Implementing the HCBS Settings Rule: One State’s Approach
Context for the Discussion

• **Not** here to tell you “how to implement the rule”
  – No “one right way”
  – Every state must determine the approach that makes the most sense for *their* state and *their* HCBS system

• Goal is to provide tools and share experiences that may be helpful in formulating your state’s approach

• Goal is also to learn things from one another that will benefit *all of us* as we continue moving forward
Agenda

- Vision
- Approach
- How do we get there?
- What should we do first?
- Develop the process: *Plan to assess*
- Education and Input
- Rolling it out: *Assess to plan*
- Discovery/Remediation
- When choice meets rule
- Heightened Scrutiny
- Ongoing Review and Monitoring
Vision

• **Begin with the end in mind** –
  What’s our vision for Tennessee?

• **At the end of the process** –
  – What do we want to be able to say?
  – How do we want to communicate the process and the results?
  – What do we want to achieve?

Not just compliance, but

*Better lives for the people we support*
Approach

• Comprehensive statewide approach across Medicaid programs and authorities
  – 1115 MLTSS *(managed care)* program
  – 3 Section 1915(c) *fee-for-service* waivers
• Full compliance as soon as possible—*before* 2019
• Not just *what we think* but *what we know* (100% assessment and review/validation)
• Leverage contractor relationships (expand capacity)
• Minimize provider (and administrative) burden, where possible
• Leverage technology for data collection and analysis
Approach

• Inform and engage stakeholders in meaningful ways
• Meet the *spirit and intent* of the regulation
• Leverage *the opportunity* to move the system forward and improve people’s lives
• Embed in ongoing processes (not just “one and done,” but a continuous process)
How do we get there?

- Determine what is needed to tell the story
  - Stakeholder input
  - Data
  - Proof of compliance
  - Member experience

- How many people on our team? 5
- How many settings? 1245
What should we do first?

• **Breathe**
• **Break it down: plan to assess, assess to plan**
  – Levels of assessment and remediation
    o **Systemic**
      - State Medicaid Agency
      - Contracted operating entities
        ▪ Managed Care Organizations
        ▪ Department of Intellectual and Developmental Disabilities
    o **Site-Specific**
      - Provider Self-Assessment
      - Individuals receiving HCBS
What should we do first?

• Breathe again

• Keep breaking it down
  – Manageable steps
  – Utilize contractor operating entities as Designated Reviewers
  – SMA validation
Develop the Process: *Plan to assess*

- **The manageable steps**
  - Self-assessments
    1. State
    2. Contractors
    3. Providers
  - Validation of contractor and provider self-assessments and transition plans
  - Individual Experience Assessments
  - Monitor implementation of transition plans
  - Monitor/assure ongoing compliance
Develop the Process: *Plan to assess*

**Training**
- Individuals receiving HCBS and families/representatives
- Designated reviewers (contracted operating entities)
- Providers
Develop the Process: **Plan to assess**

State (Systemic) Self-assessment

- What do we need to look at?
  - *Everything* that impacts HCBS
    - Licensure requirements
    - Contracts
      - Managed Care Organizations
      - Department of Intellectual and Developmental Disabilities
      - Fiscal Employer Agent
      - ADRCs - Single Point of Entry
    - State statutes
    - Rules
    - Waiver language
Develop the Process: *Plan to assess*

**State (Systemic) Self-assessment**

- What do we need to look at?
  - *Everything* that impacts HCBS
    - Policies
    - Procedures
    - Protocols
    - Practices
    - Reimbursement methodologies
    - Billing practices
    - ... *(yes, there’s more)*
Develop the Process: *Plan to assess*

## Contractor Self-assessment

<table>
<thead>
<tr>
<th>MCOs (MLTSS—managed care)</th>
<th>Dept. of I/DD (1915(c)—fee-for-service)</th>
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<tbody>
<tr>
<td>• Policies &amp; Procedures</td>
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Develop the Process: *Plan to assess*

**Provider Self-assessment**

- **We need data—how will we collect it?**
  - Provider self-assessments
  - Online survey tool (export to excel, slice & dice)
  - Create tool in fillable document that matches survey
    - Specific instructions

- **How do we get proof of compliance?**
  - Document review
  - On-site visits

- **How will know this is accurate?**
  - **Require** stakeholder involvement
  - *Ask the people receiving HCBS!*
Develop the Process: *Plan to assess*

**Individual Experience Assessment (IEA)**

- Developed from the CMS Exploratory Questions
- Administered by contracted case management entity
  - Independent Support Coordination agency
  - I/DD Dept. Case Manager
  - MCO Care Coordinator
- Phase I - individuals receiving residential and day services
- Phase II - embed in annual planning process for **all** persons receiving HCBS
- Data from IEA is cross-walked to the specific provider/setting in order to validate site-specific provider self-assessment results
- 100% remediation of any individual issue identified; thresholds established (by question) for additional remediation actions, e.g., potential changes in site-specific assessment, transition plan, policies, practices, etc.
Now what? Education and input

Tell people about the Rule!

• Communicate with consumers, families, providers and advocates
  – Open, posted introductory letter to the new rule
  – Educational materials (FAQs) and training
  – Disseminate through advocacy groups and providers
  – Consumer/family and advocate information sessions
    (again and again…)
  – Opportunities to ask questions
  – Structure public input, but leave room for more...
  – Accommodations
  – Extension
Now what? Education and input

And they loved it, right?

- Adjust the plan as needed based on public comment.
Now what? Education and input

Keep telling people about the Rule!

- Communicate *again* with individuals and families
- Communicate *again* with contractors
- Communicate *again* with providers
  - More information sessions (again and again...)
  - *While this is going on, finish developing all the things you are talking to people about...*
Rolling It Out: **Assess to plan (Site-specific)**

**Provide extensive training**

- **Train providers**
  - Detailed walk through of each tool and expectations
    - Self-assessment form (literally, each question)
    - Accessing the survey
    - Validation form
    - Transition plan
  - Demonstration of the survey
  - Expectations for document submissions
  - Stakeholder involvement requirement

- **Implement the provider self-assessment process**

- **Monitor submission progress**
Rolling It Out: Assess to plan (Site-specific)

Validation process

• 100% validation of self-assessment and transition plan required
  – Leverage contracted entities for 100% review (versus smaller sampling approach)
  – Standardized template

• TennCare validation
  – Initial reviews from each designated reviewer prior to sending to provider
  – Sample review at the conclusion of the process
  – Complicated settings
  – Upon request

• On-site visits
Discovery:
What did we learn?
Systemic Assessment
Discovery and Remediation: Systemic Assessment

HCBS Setting Standards Remediation Crosswalk

- Identifies each of the State’s “standards” applicable to each HCBS setting (regardless of State “owner”)
  - 1115 and 1915(c) waivers
  - State statute
  - State Administrative Rules
  - State contracts

- Documents assessed compliance of each “standards” document with each applicable provision of the HCBS setting rule

- Identifies specific systemic remediation actions
Discovery and Remediation: Systemic Assessment

- Additional “opportunities” identified with respect to documents and processes that implement State standards
  - Needs Assessment and Plan of Care protocols
  - Medical Necessity protocols for residential/day services
  - Provider Agreements
  - Provider enrollment processes (1915(c))
  - MCO Credentialing processes
  - QA monitoring/tools
  - HCBS Provider Manual
  - Rate methodologies
Validation of systemic remediation processes

- Review/approval of all 1915(c) policies, protocols, etc.
- Desk review of amended MCO policies, processes, etc.
- MCO onsite readiness assessments, including credentialing and re-credentialing processes
- Review of amended Provider Agreements by Tennessee Department of Commerce and Insurance
- Revise internal audit processes for ongoing compliance monitoring
Site-Specific Assessment
Total Number of Provider Settings Assessed: 1245

- Total Residential Provider Settings: 704
  - Residential Habilitation and Medical Residential: 170
  - Family Model Residential: 290
  - Supported Living: 144
  - Assisted Care Living Facility: 99
  - Adult Care Home: 1

- Total Non-Residential Settings: 541
  - Community-Based Day: 167
  - Facility-Based Day: 86
  - Supported Employment: 99
  - In-Home Day: 147
  - Adult Day Care: 42
Discovery: Provider Self-Assessment Results

Reported Compliance among Providers:

- Provider settings deemed 100% compliant with the HCBS Settings Rule - **14%**
- Provider settings who have identified at least one area that is currently out of compliance with the HCBS Settings Rule - **84%**
- Provider settings deemed non-compliant with HCBS Settings Rule and opting not to complete a provider level transition plan - **2%** (27 settings)
Whew…now what?

Site Specific Remediation: What do we do about it?
Remediation: Transition Plans

1048 Transition Plans Received

Areas identified as non-compliant:
- Physical Location: 367 or 35%
- Community Integration: 694 or 66%
- Residential Rights (Residential Only): 408 or 39%
- Living Arrangement (Residential Only): 552 or 53%
- Policy Enforcement Strategy: 936 or 89%
Remediation: Transition Plans

Helping providers achieve compliance:

- Educating boards and families
- Technical assistance
- Focus groups
The elephant in the room:

Not everyone wants to work or be integrated!

- What to do when choice meets the rule
When individual choice meets HCBS Rule:

- A person can decide if they want to work.
- A person can choose the degree of community integration/participation they want.
  - It must be *meaningful* choice.
  - It’s easy to choose NOT to do something that’s new and different and that you don’t really understand.
  - We have to help people understand; provide opportunities.
- A person can choose the setting they want to live in... even institutional. But they can’t choose a non-compliant setting and receive Medicaid HCBS funding.
When individual choice meets HCBS Rule:

• A person can choose where they spend their day, including sheltered employment. Medicaid only pays for *pre-vocational* services in a sheltered setting.

• A person can choose to live in a home in close proximity to another home where people with disabilities live.
  – The setting will have to comport in order to receive HCBS funds...which means offering meaningful support and opportunities for inclusion.
  – Must demonstrate that people are working and participating in community to the extent *they* want AND provider is doing all they can to support that.
  – People who aren’t are making those decisions in an informed and meaningful way and documented in the plan of care
  – And we NEVER give up...we keep trying. (Not one and done.)
Are we there yet?

More discovery; More remediation: Heightened Scrutiny
Settings “presumed” to have institutional qualities

• Settings that have the qualities of an institution (applies to residential and non-residential services):
  – Located in a public or privately operated building that provides inpatient institutional treatment
  – Located on the grounds of, or immediately adjacent to a public institution
  – Has the effect of isolating members who receive Medicaid funded HCBS from the broader community of people who do not receive Medicaid funded HCBS
Settings “presumed” to have institutional qualities

- Settings that have the following two characteristics potentially have the effect of isolating individuals:
  - The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.
  - The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.

- Characteristics of settings that isolate:
  - The setting is designed to provide people with disabilities multiple types of services and activities on-site, including housing, day services, medical, behavioral and therapeutic services, and/or social and recreational activities.
  - People in the setting have limited, if any, interaction with the broader community.
  - Settings that use/authorize interventions/restrictions that are used in institutional settings or are deemed unacceptable in Medicaid institutional settings (e.g. seclusion).
Settings that may be “presumed” institutional

Services/settings selected by State for potential heightened scrutiny review (based on CMS rule/guidance):

- Adult Day Care (inside inpatient facility/settings that isolate)
- Assisted Care Living Facilities (inside inpatient facility/settings that isolate)
- Critical Adult Care Homes (settings that isolate)
- Facility Based Day (settings that isolate)
- Residential Habilitation settings with more than 4 persons (settings that isolate)
- Supported Living and Residential Habilitation settings in close proximity (settings that isolate)
CMS Guidance: Settings “presumed not HCBS”

- **Types of evidence** that should be submitted to CMS to demonstrate that a setting does not isolate individuals receiving HCBS from the broader community of individuals not receiving HCBS:
  - The setting is integrated in the community to the extent that persons without disabilities in the same community would consider it a part of their community and not associate the setting with the provision of services to persons with disabilities.
  - The individuals participates regularly in typical community life activities outside of the setting to the extent the individual desires and activities:
    - Do not include only those organized by the provider agency for a group of individuals with disabilities and/or involving only paid staff
    - Do foster relationships with community members unaffiliated with the setting
    - Services to the individual, and activities in which the individual participates, are engaged with the broader community
Heightened scrutiny review will consist of:

- A review of data pertaining to services utilized by all persons receiving services in the specified setting
- An on-site visit and assessment of physical location and practices
- A review of person-centered support plans and Individual Experience Assessments for individuals receiving services in the setting
- Interviews with service recipients
- A secondary review of policies and other applicable service related documents
- Additional focused review of the agency’s proposed transition plan
  - Including how each of the above is expected to be impacted as the plan is implemented
  - Transition plans may require revisions
Heightened scrutiny review will consist of:

• State determination regarding:
  – Whether the setting in fact is “presumed to have the qualities of an institution” as defined in rule/guidance
  – Whether the presumption is overcome based on evidence

• Collection of evidence to submit to CMS to demonstrate compliance (ONLY if the state in fact feels the setting is “presumed not HCBS” AND meets the HCBS requirements)
After information is collected and reviewed:

- TennCare will compile the information and share (in a digestible format) with a Review Committee comprised of representatives from advocacy groups that serve individuals receiving HCBS
  - The Arc of Tennessee
  - Council on Developmental Disabilities
  - Disability Rights TN (Protection & Advocacy)
  - Statewide Independent Living Center
  - TN Disability Coalition

- The Advocacy Review Committee will review the evidence and help advise if each setting meets the requirements of the settings rule (or will once the transition plan is implemented).

- Settings that will be submitted to CMS will be posted (or notification will be provided directly for individual residences) for public comment.
After information is collected and reviewed:

- All settings presumed to have the qualities of an institution (as defined in rule/guidance) will be submitted to CMS for final review IF the State determines the presumption is overcome
- Evidence will be packaged in a digestible format including analysis of all evidence compiled during the HS review process, with complete documentation available for more in-depth review
And now we’re done? Not so fast...

Ongoing review and monitoring:

- Embed in person-centered planning processes
- Embed Individual Experience Assessment in annual person-centered plan review
- Embed in 1915(c) provider enrollment process
- Embed in MCO credentialing process (initial and ongoing)
- Embed in Quality Assurance review processes
- Leverage external survey processes for validation (e.g., National Core Indicators and NCI-AD)
Working together: Tennessee’s materials

  - Updates
  - All posted versions of the Statewide Transition Plan with tracked changes to ease stakeholder review
  - Provider self-assessment tools and resources
  - Individual Experience Assessment
  - Heightened Scrutiny tools and resources
  - Training and education materials
Questions?