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
    - **Systemic**
      - State Medicaid Agency
      - Contracted operating entities
        - Managed Care Organizations
        - Department of Intellectual and Developmental Disabilities
    - **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**

**MCOs** (MLTSS—managed care)
- Policies & Procedures
- Provider Agreements
- Provider Manual
- Provider Credentialing Requirements
- Staff Training Materials
- Quality Monitoring materials and processes

**Dept. of I/DD** (1915(c)—fee-for-service)
- Policies & Protocols
- Provider Agreements
- Provider Manual
- Provider Credentialing Requirements
- Staff Training Materials
- Quality Monitoring materials and processes
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.
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**
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
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
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?*
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%
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 and share (in a digestible format) with a Review Committee comprised of representatives from advocacy groups that serve individuals receiving HCBS
  - AARP
  - The Arc of Tennessee
  - Council on Developmental Disabilities
  - Disability Rights Tennessee (Protection & Advocacy)
  - Statewide Independent Living Center
  - Tennessee 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?