

HCBS Transition Plan, Revision – Public Workshop

Transition Plan
September 2, 2015
1:00 – 3:00 pm

The State of Nevada Legislative Building
401 S. Carson St., Room 2134
Carson City, NV 89701

Video-Conference Location:

Grant Sawyer Building
210 S Valley View Blvd., Room 104
Las Vegas, NV 89101

Jennifer Frischmann (Division of Health Care Financing and Policy):

Welcome to the Public Workshop. I am the Chief of the Long Term Support Services (LTSS) unit of the Division of Health Care Financing and Policy (DHCFP). We will be discussing the revisions made to the Transition Plan as requested by the Centers for Medicare and Medicaid Services (CMS) and the processes of onsite review and heightened scrutiny. This is an informal meeting, so please ask questions and make suggestions.

Rosemary Melarkey (Aging and Disability Services Division):

I work with the Developmental Services Office of the Aging and Disability Services Division (ADSD).

Tammy Ritter (ADSD):

I work with the Home and Community Based Waiver (HCBW) programs for the Frail Elderly and the Physically Disabled at ADSD.

Leslie Bittleston (DHCFP):

I am the program specialist for HCBW at DHCFP. I will start with a brief history of the process over the last year and a half. In response to the New Rule published by CMS in January 2014, the State agencies that oversee and work with the HCBS populations and programs along with various providers, advocates and recipients worked to create the Transition Plan that was submitted to CMS in March of this year. In July, CMS responded to the Transition Plan requesting clarification of several issues. The first was public notification. The State had notified the public through a series of public workshops, provider self assessments, recipient self assessments, and posted information on the DHCFP website, but had neglected to provide CMS with a full accounting of these activities in the Transition Plan. The Plan was revised to include this information in its entirety.

The second area in which that CMS requested more information was in remedial actions. CMS requested greater detail for the identified milestones in the submitted Plan. As a result, the State has provided more detail, especially regarding on-site reviews, policy changes and regulatory agency requirements.

The Transition Plan has been revised and submitted to CMS for review as well as posted to the DHCFP website for public viewing and public comment. The first page of the revised plan is a summary of the changes that were made in the Plan, including clarity about recipient notification and education.

Rosemary Melarkey:

Developmental Services sent out a self-assessment to Residential Providers in April 2014 that garnered good response. During September, State staff will receive additional training and as they visit residential setting from October to December, they will validate the assessments. If there are concerns that a site might not fully meet the HCBS requirements, a Supervisor will be asked to conduct another visit. The goal is to work with providers to determine the best methods to meet CMS' requirements without creating an undue burden on them. If needed, Heightened Scrutiny will be requested on any sites that may not meet regulations but are valuable to the program. Regarding non-Residential Providers, CMS has not yet fully addressed the ways in which they can meet the

requirements. Regional Center staff will be working to make plans with these providers. We believe the majority of the settings already meet the New Rule.

Tammy Ritter:

ADSD has started on-site visits. We have also held two meetings in Reno with providers. Meetings will be scheduled in southern Nevada soon. As we visit various sites, we are compiling a list of questions for CMS, for example, regarding door locks and visitation.

Jennifer Frischmann:

Regarding Heightened Scrutiny, if the State of Nevada believes a setting will not meet criteria, there is a process to request CMS make a determination. However, the process is much more complicated than initially thought. We will have to interview staff and recipients, photograph the site and post our assessment on the website for a 30-day public comment period. The first site for which we will request heightened scrutiny has already been posted to the website. It is for a planned development by Opportunity Village that will be called Betty’s Village. Since it has not been built yet, the State cannot interview staff or recipients, but a detailed package has been submitted and I encourage you to submit comments regarding this potential site.

Some of the things we noticed on our initial visits to Group Homes for the Frail Elderly is that we were asking questions about whether the recipients could seek employment if they wished to – clearly this population is not going to seek employment. This is one of the things we are going to ask for clarification about from CMS: can we tailor the assessment of a site to its population? Additionally, there are legitimate issues for small businesses regarding visiting hours. Once we submit the questions to CMS, we will post them on the website and we will request public comment.

Members of the Association of Home Care Owners of Northern Nevada (AHONN) and the Residential Care Home Association of Nevada (RCHAN) submitted a position statement I will read to you

*In reference to the Final Rule from Medicaid for: **The Home and Community-Based Setting Requirements for Provider Owned or Controlled Residential Settings.***

We recognize that the central philosophy behind the rules is the culture change from institutionalized setting to a Person Centered Care. Person-centered care offers a humanistic and holistic approach to caring for someone. It incorporates not only physical considerations but also the person’s psychosocial and spiritual well-being. Person-centered care (PCC) is a philosophical approach to care that honors and respects the voice of clients and those working closest with them. It involves a continuing process of listening, trying new things, seeing how they work, and changing things in an effort to individualize care based on the person’s physical, mental, psychological and cognitive abilities.

In person-centered care the individual has the right to: Make decisions; Have an individual plan of care; Be included on the care planning team with the provider; Have their hopes, dreams and goals be central to their plan.

As a group of home care providers, we strongly support Person Centered Care through a person centered planning process and following a person-centered service plan. However, we find irony and contradiction to some of the requirements and expectations/goals, because they are not specific to the frail elderly with chronic physical and mental/cognitive deficits whom we serve. Our residents require supervised settings otherwise they would have returned to their homes or been placed in Independent Living facilities. They require assistance and protective supervision 24/7 in a family care setting. The nature of their illness is usually chronic and progressive. Our goal is to maximize their independence and function in a supported home-like environment given their advanced age, physical and cognitive limitations. We honor their privacy, dignity, individuality and choice to the extent possible.

We feel that some of the requirements, for example, lockable doors with keys, may pose fire hazard and evacuation within 4 minutes may be in jeopardy as required by the State Fire Marshal. Can you imagine scrambling for 6 individual keys to open the doors in case of fire? Another requirement we find posing health and safety risks is access to food at anytime. While we provide 3 meals and snacks in between meals and as needed, most of our residents are high risk for falls when accessing the refrigerator, pantry and kitchen cabinets by themselves. Health concerns also for residents on a special diet as well as sanitation and infection control issues. Visitors at anytime will normally be not reasonable because we have to allow them time for personal care, rest and sleep. We can accommodate generous visiting hours and special visiting arrangements within reason.

In conclusion, we feel that the HCBS requirements and rules should be tailored to the population served in order to truly individualize the plans and reflect realistic expectations and goals according to assessment of needs, physical and cognitive abilities of the person. We feel that the “one size fits all” concept does not support Person-centered nor individualized planning in a group home care setting.

There is further information regarding financial analysis and costs. The complete statement can be found on the DHCFP website.

Mark Olson (LTO Ventures):

Thank you for posting everything and the new webpage design is great. I want to see the same transparency in the provider assessment reviews that are just beginning. I think that the creation of a Transition Advisory Council to work with the State on issues such as public notice and assessment would be a positive step. I would be happy to volunteer for it.

Jennifer Frischmann:

I absolutely agree that a Transition Advisory Committee or Council is a great idea. I hope we can get wide-ranging participation from the community. We experienced some difficulties setting up the Steering Committee prior to the submission of the Transition Plan and we experienced spotty attendance at those scheduled meetings.

Ed Guthrie (Opportunity Village):

Congratulations on soliciting public comment. Community is not a place it is a group of people. Thank you for including the Olmstead definition of community in your Transition Plan. I think the goal of everyone is to preserve what people want and to expand their options where possible. I appreciate that the comments from the public workshops prior to submission of the Transition Plan sparked noticeable changes in the Plan. I was able to see the State made several changes in the Plan based on public comment. One of the milestones in the Plan is to make changes in the Medicaid Service Manuals (MSM). When and where will the public be able to offer feedback on these changes? Opportunity Village could host public meetings as a way to reach a large number of recipients and their families.

I have a few questions about specific items in the Transition Plan.

Page 3 of the Revised Transition Plan lists services that are provided in recipients’ private homes and thus meet the HCBS requirements. Why is non-emergency medical transportation in this section? Can we use non-emergency medical transportation at the same time we provide day habilitation? We would like to bill for these services concurrently. We would also like to bill for nursing services.

Page 8 identifies that Nevada contracts with non-profit organizations to provide center based services. This gives the impression it is the only type of service these organizations provide. I think the wording could be changed for clarity. There is also a requirement for quarterly reporting on this page. This is a new requirement as far as I know. Will we receive a rate adjustment to offset the paperwork requirement?

Our goal is to provide the best service possible and we are happy to work with you to that end.

Jennifer Frischmann:

Regarding the nursing services, it is an allowable service in the waiver, but the types of nursing services you are referring to are not waiver services. We are working to find ways to reimburse for this and we will keep you informed. Regarding transportation, it is non-medical transportation, not non-emergency medical transportation.

Rosemary Melarkey:

Residential providers and a few Jobs and Day Training (JDT) providers can use non-medical transportation, but it is limited. We try to utilize other supports first: friends and family, paratransit, logisticare, etc. Career planning is a new service that will be added to the waiver. It is in the Transition Plan as a placeholder. Regarding the rewording, if you want to suggest some language, we would be happy to work with you to clarify this section. Quarterly reports are already required. They are done at the IEP team meetings which are held quarterly.

Barry Gold (AARP):

HCBS settings talks about where and how, it is very focused on the providers. But the issue is providing services to recipients. Where are you getting recipient input? The State previously sent 5,000 surveys to recipients; the returned as undeliverable rate was 9% and the response rate was 21%. That leaves 70% of your recipients who have not had any input. How does the State plan to obtain input from the other 70%? How will the migration of LTSS to Managed Care impact the New Rule requirements for HCBS?

Jennifer Frischmann:

The shift has been in bringing Providers into compliance, but we need to do more outreach to recipients. Suggestions about how to get more recipient input are very welcome.

Tammy Ritter:

Recipient input is part of the heightened scrutiny process. Recipients will be interviewed during the on-site assessment process the State has just begun and look to complete by the end of December.

Jennifer Frischmann:

The discussion about the expansion of Managed Care for Medicaid is in the very early stages. We are researching every possibility associated with a potential move to Managed Care. There will be public workshops once more information about how other states have implemented managed care for LTSS has been gathered. CMS has to approve the change before we can even start to implement it and the implementation process takes about 3 years.

Jeffrey Klein (Senior Services):

I would like to echo the appreciative comments made previously about the incorporation of public input into the Transition Plan. I also endorse the concept of a Transition Advisory Group and would be happy to serve on the committee and to host workshops and collaborate to get community input from the southern Nevada counties. We should include input from the Alzheimer’s Task Force. How does the State’s Alzheimer’s Plan work with the 1915 waivers with respect to partial hospitalizations or adult day services?

Diane Ross (The Continuum):

On page 5, the section for Social Adult Day Care has two references within the description to Adult Day Health Care. Which service is being referenced?

Leslie Bittleston:

There are two models for Adult Day Care – a social model in the HCBW for the Frail Elderly and a Medical model under State Plan. Providers are generally the same for both services; however, the service reference on page 5 should be described as Social Adult Day Care. We will change the language in that section.

Vangie Molino (Vista Adult Care):

Regarding the need to involve the recipients, that is of course important, but, sometimes the recipient has cognitive deficits that make it difficult. We should be able to involve their personal representative when discussing their care. Also, mentioning caring for recipients with Alzheimer’s in a licensing context will produce a request for an Alzheimer’s endorsement. I cannot afford this.

Jennifer Frischmann:

I am not familiar with the licensing requirements; that is a function of the Bureau of Health Care Quality and Control (HCQC), but I will look into it for you.

Jose Castillo (Golden Years):

From now through 2019, what are we looking forward to? What will the owners have to do to be part of this program?

Tammy Ritter:

We are working to get workshops scheduled and to get information out to everyone. If you talk to CMS, they say that it is a State decision, but we do not yet know if CMS will uphold the State in the heightened scrutiny process. There are HCQC regulations that contradict the New Rule. We are working on reconciling these, as well as any other State regulations that may present problems.

Jose Castillo:

The provider self assessment surveys you sent out last Fall had details that were not related to our businesses. It was confusing.

Tammy Ritter:

Everyone has to be compliant, but it is not a one size fits all. We are working to make the New Rule apply without being restrictive.

Jose Castillo:

We want to be part of the decision making. It is important to remember that safety is important. We provide a high quality of service in Nevada. I do not want that to diminish quality because we are complying with CMS requirements. Visits to a group home will be better than a survey.

Jennifer Frischmann:

Our fear is that we will make these on-site visits and think it is a great site and person-centered, but that CMS will come in and disagree. We want people to age in place. We are seeing that people are happy, they have been in their group homes for years. This is one of the reasons we will be doing the heightened scrutiny. A campus-like setting that is attached to a rehabilitation facility in a rural location may meet the definition of community better than relocating the recipients away from the community they have lived in all their lives. We want to know what exceptions and allowances will be made.

Please visit our website. Please make sure we have your email addresses. We will send out email blasts regarding public workshops and setting up an advisory council. If you have any recipients who would like to participate in the advisory group, let us know.

Tammy Ritter:

If AHANN or ECHO or any other organizations will be having meetings and you would like us to attend, please let me know.

Jennifer Frischmann:

Thank you for your participation today.