West Virginia Department of Health and Human Resources' Bureau for Medical Services Intellectual/Developmental Disabilities Waiver (IDDW)

Home and Community-Based Settings (HCBS) Rule Overview

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

Agenda

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Introduction

HCBS Final Rule

- In March 2014, the Centers for Medicare and Medicaid Services'(CMS) HCBS Integrated Settings Final Rule went into effect.
- CMS is the federal entity that approves and monitors state-approved waiver programs; states are required to be in full compliance with the final rule by March 17, 2022.
- The intent of the HCBS Final Rule is "that individuals receiving Medicaid-funded HCBS have the opportunity to receive these services in a manner that protects individual choice and promotes community integration."

HCBS Requirements

Any residential or non-residential setting where individuals live and/or receive HCBS must have the following five qualities by March 2022:

1. Must be integrated in and fully support full access of individuals to the greater community.
2. Must be selected by the individual from setting options including non-disability specific settings and options for a private unit in a residential setting.
3. Must ensure an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.
4. Must optimize individual initiative, autonomy and independence in making life choices including, but not limited to, daily activities, physical environment and with whom to interact.
5. Facilitates individual choice regarding services and supports and who provides them.

Residential vs. Non-Residential Settings

Residential Settings

Residential settings that are subject to additional requirements include:

- Any setting that is provider-owned, leased or controlled; and
- Specific physical places owned, co-owned, and/or operated by a provider of HCBS.

Additional requirements are intended to ensure tenant protections, privacy and autonomy for individuals receiving HCBS who do not reside in their own private (family) home.

- Bureau for Medical Services (BMS) will provide 'sample' template leases, written agreements or addendums to support providers in documenting protections and appeals comparable to those provided under West Virginia Landlord Tenant Law.
- Written language will describe the required environment to comply with such as locked doors and use of common areas.

Non-Residential Settings

Non-residential settings (licensed sites only) include the following:

- Facility-Based Day Habilitation (FBDH) settings.
- Pre-vocational settings.
- Job development settings.
- Supported employment settings.

Non-residential settings are considered integrated when two occurrences transpire:

- Individuals go into the greater community and co-mingle with the general population; and
- The setting is open to the general population so individuals co-mingle with the greater population at the facility.

Non-Residential Settings (Cont.)

- Supported employment and prevocational services may be furnished as expanded habilitation services.
- IDDW funding is not available for the provision of vocational services delivered in facility-based or sheltered work settings, where individuals are supervised for the primary purpose of producing goods or performing services.

Non-HCBS Settings

Settings that are **not** HCBS and cannot meet the integrated site rule are specified in the Final Rule and include:

- Nursing facility.
- Institution for mental disease.
- Intermediate care facility for individuals with intellectual disabilities.
- Hospital.
- Other locations that have qualities of an institutional setting.

Locations that have qualities of institutional settings cannot provide HCBS.

- Any setting that is located in a building that is also a publicly or privately operated facility and provides inpatient institutional treatment, or in a building on the grounds of or immediately adjacent to a public institution.

Integrated Rule

Integrated Rule

Integrated settings have the following qualities:

- Individuals should participate regularly in typical community life activities outside of the setting.
  - Activities should include and be open to the greater community rather than only those organized by the provider agency specifically for a group of individuals with disabilities and paid staff.
  - Activities should foster relationships with community members unaffiliated with the setting.
- Services and activities should engage with the broader community.

Isolated Settings

Settings with the effect of isolating individuals from the broader community include the following characteristics:

- Settings designed specifically for people with disabilities;
- Individuals in the setting are primarily/exclusively people with disabilities and staff providing services; and/or
- People in the setting have limited to no interaction with the broader community.

Settings with the effect of isolating individuals are not considered integrated.

Age-Appropriateness

Age-Appropriateness

In order for an item or activity to be considered age-appropriate, it must be suitable for individuals of a particular age or age group.

- Learning and development are advanced when individuals are challenged and given opportunities to practice skills using age-appropriate tools and resources.
- Lack of exposure to age-appropriate experiences is likely to prevent the person from gaining the necessary skills to move forward in his or her development.
- Pursuing meaningful activities and being a part of the community leads to continual, fulfilling relationships which offer mutual respect.

Age-Appropriateness (Cont.)

- Kindergarten and elementary school books, workbooks and supplies should **NOT** be used to teach basic skills to adults.
- Resources devoted to providing age-appropriate tools for teaching adults can be found in catalogs and on websites.
- Videos are permitted, if they are age-appropriate. Animated videos may be geared towards multiple groups. Videos that are geared only toward children are not appropriate for adults.
  - Examples: *Peppa Pig* and *Mickey Mouse* videos are not appropriate.

Age-Appropriateness (Cont.)

- Treat members with respect and dignity as we are all human beings with the same rights and feelings.
- Age-appropriateness should be incorporated in all aspects of the environment including procedures, experiences and activities.
- Continually viewing and treating individuals as children suppresses their ability to reach their full potential.
- Demonstrations of what is **NOT** age-appropriate include:
  - Collecting items such as dolls, model cars, stamps, etc. is done by many adults, however, carrying these items into the community or workplace is not age-appropriate.
  - Adults using bibs is not age-appropriate as bibs are not generally used by adults.

Age-Appropriateness (Cont.)

When discussing age-appropriateness, remember:

- The requirement does not mean that the individual must participate in only age-appropriate activities, but, in order to bill West Virginia Medicaid, services must be provided in an age-appropriate manner.
- Any services provided and funded by West Virginia Medicaid must be administered in an age-appropriate manner using age-appropriate materials and resources.

Person-Centered Planning

Person-Centered Planning

- Person-centered planning is a process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her life, not on the systems that may or may not be available.
- Person-centered planning is about the person, not their deficiencies, and is individualized to the person receiving services.

Person-Centered Planning (Cont.)

Person-centered planning includes:

- Choice
- Preference
- Individual needs
- Cultural considerations

Person-centered planning ensures:

- Health and welfare
- Some control over one's own life

Person-centered planning identifies:

- Personal strengths
- Self-determination

Person-centered planning is based on:

- Ability and needs
- Building on a foundation

Person-Centered Planning (Cont.)

- CMS specifies that service planning for participants in Medicaid HCBS programs, under section 1915(c) and 1915(i) of the Act, must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals.
- The person-centered planning process must be directed by the individual with long-term support needs and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process.
- Minimum requirements for person-centered plans developed through this process must result in a person-centered plan with individually identified goals and preferences.
  - This planning process and the developed person-centered service plan will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

Person-Centered Planning (Cont.)

Person-centered planning shifts the focus from the agency to the person.

- **Don't ask:**
  - "What can the agency provide?"
  - "When can we provide the service?"

- **Do ask:**
  - "What does the person need?"
  - "What does the person prefer?"

Person-Centered Planning (Cont.)

Person-centered planning should do the following:

- Identify a specific and individualized assessed need;
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan;
- Document less intrusive methods of meeting the need that have been tried but did not work;
- Include a clear description of the condition that is directly proportionate to the specific assessed need;
- Include regular collection and review of data to measure the ongoing effectiveness of the modification;
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
- Include the informed consent of the individual; and
- Include an assurance that interventions and supports will cause no harm to the individual.

HCBS Compliance, Process and Protocol

Process and Protocol

- All identified HCBS will have an initial assessment and be provided either a Statement of Compliance Notification or a Statement of Deficiencies.
- Providers with deficiencies are required to submit a Plan of Compliance (POC) within two weeks of receiving the Statement of Deficiencies.
  - Once the POC is approved, BMS will return unannounced for a follow-up assessment on or after the date specified on the POC.
  - If all deficiencies have been corrected, a Statement of Compliance Notification will be granted.
  - If deficiencies have not been corrected, providers will be given at least 90 days to correct deficiencies and come into compliance.
  - BMS will assist providers in either becoming compliant or being terminated as a provider of HCBS if they are unable to become compliant.
  - If the deficiencies continue, the transition phase will begin.

Transition Phase

If a review determines that a setting does not meet the characteristics necessary for HCBS, the provider setting will be disenrolled from the West Virginia Medicaid program.

- Notification to the provider will be sent by certified and electronic mail.
- The provider and/or service coordinator are responsible for the timely notification of members, with all correspondence or contacts copied to BMS.
- The provider will have 10 calendar days from the date of notification of disenrollment to alert all participants of the disenrollment and actions the provider will take to ensure person-centered planning.
- The provider will 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.

Transition Phase (Cont.)

During the transition phase, BMS will work with providers to assist in ensuring persons receiving services are provided opportunities for choice regarding the transition.

- Should an individual member request assistance beyond what is 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 60-day transition period for an individual member.

Transition Phase (Cont.)

- While the transition of members to other providers or settings will begin once the provider is notified, the provider will have 60 calendar days from the date of the notification to assist individuals with transitioning to other providers/settings.
- Within 30 working days of the date of notification, the provider will submit to BMS an agency transition plan. The plan will list the following:
  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 how and where the member will receive services in a compliant setting; and
  6. The date of the change of provider/setting.
- The provider will submit updates to the agency's transition plan weekly, completing items number four and six as the events occur.
- The provider will be expected to update BMS continually until all transitions are complete.

Ongoing Actions

- Analysis:
  - Using same hypotheses.
  - Using additional hypotheses identified by the Quality Improvement Advisory (QIA) Subcommittee.
- Heightened scrutiny.
- Training based on identified needs/data.

Questions and Answers

Contact

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