) 441.710(a)(1)(v)/441.530(a)(1)(v)

Any member residing in a setting that does not meet these standards will be referred to their case management agency for remediation to attempt to attain compliance. These remediation attempts will be monitored by BMS, and assistance provided if needed. If the setting cannot be remediated to meet the standard, then the member will be referred to transition to an approved setting. If this transition is not successful, then, as a last resort, the member will be discharged from the program.

The member-controlled setting assessment may be found under the Resource tab of the Statewide Transition Plan webpage available here: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/WVSWTP/Pages/Resources.aspx

The case manager must complete mandatory training on the STP prior to completing the member-controlled assessments. Direct Support Professional staff must also receive mandatory training on the STP. Members will receive educational information on the STP from their case managers.

Provider-Controlled Settings

Provider-controlled settings are settings where member resides with a paid unrelated caregiver or with an agency provider who provides HCBS services the majority of the day. Any day settings such as IDDW Facility-Based Day Habilitation sites are defined as provider-controlled settings.

In the IDDW program, Specialized Family Care Homes are considered provider-controlled settings and 24 hour Intensively Supported Settings (ISS) and Group Homes with 4 or more members are also considered in this category.

In the CSEDW program, Therapeutic Foster Homes are considered provider-controlled settings.

All provider-controlled settings and members who receive services in these settings will be evaluated at least annually by BMS or its designee at least 90 days prior to their annual anchor date to ascertain that the setting continues to exhibit the characteristics of a provider-controlled setting and that the setting meets the standards as described below:

1. The setting was selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

2. The individual participates in unscheduled and scheduled community activities in the same manner as individuals not receiving Medicaid HCBS services.

3. The individual has opportunities to seek employment and work in competitively integrated settings and engage in community life.

4. The individual has his/her own bedroom or shares a room with a roommate of choice.

5. The individual chooses and controls a schedule that meets his/her wishes in accordance with a person-centered plan.

6. The individual controls his/her personal resources.

7. The individual chooses when and what to eat and may have access to food at any time.

8. The individual chooses with whom to eat or to eat alone.

9. Individual choices are incorporated into the services and supports received.

10. The individual chooses from whom they receive services and supports.

11. The individual has access to make private telephone calls/text/email at the individual's preference and convenience.

12. Individuals are free from coercion and restraint.

13. The individual, or a person chosen by the individual, has an active role in the development and update of the individual's person-centered plan.

14. The setting does not isolate individuals from individuals not receiving Medicaid HCBS in the broader community.

15. State laws, regulations, licensing requirements, or facility protocols or practices do not limit individuals' choices.

16. The setting is an environment that supports individual comfort, independence and preferences.

17. The individual has unrestricted access in the setting.

18. The physical environment meets the needs of those individuals who require supports.

19. Individuals have full access to the community.

20. The individual's right to dignity and privacy is respected.

21. Individuals who need assistance to dress are dressed in their own clothes appropriate to the time of day and individual preferences.

22. Staff communicates with individuals in a dignified manner.

23. The individual is able to have visitors of their choosing at any time.

24. The individual's unit has a entrance door that is lockable by the individual, with only appropriate staff having keys to doors.

Any provider-controlled setting that does not meet these standards will be referred to BMS or its designee for remediation to attempt to attain compliance. If the setting cannot be remediated to meet all of these standards, then the setting will be removed from approved provider listing and the member(s) will be referred to transition to an approved setting. If this transition is not successful, then, as a last resort, the member will be discharged from the program.

The provider-controlled setting assessment may be found under the Resource tab of the Statewide Transition Plan webpage available here: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/WVSWTP/Pages/Resources.aspx

The case manager and the direct Support Professional staff must complete mandatory training on the STP. Members will receive educational information on the STP from their case managers.

In addition, all waiver agencies will be contacted annually to verify the settings owned, leased or operated by the provider agency. It is the responsibility of the agency to notify BMS within 15 days of any change in status, i.e., sites are added or removed. When a new setting is added, BMS or its designee must review the site to ascertain the site is in compliance before any HCBS services may be billed.

All HCBS Settings

All home and community-based settings must have all of the following qualities, and such other qualities based on the needs of the individual as indicated on their person-centered plan:

1. The setting is integrated in and supported full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitively integrated settings, 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.
2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
3. The setting ensures the individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
4. The setting optimizes, but does not regiment, individual inititave4, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact.
5. The setting facilitates individual choice regarding services and supports, and who provides them.

Heightened Scrutiny Overview

As the State reviewed each distinct setting/address, settings were sorted into one of five categories. These included:

- The setting meets the HCBS characteristics and is compliant.
- The setting does not currently meet HCBS characteristics but intends to become compliant.
- The setting cannot meet the HCBS characteristics.
- The setting is presumptively institutional and is determined incompatible with HCBS.
- Settings that are Intermediate Care Facilities for Individual with Intellectual Disabilities (ICFs/IID), Institutions for Mental Disease (IMD), Nursing Facility (NF) or Hospitals do not provide HCBS and were not subject to transition.

The State of West Virginia worked with Waiver Providers to monitor their plans to come into compliance. If a setting is unable or unwilling to become compliant with remediation, as determined by on-site review of the setting, then the state will initiate the process for resolution of beneficiary concerns when in a setting that will not be compliant.

Some settings may be presumptively non-HCBS settings that isolate and these are described below:

- Settings that are located in a building that is also a publicly or privately-operated facility that provides inpatient institutional support treatment,

- Settings that are located in a building on the grounds of, or immediately adjacent to, a public institution, or
- Any other settings that have the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS, including:

    i. Where members have limited, if any, opportunities for interaction in and with the broader community, including with individuals not receiving Medicaid funded HCBS
    ii. Where the setting restricts member choice to receive services or to engage in activities outside of the setting
    iii. Where the setting is physically located separate and apart from the broader community and does not facilitate member opportunity to access the broader community and participate in community services, consistent with the member's person-centered service plan

These settings will be subject to the heightened scrutiny process. These are those settings that the state has determined are presumed institutional and that the state has determined have or will overcome the institutional presumption and comply with the settings criteria by the end of the transition period. In such cases, the setting would be submitted to CMS for a heightened scrutiny review. Evidence compiled by the State will accompany this submission. This evidence will include review documents, stakeholder interviews and comments and other evidence as necessary.

At present there are no such determined settings. West Virginia does not have any Waiver settings that are in a building that provides inpatient institutional treatment. West Virginia does not have any Waiver settings on the grounds of, or adjacent to, a public institution. All settings where Waiver services are provided have been evaluated through the Setting Review Process for each respective Waiver and all provide integration into the broader community. Data analysis from these evaluations can be viewed in the following link: https://dhhr.wv.gov/bms/Programs/WaiverPrograms/WVSWTP/Pages/default.aspx

WV will be adding all settings that provide services to more than 4 members to their heightened scrutiny process.

Transition of Members Overview

When a case manager or BMS' designee discovers a setting that no longer meets the standards of the Integrated Settings Rule, the case manager will work with the provider to develop a remediation plan within 30 days of this discovery. This plan may include transfer to another setting that complies. The provider will have 30 additional days to complete the remediation plan and the case manager will have an additional 30 days to make a visit to the setting to ensure the plan is completed. If, after this 90-day total period, the setting is not in compliance, then it shall be determined that the setting does not meet the characteristics necessary for HCBS and remediation efforts have been unsuccessful. At this point, the member will be dis-enrolled from the Medicaid program and the setting will

be removed from the HCBS program. Notification to the provider will be by certified mail as well as electronically. The provider is responsible for notification of members, with all correspondence or contacts copied to the Bureau for Medical Services.

BMS will also notify the individual members five working days after the provider notification, to assure that all stakeholders are notified of the dis-enrollment. This Information will include material on transition assistance and extensions and will be provided through 1) the specific time frame letter sent to each member by letter and 2) through the general informational meetings for members as noted below.

While the transitions of members to other providers or settings will begin as soon as the provider is notified, the provider will have 90 calendar days from the date of the notification to assist individuals to transition to other services and/or settings that do comply with the Rule. The Provider will have 10 calendar days from the date of its notification of disenrollment to notify all participants of the disenrollment and actions the provider will take to ensure person centered planning. BMS will be copied on all provider to member correspondence. The Operating Agency or Utilization Management company will also notify the member within 10 calendar days of the date of notification.

Individuals may remain at the setting, but HCBS services may not be billed for that individual. Individual team meetings will be held and the individual and their legal representative (if applicable) will make the final choice of available settings/sites. Provider disenrollment will occur at the end of the 45 days or when all members are successfully transitioned.

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

BMS shall be copied on all correspondence with members and/or families.

Members will also be encouraged to call BMS should they have any questions with BMS contact information made available to all affected members at Critical Juncture meetings and on the BMS website.

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. Requests should be made through phone, email or letter. In isolated instances, BMS may extend the 90-day transition period for an individual member to assure that there is no interruption of services to the individual member. It is anticipated that approximately 10% of members in an affected setting would have need of some mode of direct intervention from BMS.

This procedure would also apply to a provider which concurs with the setting review that the site is not HCBS compliant.

Thus far, no sites have been disenrolled from any of the Waiver programs and no members have been transitioned to other providers or discharged from the program.