Missouri Department of Mental Health (DMH)
Division of Developmental Disabilities (DD)
Federally Mandated Home and Community-Based Services (HCBS) Settings Transition Plan

Questions and Answers

(All new information has been added in red font)

Home and Community-Based Services (HCBS) Settings Rule: State-wide Transition Planning

A final rule came out on March 17, 2014 from the Centers for Medicare & Medicaid Services (CMS). It is called the HCBS Settings Rule. In Missouri, this affects all 1915 (c) waiver programs. A 1915(c) waiver is a program that uses Medicaid dollars to provide services to a target group of people who would otherwise require services in an institution. The Missouri 1915(c) waivers are:

- DMH Waivers:
  - Autism Waiver
  - Comprehensive Waiver
  - Missouri Children with Developmental Disabilities Waiver
  - Partnership for Hope Waiver
  - Support Waiver
- Department of Health and Senior Services (DHSS) Waivers:
  - Adult Day Care Waiver
  - Aged and Disabled Waiver
  - AIDS Waiver
  - Independent Living Waiver
  - Medically Fragile Adult Waiver

Q: What is the HCBS Rule about?

The rule says that individuals receiving waiver services should be supported in their choices to be a part of their community like everyone else.

Q: What does that mean to me?

If you are an individual who receives waiver services, it means that you have the right to be supported with respect and in a very person-centered way so that you make decisions about how, when and where you get your services. It also means that you should have the opportunity to pursue employment and be involved in your community, coming and going where and when you want.

Q: How do I provide feedback?

You can also complete participant surveys on an annual basis to help the state understand where improvements are needed. This survey may be completed anonymously. Additional methods of communicating with you include an FAQ document, DD email "dings", and an updated HCBS website, all of which may be found at http://dmh.mo.gov/dd/hcbs.html.

Q: What does it mean to providers?

If you are a provider of waiver services, it means that you will be subject to new and enhanced policies that require providers to comply with the rule. It may mean that you will need to modify and adopt your own policies and provide training to assure your staff understands the expectations of the rule. It also means you must participate in provider surveys of how you currently deliver services as part of the final rule.

Q: What Is the Transition Plan?

States have to develop a Transition Plan to describe how they are going to determine if their HCBS services are compliant with the final rule. The Transition Plan requires states to assess HCB service settings, and to work with individuals and providers to determine remediation strategies to fix the areas that don't comply. This is the first time CMS has put in regulation a description of HCBS in this way. Because it is new, states are allowed some time to come into compliance. States must be in compliance by March 17, 2019.

Q: What is the Survey?

The Transition Plan outlines how the state will move toward and ultimately achieve compliance with the new HCBS Settings Rule. To describe the process, the state must ***assess*** where we are to compare where we are going. The state will require all providers to conduct a self-assessment survey annually. The state will invite individuals to complete their own survey, too.

The surveys will ask questions about individuals' experiences based on the quality characteristics of how CMS has defined home- and community-based services such as:

- Does the individual have rental rights?
- Does the individual have privacy where he/she sleeps and a private space, such as the door can be locked and the individual, not the staff, has the key to the room?
- Did the individual have a choice of roommates?
- Does the individual have the freedom to furnish and decorate his/her residence to their liking?
- Does the individual have freedom and support to control his/her schedules and activities?
- Does the individual have the freedom to choose meals and have access to food any time?
- Does or may the individual entertain visitors at his/her choosing?
- Has the individual been affirmed of their rights to explore and pursue competitive employment in the community?

Q. It is very important that persons with disabilities and families feel they have a voice in the overall process.

Individuals with disabilities and their families do have a voice in this process. The state drafted a state-wide transition plan on December 29, 2014 and is collecting public comments for 30 days. You can find the draft transition plan at http://dss.mo.gov/mhd/ or any of the Department of Mental Health Regional Offices. DD will also request participants to complete an annual survey to share their experiences. This survey may be completed anonymously. Additional methods of communicating with you include an FAQ document, DD email "dings", and an updated HCBS website, all of which may be found at http://dmh.mo.gov/dd/hcbs.htm.

Q: What should I do about this?
Learn more! Get involved in Missouri's self-assessment surveys and Transition Planning process. You can find information regarding the HCBS rule and Transition Plan at http://dmh.mo.gov/dd/hcbs.htm.

Q. I have heard people will lose their services with this proposed change.
No provider will be forced to close and no funding cuts are being proposed. An individual's level of services should not change or be reduced. Supports will continue to be based upon individual needs identified in their plan. If a person has an employment goal in their individual plan, the state must ensure continued supports. The Support Coordinator is responsible for monitoring the plan goals and services to ensure this is occurring for the individual.

The intent of the rule change is to provide people with disabilities the full range of opportunities that people without disabilities can access. All providers of HCBS waiver services will have the opportunity to change and expand the supports they offer to meet federal expectations for more community-based options.

Q. What resources are available to make this easy to understand?

You will find easy to understand informational fliers on the DMH Division of Developmental Disabilities HCBS webpage at http://dmh.mo.gov/dd/hcbs.htm. The fliers included in this webpage explain the final rule in simple language to assist families in understanding the changes occurring.

Q. How does the HCBS final rule support individuals so that they can live at home and in their own communities?

The intention of the HCBS final rule is:

- So individuals can live at home in their communities
- Can work and have meaningful experiences
- Build upon and encourage strengths
- Build social connections
- Teach social skills

It is designed to improve the quality of services for individuals receiving HCBS and community services. Integration is a key component.

Q. I have heard the proposed change will make providers shut down.
Missouri's plan gives several years plus technical support to providers to help them meet this federally required change. CMS requires that all service settings are compliant by March 17, 2019.

Individuals will not lose their supports, and Missouri's plan gives assurances for individuals in this regard.

Q. I have heard that I won't get to keep my roommate.
The rule requires you to have a choice of your roommate or to not have a roommate, as it fits within your budget.

Q. I have heard that multiple homes on a street receiving Independent Supported Living (ISL) services will not meet the requirements of the final rule.
This does not mean that your service will not meet the requirements of the rule, but it will mean that it will fall under what Centers for Medicare and Medicaid Services (CMS) refers to as a "Heightened Scrutiny" setting. "Heightened Scrutiny" settings mean that the location appears to have the effect of isolating individuals from the broader community. CMS will presume these settings to have the qualities of an institution unless they determine through "heightened scrutiny" assessment that the setting actually does have the qualities of a home - and community-based setting, and not an institution. The state will be assessing the "heightened scrutiny" service settings and will submit to CMS for approval the information supporting that the service setting meets the requirements of the final rule.

Q. I have heard that I will have to move to an urban area.
You are not required to move to an urban area. It is a requirement that you have the same choices and access to the community as others who do not have disabilities.

Q: I have heard that because of the final rule people will be forced to sit at home and do nothing.
This is not accurate. The intent of the rule change is to provide people with disabilities the full range of opportunities that people without disabilities can access.

Q: During a recent presentation by ANCOR to MARF, it was mentioned that HCBS funding is available for non-residential services (such as day program) ONLY for those whose residential situation meets the rule standards. Some providers get a large number of our individuals from Residential Care Facilities. While these are not "waivered" residential programs, they do not also meet the rule. Would that make them ineligible to receive services (day hab)?

CMS has indicated that Residential Care Facilities will need to be in compliance with the rule if individuals living there receive any HCBS waiver services. Compliance will be determined based on the opportunities and experiences of the individuals receiving HCB waiver services, according to the standards set in the HCBS rule, including but not limited to whether the individual has selected the setting from all available choices; whether the individual's rights to privacy, dignity and respect, and freedom from coercion are protected; whether the individual has choice in services

and providers; whether the setting is integrated in and facilitates the individuals access to the greater community. The state is currently researching this CMS guidance for the impact and authority.

Q. Will ALL providers be required to do annual self-assessments or just those that provide the 3 services currently being assessed?

Provider self-assessments will be posted January 1st and providers will be encouraged to complete the provider self-assessment by April 1, with results compiled by May 15.

Q. Does the individual's person-centered service plan document the individual's resources were considered when given options for residential room and board? ***What does this mean as far as what information is being requested to be present in the plan?***

At initial placement and annually thereafter, the ISP should document that the planning team reviewed with the individual their benefits, how they're being utilized and if any changes are necessary, what those options might be. For example, if an individual is looking to move to a new location, what discussions have occurred to identify resources available?

Q. Does the individual's person-centered service plan document the individual was given the information necessary to make an informed choice regarding housing? ***If someone has a guardian how do we offer choice on housing? Also what type of information is being required for this in the plan because putting a statement in the plan that the "individual was given information" does not seem sufficient?***

The term "individual" includes both the individual and the guardian, if appropriate. Although an individual may have a guardian, they should still be a part of the planning and discussions. At initial placement and annually thereafter, the ISP should document that the planning team reviewed housing options such as HUD vouchers, HUD housing, any housing assistance, preferences for location and type of housing desired, and if any changes are necessary, what those options might be. For example, if an individual is looking to move to a new location, what discussions have occurred to identify the housing options that are available in the community?

Q. The ISP guide does not indicate that information necessary to make informed choice regarding housing has to be in the person centered service plan but our remediation indicates it has to be in the personal plan. ***Why is this and where does it state this requirement?***

The ISP is the "guide" to all of the individuals' needs and preferences. As each individual has specific support needs. For example, if an individual has indicated they are upset when new staff appears and the individual was not notified of the staff change. This should be addressed in the ISP. This ensures the individual's support needs are noted and from there the provider can set up supports to meet the individual's needs.

As individuals have the right to choose their provider of services and change that provider at will, the ISP should document that the planning team discussed the individuals satisfaction with services and educated the individual on their ability to select a new provider and through whom they would make the request.

Q. **Have Day Service begun to receive interviews/surveys?**

Yes, day service assessments are currently taking place.

Q. How many total interviews will be completed for St. Louis?

Approximately 195 on-site assessments will be completed in the St. Louis region.

Q. Have any agencies been assessed at this time or is it still individual assessments?

On-site assessments are individually-based. Agencies will receive summaries and requests for remediation with individual assessments.

Q. May a group home have a lease agreement that is for a "bedroom" as the rest of the home is considered a common area?

Yes, as long as the individual has the same protections as individuals not receiving HCB services

Q. Are providers required to have a lease, or written agreements in effect now, or do they have until March 2019 to fully implement?

The intent of the assessments is to determine what the providers, support coordinators, guardians, and the state need to change in order to be compliant with the Federal HCBS rule by March, 2019. The remediation responses expected from providers and support coordinators is a proposed plan to embed the requirement into policies and practice, including the milestones/timelines to ensure compliance prior to March, 2019.

Q. How do providers and support coordinators ensure leases meet the HCBS requirements when landlords are reluctant to have multiple tenant or lessee names on the lease or written agreement?

Per CMS guidance dated June 26, 2015, in a provider owned or controlled setting, the state must ensure that a lease, residency agreement or other form of legally enforceable, written agreement will be in place for each waiver participant; the document must provide protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/ tenant laws.

Q. What needs to be in the lease agreement? If the provider has a lease agreement with the individual, does it need to address 30-day notice? Providers can do that to their individuals, which is very different than what landlords can do.

The lease, residency agreement or other form of written agreement must be in place for each HCBS participant in a provider-owned or controlled residential setting, and the document must provide enforceable protections that address eviction processes and appeals comparable to those provided under the jurisdiction' s landlord tenant law. The lease or written agreement needs to address the 30-day notice.

Q. Are individuals who have a guardian also required to sign the lease?

The individual and guardian should both be signing the lease when possible.

Q. Can a Targeted Case Management refer the individual to the Regional Office for anonymous complaints?

The anonymous complaint process should go through the Department of Mental Health Office of Constituent Services. The main goals of the constituent office are to ensure that constituent rights are not being violated; to review reports of abuse or neglect; and to provide useful information to constituents and family members about mental health issues.

Q. What do settings mean?

Settings are where and how an individual receives their waiver services. It means that "settings" are more about the nature and quality of an individual's experiences with the services, not only about buildings where the services are delivered. Services, programs, models, methods are all included in the definition of setting.

Q. How is choice of provider under the HCBS Rule balanced with cost? For example, an individual moves to another county and wants to keep their same day program in the previous county, which would result in an additional cost of $25,000 for the transportation.

Individuals should be encouraged to research the cost of living, housing costs, career opportunities, available services and supports (including medical, dental, etc.) and other areas of need prior to making the determination to move. The Support Coordinator may assist individuals with this by using the Missouri Values Test. The Missouri Values Test is a set of decision-making criteria for evaluating the necessity and reasonableness of services and supports that may (or may not) be purchased with state tax dollars for individuals with developmental disabilities and their families, and should be utilized. This document is found at http://dmh.mo.gov/docs/dd/f12-themissourivaluestest7-28-11.pdf

Q. How do Support Coordinators handle the situation where an individual/family says they don't need choices, because they already know who they want as a provider? Is it acceptable for the Support Coordinator to document options or choices were not wanted?

Even if an individual/family indicates they know the provider they want, the Support Coordinator must share the provider referral database with them to ensure informed choice was offered. The individual may still choose their known provider. All documentation would be included in the

Individual Support Plan. The Targeted Case Management Technical Manual will be updated to include the reference to utilizing the provider referral database with offering choice.

Q. May individuals use waivered transportation to sheltered workshop? May residential providers pick up an individual for lunch from the workshop setting and bring them back to workshop after lunch?

Waiver transportation may be utilized to sheltered workshops as specified in the ISP, if the individual is in a natural home. If they are receiving a residential service (group home, ISL, or shared living) transportation would be included as part of the residential service.

Q. How do we distinguish between individualized and group services? Are Group services HCBS compliant?

The HCBS final rule ensures that services are being provided in an individualized manner. The planning team determines the appropriate service to meet the individuals' needs. Any setting in which individuals are clustered or grouped together for the purposes of receiving HCBS must be compliant with the federal HCBS settings rule.

Q. Can agencies implement rules and restrictions across an identified group?

Restrictions or modifications that would not be permitted under the HCBS settings regulations cannot be implemented as "house rules" in any setting, regardless of the population served and must not be used for the convenience of staff.

Q, What are Licensure & Certification expectations regarding "court ordered" restrictions? Do "court ordered" restrictions have to go through the Due Process?

The HCBS rule requires all modifications/restrictions of rights to be reviewed through due process. This applies whether ordered by a court, guardian, or physician. To know whether something is restricting ones rights, the impact on the individual must be reviewed.

The guardian may have the authority to restrict many areas of the individuals life due to a court order; however the guardian, support coordinator and providers have a responsibility to the individual to ensure everyone is respecting person-centered philosophies and serving the person in a manner that respects who they are, what they prefer, likes and dislikes, as well as what is important for the person. Additionally, the provider must also agree to implement any restriction, since some providers may not be willing to impose certain restrictive interventions onto participants.

Due process is a great way for the planning team to review particular restrictions and ensure they are truly necessary and relevant. Also, it helps all parties to recognize there may be alternative ways to accomplish the same goal through a lesser restrictive intervention (supervised visits, diet

cheat days), establish the restrictions may not be permanent (timelines for review) and allows for the individual to have an external advocate involved.