VERMONT

Vermont's Plan to Comply with New Federal

Home and Community-Based Services Requirements

Provider Questions and Answers

This Question and Answer document provides an overview of the requirements from the final regulations for Home and Community-Based Services (HCBS), published by the federal Centers for Medicare and Medicaid Services (CMS). The final regulations require HCBS Waiver settings to comply with them by March 17, 2024. The new regulations are located at 42 CFR 441.301(c)(4), (5) and 441.710(a)(1), (2). Vermont's plan for complying with these regulations is available at the following web address:
http://dvha.vermont.gov/global-commitment-to-health/comprehensive-quality-strategy

1. What are the new federal HCBS rules, and what is the Statewide Transition Plan?

The new federal HCBS rules apply to Medicaid HCBS Waiver settings. The rules are designed to enhance the quality of home and community-based services, provide additional protections to HCBS program participants, and ensure that individuals receiving services through HCBS programs have full access to the benefits of community living. (The rules state requirements for HCBS settings, and they grant states and settings until March 17, 2024, to comply.) Sites that do not comply by that date would be barred by federal law from participating in an HCBS Medicaid waiver program.

In response to these new federal rules, Vermont developed a Comprehensive Quality Strategy Plan, available at the above link, to show how Vermont will help providers meet the new federal HCBS rules. The state kicked off the plan by trying to get a better understanding of where the sites stand in relation to the new rules through a self-assessment survey. Vermont will evaluate and categorize each site based on the survey results, as explained in Question 3 below. After categorization, some sites will receive an on-site validation visit and a remediation plan, if needed, to reach full compliance. This is explained further in Questions 4, Question 5 and Question 6. Generally, sites can expect this on-site process to be similar to their existing regular Quality Service Reviews. After the on-site visit, many sites may need to make some changes in order to reach full compliance. The State plans to continue working with providers during the transition period to help them reach compliance by March 17, 2022. The new federal rules will become one of the things the State looks for in its routine monitoring checks.

2. To whom do the rules apply?

This rule applies to all agencies, residential and non-residential, that provide Medicaid HCBS.

3. I have heard that the State has divided its providers into categories. What does the category classification mean to me?

To determine whether HCBS providers already comply with the federal rule or whether they need to make changes, Vermont asked its HCBS providers to complete a self-assessment survey. These surveys helped divide all providers into three different categories:

1. Settings that fully align with the federal requirements;
2. Settings that do not comply with the federal requirements but may comply with modifications; and
3. Settings that are presumably not home and community-based (i.e., are presumed to be institutional), but for which the State may provide justification/evidence through the federal heightened scrutiny process to show that the settings do not have the characteristics of an institution and do have the qualities of home and community-based settings.

The categorization itself will not lead to any action or decision on whether a setting complies with the federal rule; it will help establish the method the State will use to determine whether a setting meets the federal rule.

Category 1 or 2 settings will be asked to be sure they comply by the March 17, 2022 deadline. Those settings are likely to have to make minor changes (or no changes at all for Category 1) to show that they are compliant. Those sites may be asked to send the State a letter or other documentation so that the State knows they have made any changes needed for compliance, as explained in Question 7.

Category 3 settings presumed to be institutional. As with Category 2, settings that fall into Category 3 will not be shut down automatically. Instead, Category 3 settings must be approved through the federal heightened scrutiny process (described in Question 8) in order to continue to participate in Vermont's Medicaid's HCBS programs.

4. Will I receive an on-site visit as part of the assessment process?

Federal CMS requires the State to "validate" the results of its provider surveys by having on-site visits.

The State expects to begin this process by publishing a list of the sites it has placed in Category 3(to the extent it can do so without violating privacy interests) to get public comment on how those settings were categorized. The State's on-site reviewers will use any public input to help create the results for on-site visits.

For Category 1 and 2 settings, federal CMS requires the State to do on-site visits to a "statistically valid sample" of settings. State reviewers will make their work, interviews, and inspections for this plan fit into the work they normally do to monitor settings.

All settings that have been categorized as Category 3 can expect an on-site visit. This process is further explained in Question 5.

This survey validation process will happen only one time. Once the surveys have been validated, settings' compliance with the new federal rule will be monitored on an ongoing basis as part of the State's normal review process. Any issues of non-compliance in future Quality Service Reviews will be addressed as part of the standard QSR process.

5. What can we expect in an on-site visit?

DAIL will make the on-site visit align as much as possible with existing monitoring. The on-site visits will include interaction with individual clients, record reviews, meetings with key setting staff, and reviews of individual service plans. All on-site Quality Service Reviews will be conducted using a checklist based on published CMS guidance.

6. What types of actions should we take to prepare for an on-site visit?

Sites should prepare for the on-site visit in the same way they prepare for their existing regular Quality Service Reviews. In order to minimize the burden on providers, the State will combine the HCBS Plan on-site visit with existing State visits.

7. What types of changes will we be required to make to comply with the federal HCBS rules?

For agencies whose assessment survey and validation show only small areas of non-compliance, the setting will be asked to (1) submit documentation such as a letter describing the changes that have been made to achieve full compliance along with specific dates; and (2) demonstrate full compliance with both the claims in the letter and with the HCBS requirements.

For agencies with more substantial non-compliance with the rule, the State will require the setting to submit a corrective action plan for achieving full compliance before the effective date of the federal rule, March 17, 2022. The state will notify providers within 90-days of the site review if these letters of correction are needed.

8. We understand that redesignation reports will address the new HCBS rules. How will those reports reflect findings?

- Prior to March 2022: The redesignation reports will note if a service or site is found to be non-aligned with the new HCBS rules and indicate if the agency needs to send either a letter (minor change needed) or corrective action plan (extensive change needed) to DAIL within a 60-day time period. If part of the corrective action plan by the agency is to address new issues in individual service agreements, the QSR team will note where the agency is in the calendar when making observations. On its own, non-alignment will not be grounds for withholding designation.

- After March 2022: The redesignation reports will note if a service or site is found to be non-aligned with the HCBS rules. Corrective action plans that are needed as a result will be included with the full redesignation report and may be grounds for withholding designation.

9. What are the minimum expectations of the corrective action plan?

The corrective action plan should include short term actions to update written policies, contract wording, staff training and changes in recruitment and home provider selection strategies to address the protections of the new rules. These include but are not limited to:

- The individual has privacy in their home including lockable doors, choice of roommates and freedom to furnish or decorate;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The person's home is physically accessible, and is:
    - Integrated in and supports full access to the greater community;
    - Is selected by the individual from among setting options;
    - Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
    - Optimizes autonomy and independence in making life choices; and
    - Facilitates choice regarding services and who provides them.

10. How will the state expect compliance with the need for residency agreements?

The following must be included in a Residency Agreement:

- Reasons for which an individual may be asked to move out
- Minimum of 30-day notification for exit notices
- Notification of the individual's appeal rights when they are asked to move out
- Conditions when a provider may give less than a 30-day notice
- Signature of the individual (or the individual's legal representative)

If a person lives in a home that is owned by someone else and is receiving services funded through HCBS Medicaid, then they must have this protection from an agency with authority to provide the protections. Therefore, this agreement can be between a person and their designated agency or specialized service agency.

11. What if there is a need to have conditions in place for someone's safety that may compromise the protections outlined in the new HCBS rules?

The federal rules allow individually-based limitations to the specific setting rules in certain circumstances. The only rule requirements that can potentially be limited on an individual basis in a provider-owned, controlled, or operated setting are:

- Each individual has privacy in their bedroom or living unit:
    - Bedroom or living units have doors lockable by the individual, with only appropriate staff having keys to doors as needed.
- Individuals sharing bedrooms or units have a choice of roommates in that setting.

- Individuals have the freedom to furnish and decorate bedroom or living unit within the lease or other agreement.
- Individuals have the freedom and support to control their own schedules and activities.
- Individuals have freedom and support to access to food at any time.
- Individuals are able to have visitors of their choice at any time.

12. What must be in the modification plan?

For those instances where appropriate limitations have been determined and justified in the person-centered plan consistent with § 42 CFR section 442.301(c)(4) and 441.530 (a)(1)(vi)(F), the following must be documented:

- 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.
- Include an assurance that interventions and supports will cause no harm to the individual. (i.e. in accordance with all guidelines and protections included in the Behavior Support Guidelines)

13. What principles should be applied when considering individually-based limitations?

It is expected that support providers will apply the principle of presumed competence for each of the six areas. It is also expected that the assumptions used in supported decision making will be explored. Specifically, this means that the freedoms described in the settings rule involve decision making and that it is natural for someone to seek others of their choosing to help in making various decisions and that decision making itself is an acquired skill. It is also presumed that a bad decision in and of itself is not evidence that someone should be denied the opportunity to make decisions in the future.

14. What is the "Heightened Scrutiny" process?

The new federal rule says that certain types of settings, such as

- Farmstead intentional communities,
- Settings that are designed specifically for people with disabilities, or for people with a certain type of disability.

These must be presumed to be institutional. That is, the federal rule requires Vermont to assume these sites do not comply. Those sites will be placed in Category 3, described in Question 3.

However, the federal rule provides a process that lets the State argue that a Category 3 site should be able to stay on as a Medicaid HCBS provider. This process is called the "heightened scrutiny process."

Under that process, the State may present evidence to federal CMS that a site that has been presumed to be institutional is home or community-based. The federal government has the final authority to decide whether a provider is a community or institutional setting. The State makes the initial determination on whether to challenge the presumption and seek federal heightened scrutiny review.

To make this determination, the State will form a Personal Outcome Assessment Team. Members of the team will include state Quality Service Review (QSR) personnel, representatives from the agency operating the site, employees from community agencies and self-advocates. Team members will receive training and credentialing from the Council on Quality & Leadership in the use of Personal Outcome Measures. Interviews will be conducted with the people who experience the setting. The findings of the assessment team will be evaluated by the Department of Disability, Aging & Community Living (DAIL) who will make the final determination on whether to apply to CMS for heightened scrutiny and consideration of continued funding with HCBS Medicaid.

15. What is the timeline for this project?

The State has already taken several steps towards complying with the new federal rule, including development of a Comprehensive Quality Strategy plan and the survey process of HCBS settings. The State expects to complete all of the on-site visits as well as initial Heightened Scrutiny recommendations for this process by the end of Fiscal Year 2018. Any applications to CMS for heightened scrutiny will be available for public notice and comment prior to submission to CMS. Additionally, the State will modify review documents, DD Act rules, and provider agreements. While the State will be working towards several important deadlines, everything must be completed by March 17, 2022.

16. Where can I find more information?

Final HCBS Regulation: https://www.federalregister.gov/documents/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waivers-provider

HCBS Training by CMS: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/longterm-services-and-supports/home-and-community-based-services/hcbs-training.html

Exploratory Questions to Assist States in Assessment of Residential Settings - https://www.medicaid.gov/medicaid/hcbs/downloads/exploratory-questions-re-settings-characteristics.pdf

Keeping the Promise: Self Advocates Defining the Meaning of Community Living – https://autisticadvocacy.org/wp-content/uploads/2012/02/KeepingthePromise-SelfAdvocatesDefiningtheMeaningofCommunity.pdf