Home & Community-Based Settings and Person-Centered Planning Federal Rule Changes:

A Conversation with Consumers, Families, and Caregivers

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Agenda

Today we will be talking about the new federal Rule concerning Home and Community Based Services that took effect March 17, 2014. There are two important aspects to this Rule:

1. **The Person-Centered Planning Process**, which increases the person's input in how services are planned and what is included in the plan of care; AND

2. **Home and Community Based Services Settings,** which increases protections relating to where people receive Home and Community Based Services.

Note: You may hear Home and Community Based Services referred to as HCBS, and you may hear Person-Centered Planning referred to as PCP.

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Agenda

Specifically today, we want to help you understand the Rule and how Tennessee plans to make changes to comply with the new rule.

Understanding the Rule:

- Person-centered planning
- Standards for HCBS Settings

How Tennessee will comply with the new rule:

- The State's transition process
- Stakeholder involvement

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Why does the New Rule Matter to You?

- These rules will be applied to *everyone* receiving HCBS funded by Medicaid, including people receiving HCBS in:
  - 1915(c) waivers—in TN, the three DIDD HCBS waivers for people with intellectual disabilities (Statewide, Arlington and Self-Determination)
  - 1115 waivers—in TN, includes the CHOICES program for seniors and adults with physical disabilities and will include the new Employment and Community First CHOICES program
- All states must review their HCBS programs and services
  - HCBS providers have to look at where and how they provide services to you.
  - You will be asked to tell us about your experience in planning and receiving HCBS.

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Person-Centered Planning Process

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Person-Centered Planning Process

Intent

- The person-centered service plan for people in Medicaid HCBS programs must be developed through a person-centered planning process
- Certain things must be included in the person-centered plan of care

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Person-Centered Planning Process
Requirements

- The Person-Centered Planning process must:
  - Be **directed *by the person served***
  - Include people chosen by the consumer
    - Consumers also choose who ***does not*** attend the planning meeting
  - Provide necessary information and support to the person to help them direct the planning process as much as possible
  - Be timely and occur at a place and time that works best for the person

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Person-Centered Planning Process

Requirements

- Person-Centered Planning means:
  - The person understands the process and the service plan
  - The person chooses the setting in which they will live and receive services (from available and necessary services and taking into account their resources for community living expenses)
  - The person understands the services available, chooses their services based on their needs, and chooses their service provider
  - A provider cannot write the plan unless there is no other qualified, entity to facilitate the PCP process. In TN we have ISCs, case managers and care coordinators for each person, so this is not an issue.
  - The service plan includes ways to solve conflict/disagreements
  - The person knows they can ask for an update to their plan

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Person-Centered Planning Final Rule

Requirements

The Person-Centered Plan must include the person's:

- Strengths and preferences
- Both clinical and support needs (medical or behavioral needs and HCBS needs)
- Goals and desired outcomes
- Services and supports (paid and unpaid) that will help the person to meet their goals
- Risk factors and how those risks will be prevented
- Back-up plans
- The setting in which the person lives/will live, which was chosen by the person and which supports the person's opportunities to live and work in their community

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Person-Centered Planning Final Rule

Requirements

The Person-Centered Plan must:

- Be understandable to the person receiving services and supports, and to all the people important in supporting him or her
- Identify the ISC, case manager or care coordinator
- Be signed by the consumer and providers who will be providing the services
- Be given to the person and other people and providers involved in the plan
- Include services the person elects to self-direct (as applicable)

Note: ***The service plan must not include services that the person does not need or are not appropriate to support the person.***

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Home and Community Based Service Settings Final Rule

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HCBS Settings Final Rule

Intent

- For the first time, sets federal standards to ensure that Medicaid-funded HCBS are provided in settings that are **not institutional** in nature.
- These standards apply to residential and non-residential (for example, day program) services and settings.
- The rules focus on the ***experience*** of each person receiving services and supports—Are they living the life they want? Can they work? Are they part of their community?
- The goal is to ensure that every person receiving HCBS:
    - Has access to benefits of community living;
    - Has full opportunity to be integrated in their community; and
    - Has enhanced protections

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HCBS Settings Final Rule

Defines

- Settings that are **not** HCBS
- Settings that are **presumed** not to be HCBS
- Requirements for HCBS settings
- *Additional* requirements for provider-owned or controlled HCBS residential settings
- State compliance and transition requirements (what the State must do to comply with the new rules, including changes that are needed to comply with the new rules)

NOTE: NO agencies/programs will be 'grandfathered.'
ALL must come into compliance.

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HCBS Settings Final Rule

*What is **not** HCBS?*

- Nursing homes
- Hospitals
- Institutions for mental diseases (IMD)
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

HCBS, including respite or assisted living cannot be provided in these settings in Medicaid HCBS programs.

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HCBS Settings Final Rule

*What is **presumed** not HCBS?*

Settings that have the qualities of an institution (this applies to residential and non-residential services):

- Facilities or homes located in a public or privately-operated building that provides inpatient institutional treatment
- Located on the grounds of, or right next 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

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HCBS Settings Final Rule

*What is **presumed** not HCBS?*

Isolation is likely:

- In a gated or secured “community”
- Multiple settings located together and operated by the same provider

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HCBS Settings Final Rule

Those settings that are presumed to not be HCBS may **not** be included in states' HCBS programs ***unless***:

- The State submits evidence (including public input) to CMS showing that the setting *does* have the qualities of an HCBS setting and **not** the qualities of an institution;
  (We need input from providers and consumers/families on what kind of evidence should be required to prove that a setting really is HCBS and will be judicious about making such requests.)

  AND

- CMS (the federal Centers for Medicare and Medicaid Services) agrees the setting meets HCBS setting requirements
  - CMS will require "strong evidence" to prove that a setting in the "Presumed" category is actually HCBS

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HCBS Settings Final Rule

Continuous Care Retirement Communities (*CCRCs)*

- These settings include independent living units, assisted living, and NF located close together
- Most likely qualify as HCBS
- CMS stated that the isolation risk in CCRCs is limited "since CCRCs typically include residents who live independently in addition to those who receive HCBS"

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Standards that Apply to ALL HCBS Settings

- **Integration with community**
  - Setting must support full access the person's to the community
- **Choice**
  - The person must be able to choose the setting from other options
- **Rights**
  - The person must have the rights to privacy, dignity, respect and freedom from coercion and restraint
- **Independence**
  - Setting must maximize the person's ability to make life choices

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HCBS Settings Standards

It's all about the person's experience.

- **Integration with community**
  - Is the setting a part of the community so that people can access and use their community?
  - CMS expects to see that people in Medicaid HCBS programs have the same chances as everyone else does to be in and use their communities – to find jobs, go to activities in their community, use the library, get a hair cut when and where they want, etc.
    - Do people in the setting have access to public transportation?
    - Can people work if they want to?

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HCBS Settings Standards

It's all about the person's experience.

- **Choice**
  - Is the setting selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting?
  - This means that the person must be able to choose where they live, not just be 'assigned' to live in a home or setting meant only for people with disabilities.
  - Also, this does not mean everyone gets a private unit. This means that if someone wants AND can afford to live alone, they must be given options of settings that include a private unit.

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HCBS Settings Standards

It's all about the person's experience.

- **Rights**
  - The setting must ensure the person has rights of privacy and dignity, and is treated with respect.
    - Are schedules for therapy or medical appointments posted in public areas where everyone can see them?
    - Are people called by their preferred name or are they called "hon" or "sweetie"?
  - The setting must ensure the person will have freedom from coercion and restraint (will not be forced to do things they do not want to do)

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HCBS Settings Standards

It's all about the person's experience.

- **Independence**
  - The setting must support the person to maximum their ability to be independent in making life choices, this includes things like:
    - What I do each day
    - Where I live and how it is decorated
    - Who I hang out with
  - The person must be supported to choose the services they need and who provides them

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HCBS Settings Standards

Additional requirements for provider-owned/controlled residential settings

CMS has set additional requirements for residential settings that are owned and or controlled by the provider.

- Provider-owned/controlled residences includes Residential Habilitation services and Assisted Care Living Facilities.

If the person lives in one of these settings, the person has rights that the provider must honor. These rights are:

- **Protection from eviction;**
- **Privacy rights;**
- **Freedom of choice;**
- **Right to receive visitors at any time; and**
- **A setting that is physically accessible**

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Provider Owned/Controlled Residence

- Protection from eviction
  - The person must have a legally enforceable agreement, such as a lease
  - The agreement or lease must meet standards that are set in state and local laws regarding landlords and tenants
  - This means that even in a Residential Habilitation or Assisted Care Living Facility, the person must have an agreement or lease that protects them from being evicted, just as they would if they were renting a house or apartment outside of Medicaid HCBS programs.

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Provider Owned/Controlled Residence

- Privacy rights
  - The person must be able to lock entrance doors to their private space
  - Only appropriate staff can also have a set of keys
    - The person should have a say in, and agree to, which staff members have keys
  - Choice of roommate when applicable
    - The Rule does not require a private living unit or bedroom, but the person must have a choice of roommate if the person chooses a shared room
  - Freedom to furnish and decorate personal space

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Provider Owned/Controlled Residence

- Freedom of choice
  - The person must have freedom and support to control his or her schedule, activities, and have access to food at any time
  - The person must have the ability to access the community and participate in community activities, including accessing public transportation
  - The person must have access to food, not just snacks, 24/7, including control in selecting food, storing food in his or her room, eating in his or her room, and deciding when to eat

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Provider Owned/Controlled Residence

- Right to receive visitors at any time
  - The person has the right to receive any visitor at any time of day, including overnight
    - However, all visitors must be within the limits of the lease to avoid a ‘visitor’ who moves in

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Provider Owned/Controlled Residence

- Physically accessible
  - The person has the right to settings that are able to access both in inside and around the outside
    - For example: Are there any steps, lips in a doorway, or narrow hallways that might make it hard for the person to get around?

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When following the rule doesn't make sense for the person…

- There may be times that **not** following the new rule is necessary to protect the health and safety of the person.
  - For example, "access to food 24/7" would not be safe for a person who has diabetes, Prader Willi syndrome, etc .
  - Freedom to come and go may not be safe for a person who has Alzheimer's and a tendency to wander

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When following the rule doesn't make sense…

- Anytime some part of the new rule can't be followed for a specific person, these steps are required:
  - You must first try other strategies (that would comply with the new rule) and document that they didn't work
  - The specific part of the rule that won't be followed must be included in the service plan, along with the reason why (for example, food will be available only at designated meal and snack times)
  - The person or representative must agree (This means that a person or representative has control over any requested change and **can say no.**)
  - The provider must assure that not following that part of the new rule will not cause harm to the person
  - Data is collected to show that the change is working
  - The ISC, case manager or care coordinator review this part of the person's plan at specific times to make sure it's still necessary

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Modifications to Requirements for Provider- Owned/Controlled Settings

- A provider can ask to not follow certain parts of the new rule for a specific person, **except** the requirement that the setting be physically accessible.
    - The provider **cannot** request to modify the requirement that the setting be physically accessible.

- Any request to not follow any part of the new rules must still follow all of the requirements on the last slide.

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HCBS Settings Final Rule

Non-residential services

- States are still awaiting further guidance from CMS on non-residential services

Additional guidance will be shared immediately upon release.

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The State's Transition Process and Stakeholder Involvement

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State Transition Plan and Consumer/Family Involvement

- Every State must assess its HCBS programs and services to see if they comply with the new rule.
- Every State must write a plan that shows how they will make changes in their HCBS programs and services that are needed in order to comply with the new rule.
  - This is called a “Transition Plan.”
- States renewing or amending a waiver must submit their plan with that waiver renewal application or amendment.
- Every State must get input from consumers, families, and other stakeholders on the plan.

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State Transition Plan and Consumer/Family Involvement

- Tennessee's Statewide and Arlington waivers expire December 31, 2014; renewal applications are due by October 1, 2014 in order for those programs to continue

- The State is working on a Transition Plan to submit to CMS that will show how we will comply with the HCBS Rule
  - We must submit the plan to CMS with our renewal applications by **October 1, 2014**

- We have posted our draft transition plan documents on our website at www.tn.gov/tenncare/

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State Transition Plan and Consumer/Family Involvement

- As part of the Transition Plan process, the State will do a self-assessment, including:
  - DRAFT waiver renewal applications/amendments reflect changes needed to comply with the new rule
  - State laws, policies, procedures, contracts, rates, computer systems, etc.
  - DIDD (the Department of Intellectual and Developmental Disabilities, contracted with TennCare to operate HCBS waivers) and MCOs will also review their policies, procedures, contracts, systems, etc.
    - TennCare will review DIDD and MCO self-assessments and ask for more proof or changes to comply with the new rules, as needed

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State Transition Plan and Consumer/Family Involvement

- HCBS providers will also do a self-assessment and provide (DIDD for waiver providers and MCOs for CHOICES providers) evidence that they are following the new rules, or tell us what they will change to begin following the new rules
  - DIDD and MCOs will review the evidence, ask for more proof if needed, or a plan if changes are needed to comply with the new rule
  - If a provider is unwilling or unable to comply with the new rules, they can no longer provide HCBS
    - People served will transition to new providers

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State Transition Plan and Consumer/Family Involvement

- All entities who provide case management must also do a self-assessment and provide evidence that they are following the new rules, or tell us what they will change to begin following the new rules, including:
  - ISC agencies (for the Statewide and Arlington waivers)
  - DIDD (for the Self-Determination waiver)
  - MCOs (for CHOICES)
- Contracting entity (DIDD for ISC agencies and TennCare for DIDD and MCOs) will review the evidence, ask for more proof if needed, or a plan if changes are needed to comply with the new rule
- Public input on behalf of each entity saying they are following the new rules is required

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Implementing the HCBS Rule Changes

State Transition Plan and Member Involvement

Each person receiving HCBS will also take part in an Individual Experience Assessment –this will help us make sure that *every* person is receiving HCBS in a way that follows the new rules.

- Your ISC, DIDD case manager or MCO care coordinator will help you with this assessment
  - TennCare will provide a tool that persons or their representatives will complete between **October 1, 2014 - September 30, 2015.**
  - The tool will be posted on the TennCare website soon. It uses questions that CMS gave states to help them make these decisions. You can review it and tell us how to make it better.
  - For new people who start getting HCBS, the assessment will occur as part of *initial* plan of care. It will be reviewed at least every year.
  - For people already getting HCBS, the assessment will occur with the next annual review or plan revision, and will be reviewed at least every year

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Implementing the HCBS Rule Changes

State Transition Plan and Member Involvement

- CMS will approve transition plans of up to five years.
  - –Length of transition period depends on each state's circumstances.
- CMS expects states to transition to new settings requirements as quickly as possible.

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State Transition Plan and Consumer/Family Involvement

We need you to be involved! Here's how:

- **Give us your input on:**
  - **The Transition Plan** – Help us write a plan that will make sure we are following the new rule and that we make any needed changes in a way that protects people receiving HCBS
  - **The timeline** – Help us make sure we allow enough time to look at everything we need to review and make any needed changes
  - **The assessment tools**– Help us make sure we are looking at all the things we should look at and asking the right questions
  - **Input on case management entities and entities "presumed" not HCBS**—Tell us if you think they are following the new rule

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State Transition Plan and Consumer/Family Involvement

We need your input!

- Please go to the TennCare website and review the transition plan documents. If you do not have a computer, ask your provider if they can give you a copy.
- You can submit your comments to us **through September 19th**
- The State will consider comments and update the Transition Plan as appropriate
- You can submit your comments to us on TennCare's website, www.tn.gov/tenncare/
- You can also mail your comments to us:

  TennCare
  Attn. LTSS Comments on Transition Plan
  PO Box 450
  Nashville , TN 37202

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Questions & Answers

- We will now take questions for the remainder of the time
- Right now everyone is on mute, but in just a minute, we are going to tell you how to “un-mute” your phone if you want to ask a question
- Please only un-mute your phone if you want to ask a question
- It is important to understand that there are a lot of people on this call
- We have no way of knowing how many people want to ask questions or put people in order to ask their questions
- Once you un-mute yourself, please be aware that other people may try to talk at the same time as you
- If you hear someone else talking, please be polite and let that person finish before you try to ask your question; we want to be sure everyone can hear each response
- To un-mute your phone and ask a question, press *6

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Thank you

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