TRANSITION PLAN

For Complying with the CMS Home- and Community-Based Services Medicaid Rule

FOR THE STATE OF WEST VIRGINIA

The CMS-approved West Virginia transition plan can be found at:
https://www.medicaid.gov/sites/default/files/2023-05/wv-appvd-plan.pdf

The CMS-approved West Virginia Corrective Action Plan (CAP) can be found at:
https://www.medicaid.gov/sites/default/files/2023-09/wv-appvd-cap.pdf

SITE-SPECIFIC ASSESSMENTS

The Centers for Medicare & Medicaid Services (CMS) required states to conduct validated, site-specific assessments of all provider-owned or controlled settings.

Types of Settings/ Residents and Funding Authorities	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. • The Aged and Disabled Waiver (ADW) program serves individuals over the age of 18 who choose home and community-based services as a long-term care alternative to nursing home placement. • The Intellectual and Developmental Disabilities Waiver (IDDW) program is West Virginia's home and community-based services program for individuals with intellectual and/or developmental disabilities over the age of 3 and is an alternative to Intermediate Care Facilities for Individuals with Intellectual Disabilities. The IDDW program provides services based on the member's annual functional assessment and assigned individualized budget in natural settings including the member's home and public locations in the member's community. • The Traumatic Brain Injury Waiver Program (TBIWP) is a long-term care alternative which provides services that enable individuals over the age of 3 to live at home rather than receiving nursing facility care.
Compliant/Non-Compliant	As of October 18, 2022: Compliant: • IDDW Facility-Based Day Habilitation: 57 • IDDW ISS Serving 1-3 People: 55 • IDDW Group Home Serving 4+ people: 13 • IDDW Specialized Family Care Homes: 63 • ADW Private Homes: 9 May be compliant with remediation: • IDDW ISS Serving 1-3 people: 304

	• IDDW Private Homes: 4,482 • ADW Private Homes: 7,382 Non-Compliant: • No settings were determined to be non-compliant. **NOTE**: West Virginia received approval of its corrective action plan (CAP) on September 8, 2023. The CAP provides updated timeframes for completion of site-specific assessments and the heightened scrutiny review process. Therefore, setting classifications in the STP may be out of date. The updated CAP sets December 31, 2023, as the completion date to complete validation of provider remediation via on-site visits to identified providers including service plan reviews. Complete disenrollment of non-compliant settings and relocation of participants to compliant HCB settings or secure alternative funding, if applicable, will take place by March 31, 2024.
Reasons for Non-Compliance	Specific reasons for non-compliance not included in plan.
Transition plans	A review of West Virigina regulations and supporting documents across the three waiver programs with residential and non-residential settings was conducted. Operating agencies implemented the HCBS setting evaluation tool to conduct setting reviews of providers of HCBS. Site-specific assessments took place to choose which settings need to be submitted to CMS for heightened scrutiny. The outcomes of the assessment will be used to identify existing settings as well as potential new settings in development that may not meet the requirements of the rule will be incorporated. For settings that are presumed institutional, evidence and information on settings will be gathered before submitting to CMS. For settings found not in compliance by CMS, member, guardians, case managers, and facility support staff will be notified that the setting is not in compliance and that relocation or alternate funding sources are required.

SETTINGS PRESUMED INSTITUTIONAL

CMS presumes some settings have qualities that are institutional or isolating in nature. These settings must go through a heightened scrutiny review by CMS.
CMS presumes the following types of settings have institutional or isolating qualities:

- *Category 1: Located in a hospital, nursing facility, or other institutional setting.*
- *Category 2: Located adjacent to a public hospital, nursing facility, or other institutional setting.*
- *Category 3: Have the effect of isolating people from the broader community.*

% Presumed Institutional (No. of Residents Affected)	No settings were presumed institutional.
Type of Setting/Residents	N/A
Reason for Presumption	N/A

Heightened Scrutiny Process	For any setting presumed institutional, 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. Should the setting be determined non-compliant, participants will be relocated to a setting in compliance.

NON-COMPLIANCE COMMUNICATION

States must describe their process for notifying residents when a setting is unwilling or unable to comply with the rule, and supporting residents to select and transition to a new setting.

% Cannot/Will Not Comply (No. of Residents Affected)	No settings cannot/will not comply.
Type of Setting/Residents	N/A
Reason for Determination	N/A
Communication Strategy	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 of the member 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 setting visit 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 setting will be dis-enrolled from the Medicaid 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.
Assistance to Residents?	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. Should a member choose to stay in the setting upon being notified of the setting's dis-enrollment from Medicaid, the member would then be dis-enrolled from receiving HCBS given that the setting would no longer be part of the Medicaid program. Alternatively, should a member wish to continue receiving HCBS, it is BMS' responsibility to work with the member and help the member find and relocate to an appropriate enrolled setting. 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.

ONGOING MONITORING

States must describe their planned process for ensuring ongoing compliance with the rule.

Monitoring Procedures	• All members and settings for all of the waiver programs will be reviewed annually. • The ADW program monitors conflict of interest by monitoring providers initially and on an ongoing basis in the Continuing Certification process • 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.
Quality Assurance Measures	• Update the member handbooks for the ADW and TBIW programs to match new CMS person centered requirements. • A Quality Improvement/Quality Assurance council meets quarterly. • Develop or revise on-site monitoring tools to meet compliance (e.g., opportunities for “informed” choice, choice of roommate and setting, freedom from coercion). • Include outcomes measures on settings within the current 1915c waiver quality improvement system. • Build community character indicators within the six CMS Quality Assurances reviewed through the provider self-review process. • Expand upon the Quality Improvement Advisory council to include responsibility to monitor data associated with meeting transition plan action items and outcomes data. Establish a baseline of outcomes data and measure throughout transition plan implementation. • Crosswalk quality assurance tools against settings characteristics and person-centered planning requirements to identify areas of potential enhancement to the quality improvement system.