Tennessee Home and Community-Based Services Settings Rule
Statewide Transition Plan
November 2, 2015
Revised November 13, 2015

Tennessee's State Medicaid Agency (SMA), the Bureau of TennCare (TennCare) submits this amended Statewide Transition Plan in accordance with requirements set forth in the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Services (HCBS) Settings Rule released on January 16, 2014 (see 42 C.F.R. § 441.301(c)).

This amended Statewide Transition Plan will build on the originally proposed Statewide Transition Plan previously submitted. This plan will include data gleaned from the provider self-assessment, information submitted in response to the CMS Letter of Reaction, further details about settings and assessment validation based on the 10/14/2015 conference call with CMS, as well as historical context that has led to this amended version of Tennessee's Statewide Transition Plan. Due to the need to renew the Statewide and Comprehensive Aggregate Cap (CAC, formerly Arlington) Waivers and amend the Self-Determination Waiver, TennCare submitted and received approval for Transition Plans specific to each waiver renewal application. Transition Plan activities were designed to lead to both a waiver-specific plan for each waiver program as well as a Statewide Transition Plan. Tennessee's originally proposed Statewide Transition Plan differed from the approved waiver-specific Transition Plans in the areas specified below:

- Section 1: The description of additional public input activities specific to the Statewide Transition Plan
- *The addition of Section G: State Self-Assessment Results and Compliance Activities
- Summary of *Additional* Comments on Statewide Transition Plan and Changes Made

*Note: Findings of the State Self-Assessment and Compliance Activities previously set forth in Section G have been incorporated into relevant sections of the amended Statewide Transition Plan, rather than as a separate section.

This amended Statewide Transition Plan differs from the originally proposed Statewide Transition Plan in the areas specified below:

- Section 2: The description of TennCare's systemic assessment process, outcomes of the TennCare's systemic assessment and systemic assessment remediation milestones and timelines
- Section 4: The description of TennCare's individual site assessment and assessed settings; the outcomes of TennCare's site assessments; TennCare's remediation process for non-compliant settings, milestones needed to address non-compliant settings and timelines for milestones to be completed; and TennCare's oversight and monitoring process to ensure ongoing compliance with the final rule

- Once the public process has concluded, description of public comment for the amended Statewide Transition Plan and amendments to the three 1915 (c) waivers will be incorporated into the Statewide Transition Plan and the waiver amendments.

In preparation for development of the state's approved waiver-specific and originally proposed Statewide Transition Plans, TennCare completed certain activities believed to be pertinent to the development of each plan. Those activities are detailed below. The Provider Self-Assessment and Individual Experience Assessment tools, the Assessment Worksheet including instructions with timelines were submitted separately to the CMS regional project officer.

Section 1: Transition Plan Development and Public Input Activities (Forms of Public Notice)

Provider information and training meetings:

- Invitations were posted on the TennCare website and distributed through provider and advocacy organizations, the Department of Intellectual and Developmental Disabilities (DIDD) and contracted Managed Care Organizations (MCOs). Copies of the materials were submitted separately to the CMS regional project officer.
- Seven separate meetings were held across the state between July 8th and 24th, 2014 on the U.S. Department of Labor's and CMS' Final Rules titled "The Impact of new Federal Regulations on Home and Community Based Service (HCBS) Provider." In this invitation is a listing of all provider training dates, times and locations: http://www.tn.gov/assets/entities/tenncare/attachments/ProviderNewRuleSessionFinal.pdf.
- 628 attendees in total
- The PowerPoint presentation was posted on the TennCare website on July 25, 2014 and submitted separately to the CMS regional project officer.

Consumer and family information materials and meetings:

- Consumer/family friendly materials were developed with input from provider and advocacy organizations.
- Materials were posted on the TennCare website and distributed through provider and advocacy organizations, including independent support coordinator agencies, DIDD and MCOs.
- TennCare hosted 2 open forum conference calls to educate consumers and families on the HCBS Settings Rule and the importance of their public input.
    - A total of 251 distinct phone numbers accessed the calls, but since there were several participants who were gathered in groups, the actual number of

participants is unknown, but greater than the number represented by distinct phone numbers.
    - HCBS providers participated in these calls as well as consumers and families.
- Some providers held family meetings.
- Copies of the materials utilized were submitted separately to the CMS regional project officer.

State posting of draft transition plan and assessment tools for public comment:

- All Transition Plan and Assessment Tool documents were posted at: https://tn.gov/tenncare/topic/transition-plan-documents-for-new-federal-home-and-community-based-services. Individuals could provide comments online through the website, via the US postal service, or by emailing program staff directly.
- The comment period extended from July 25 through September 19, 2014 as an interactive, working time between the state, providers, advocates, consumers and families. TennCare updated documents based on comments received and reposted the documents to the TennCare website as updated drafts.
- The Transition Plan was revised based on:
    - Public comments received regarding timelines and assessment activities; and
    - Feedback received from CMS, including removal of Person-Centered Planning (PCP) components.
- The proposed Transition Plan was revised and reposted on September 18, 2014.
- Documents were finalized (based on additional comments received), posted and entered into CMS web portal with waiver submission on October 1, 2014.
- Cover letter, assessment tools and assessment tools instructions were submitted separately to the CMS regional project officer.
- The final version of the Transition Plan submitted to CMS was posted on the TennCare website:
  http://www.tn.gov/assets/entities/tenncare/attachments/TNProposedStatewideTransitionPlan.pdf.

State posting of originally proposed Statewide Transition Plan:

In addition to public input activities conducted in advance of the previously approved waiver-specific Transition Plans, the originally proposed Statewide Transition Plan was made available for additional public comment via the following activities:

- The proposed Statewide Transition Plan was posted on the TennCare website at https://tn.gov/tenncare/topic/transition-plan-documents-for-new-federal-home-and-community-based-services on December 23, 2014 for a 30 day public comment period. Reviewers were invited to provide comments via the website.
- On December 23, 2014 an email was sent directly to stakeholders, including advocacy organizations and provider associations, requesting each to share with their membership and the consumers and families they serve. In addition, the proposed plan was emailed to the Department of Intellectual and Developmental Disabilities and the State's three contracted MCOs to share with their provider networks.

State posting of amended Statewide Transition Plan:

- The amended Statewide Transition Plan will be posted on the TennCare website at: https://tn.gov/tenncare/topic/transition-plan-documents-for-new-federal-home-and-community-based-services on November 2, 2015 for a 30 day public comment period. Stakeholders have been and will be invited to provide comments via the website US Postal mail or directly to TennCare staff.
- On November 4, 2015 an email including the Statewide Transition Plan was sent directly to stakeholders, including advocacy organizations and provider associations, to share with their membership and the consumers and families they serve. In addition, the proposed plan was provided to the Department of Intellectual and Developmental Disabilities and the State's three contracted MCOs to share with their provider networks, with a request to also share with the individuals they serve and their families.
- On November 13, 2015 the Statewide Transition Plan was revised to include an updated explanation of the state's Heightened Scrutiny process and reposted. An email notification including the November 13th Statewide Transition Plan was sent directly to stakeholders, including advocacy organizations and provider associations, to share with their membership and the consumers and families they serve. In addition, the revised proposed plan was provided to the Department of Intellectual and Developmental Disabilities and the State's three contracted MCOs to share with their provider networks, with a request to also share with the individuals they serve and their families.
- The TennCare website post will include guidance for individuals who may need an accessible format of the Statewide Transition Plan or assistance with reading the plan and submitting comments. In addition, providers and advocacy organizations are encouraged to assist persons and families they support as needed in reading and understanding plan, and providing comments.

Section 2: SMA Self-Assessment, Outcomes and Remediation:

TennCare's Self-Assessment Process:

The state initiated ongoing internal strategy meetings to assess all rules, regulations, policies, protocols, practices and contracts. Additionally, the State developed and implemented strategies for obtaining consumer and family, provider, advocate, and other stakeholder input into the self-assessment of state standards, requirements and practices. TennCare presented specialized webinars to consumers, families, and caregivers. During these webinars TennCare asked for stakeholder input on the development of the transition plan, help establishing a timeline for reviewing compliance, assistance with developing the assessment tools and input on entities presumed not HCBS. Instructions for adding input were included in the PowerPoint presentation: http://www.tn.gov/assets/entities/tenncare/attachments/NewRulePresentationforConsumersFamilies.pdf. Finally, information such as CMS Exploratory Questions and CMS Fact Sheets were made available on the tn.gov website http://www.tn.gov/tenncare/search?keywords=hcbs.

TennCare's Systemic Assessment:

The State's systemic assessment included a review of state statutes, 1915(c) waivers, rules, contracts, rate methodologies and billing practices, protocols, policies, and procedures across all departments involved in the licensure and administration of Medicaid-reimbursed HCBS. The specific items reviewed during this assessment are explained in greater detail below:

State statutes: The State assessed state statutes concerning licensure for all state departments authorized to license Medicaid-reimbursed HCBS settings. The assessment involved reviewing statutory authority concerning the Tennessee Departments of Mental Health and Substance Abuse Services (DMHSAS), Intellectual and Developmental Disabilities (DIDD), Health (DOH), and Human Services (DHS) located in Tennessee Code Annotated Titles 33, 68, and 71, respectively.

1915(c) and 1115 Waivers: The State assessed its three 1915c Waivers serving individuals with intellectual disabilities that are administered by the DIDD, and the 1115 Demonstration Waiver which provides authority for the CHOICES HCBS program. All aspects of the waivers were reviewed.

State rules: The State assessed rules for all state departments authorized to license and administer Medicaid-reimbursed HCBS settings. This assessment involved reviewing state rules for the Bureau of TennCare, DMHSAS, DOH, and DHS concerning the areas of licensure, HCBS setting definitions, and residents' rights in TennCare Rule 1200-13-01, DMHSAS Rules 0940-01 – 0940-06, DOH Rules 1200-08-01 – 1200-08-36, and DHS Rules 1240-01 – 1240-09.

State contracts: The State assessed all state contracts concerning the administration and provision of services in Medicaid-reimbursed HCBS settings. This assessment involved reviewing the State's Contractor Risk Agreement (CRA) with its three Managed Care Organizations (MCOs), its 1915(c) Waiver Interagency Agreement with DIDD, the DIDD Provider Agreement, and the MCOs' HCBS Provider Agreements. Of note, the MCO HCBS Provider Agreements must also be approved by the Tennessee Department of Commerce and Insurance (TDCI).

TennCare's Self-Assessment Outcomes:

HCBS Definitions and Provider Qualifications: Many of the proposed changes to waiver definitions were included in waiver renewal applications and amendments, including amendments for the following definitions: Residential Habilitation; Support Coordination; Nursing Services; Employment and Day Services; Family Model Residential; Intensive Behavioral Residential Services; Medical Residential Services; and Supported Living. In addition, there were areas identified for strengthening language and requirements related to the care planning process and participant rights.
Additional changes to Employment and Day services have been identified and will be submitted as waiver amendments by December 31, 2015.

State Statutes: As a result of assessment, the State determined that Tennessee Code Annotated Sections 33-2-404, 68-11-202, and 71-2-412 relating to DMHSAS, DIDD, DOH, and DHS should be amended to include compliance with the new federal HCBS setting rule. TennCare worked in collaboration with DIDD as it relates to Title 33. Statutory revisions were submitted (including authority to revise licensure and other rules, as applicable) during the Tennessee's legislative session January through April, 2015.

State Regulations: Rules requiring modification included those that are under the authority of another state department (Tennessee Code Annotated Sections 33-2-404, 68-11-202, and 71-2-412 relating to DMHSAS, DIDD, DOH, and DHS). In addition to promulgating revised regulations under its own purview, as determined to be appropriate, TennCare will provide appropriate education and explanation to other state departments regarding need for any rule revisions, which TennCare will formally request in writing, in order to allow the state to come into compliance as applicable. Legislation to provide statutory obligation and authority to make such rule revisions was passed in the 2015 legislative session.

State Rules: As a result of assessment, the State made separate determinations of compliance for each state department it assessed.

The State determined that DMHSAS Rules contain two provisions that are non-compliant with the HCBS Settings Rule in DMHSAS Rule Section 0940-05-06. The first provision limits

participant rights concerning times for visitors and the second provision states a process for the modification of participant rights that is different than the modification process for provider-owned and operated settings in the HCBS Settings Rule. Additionally, the State determined that the participant rights' sections of the DMHSAS Rule could be strengthened by amending the section to include reference to the rights provided in the HCBS Settings Rule.

The State determined that the DOH Rules contain two provisions that are non-compliant with the HCBS Settings Rule in DOH Rule Section 1200-08-25-.14 concerning assisted care living facilities and 1200-08-36-.15 concerning adult care homes – level 2. These sections limit times when residents can receive visitors or access common areas. Additionally, the State determined that the participant rights' sections of the DOH Rules could be strengthened by amending these sections to include references to the rights provided in the HCBS Settings Rule.

The State determined that DHS Rules contain two provisions that are non-compliant with the HCBS Settings Rule in DHS Rule Section 1240-07-10. These provisions both reference providing adult day care in a nursing facility.

State Protocols, Procedure and Policies (including Quality Management practices): As a result of the assessment, the State determined that compliance with the HCBS Settings Rule could be strengthened by amending TennCare's Needs Assessment and Plan of Care Protocols to incorporate the HCBS Settings Rule requirements into those protocols, and by amending the following six DIDD protocols concerning HCBS settings to similarly strengthen compliance with the Rule: Employment and Day Services, Family Model Residential, Medical Residential, Residential Habilitation, Semi-Independent Living Services, Supported Living.

Training Requirements: As a result of the assessment, the State identified areas in the DIDD Provider Manual that could be amended to strengthen compliance with the HCBS Settings Rule. The State also determined that its CRA with its MCOs could be amended to include references to the HCBS Settings Rule related to provider credentialing and re-credentialing and ongoing education and training.

State Contracts, Rate Methodology, and Billing Practices: This included contracts/Interagency Agreements TennCare currently holds with DIDD and the MCOs. As a result of assessment, the State identified several areas in which it could strengthen compliance with the rule. The State determined that its CRA with its MCOs could be amended to include references to the HCBS Settings Rule as follows:

- In the plan of care process, include expectations pertaining to employment and community integration
- Require MCOs verify provider compliance with the Rule when credentialing and re-credentialing HCBS providers;

- Require MCO Provider Agreements contain language requiring providers to maintain compliance with the Rule; and
- Require ongoing provider education and training on the Rule.

The State determined that its 1915(c) Waiver Interagency Agreement with DIDD should be amended to include a requirement that DIDD ensure prior to contracting with a new provider that the new provider is compliant with the HCBS Settings Rule, and to also conduct ongoing compliance monitoring for existing HCBS providers. The State determined that the DIDD Provider Agreement should be amended to include language requiring providers to comply with the HCBS Settings Rule and maintain ongoing compliance.

The state determined that in its 1915(c) waivers, the rate methodologies and billing practices should be revised to better align with the intent of the HCBS Setting rule and incentivize providers to provide services in a more integrated manner.

- **Information Systems:** While no areas of non-compliance were identified as a result of the assessment, The State recognizes the opportunity to continually work internally, as well as externally with contracted entities to ensure infrastructures are flexible when needed.

TennCare's Self-Assessment Remediation Milestones and Timelines:

State Statutes: In order to amend the state statutes (as detailed above) the State needed to submit and pass legislation authorizing the departments that license Medicaid-reimbursed HCBS to amend their departmental rules.

- The State proposed legislation to amend Tennessee Code Annotated Sections 33-2-404, 68-11-202, and 71-2-412 as detailed above during the 2015 legislative session of the 109th General Assembly. Rather than attempting a comprehensive re-write of statutory language, TennCare proposed language to be added to each of the applicable statutes that would allow the licensing authority to modify its rules to ensure compliance with the HCBS settings rule, even if such rule is in conflict with a previously existing statutory provision—in essence, pre-empting the previous requirements of state law to ensure compliance with the federal HCBS settings rule. HB101/SB112 was passed on April 2nd and approved on April 16th granting authority for the DOH board for licensing healthcare facilities and the DMHSAS, DHS and DIDD to amend licensure rules to be consistent with the federal HCBS Settings final Rule. Therefore, the statutory assessment and revision process is complete (http://www.tn.gov/sos/acts/109/pub/pc0153.pdf).

1915(c) Waivers: In order to amend the State's 1915(c) Waiver definitions in Appendices C, the State needed to revise the service definitions in the Waivers as well as revise language related to the care planning process and participant rights, and submit these revisions as part of its Waiver amendment and renewal requests to CMS. Additional changes in employment and day services to further strengthen compliance in non-residential settings are part of an amendment to each of the State's 1915(c) waivers that will be posted for public comment in November 2015. An approach for modification of the reimbursement structure to de-link staffing ratios from rates of reimbursement for certain services is being contemplated for 2017, and provider education around person-centered plan development and implementation to ensure that expectations pertaining to protection from harm are not prohibiting individual choice and freedom began in the fall and will continue with revisions to the provider manual in 2016 (https://www.tn.gov/tenncare/topic/hcbs-for-individuals-with-intellectual-and-developmental-disabilities).

- The State submitted waiver renewals to CMS on October 1, 2014. Changes to the waivers in areas as identified above in two of its three 1915(c) Waivers, and comparable changes were submitted in an amendment to the State's remaining 1915(c) Waiver, as applicable, on October 15, 2014. Waiver renewal requests and all amendments were approved by CMS on March 27, 2015. Additional amendments to further strengthen compliance in non-residential settings are in process and expected to be submitted in conjunction with this amended Statewide Transition Plan, following the public input process. Redesign of reimbursement methodologies to eliminate staffing requirements has begun, including an initial planning meeting with HSRI through a Technical Assistance Grant funded by CMS via New Editions Consulting, and initial stakeholder discussions. We expect that design and implementation of a new reimbursement approach cannot be completed until at least July 1, 2017. Provider education around person-centered plan development and implementation to ensure that expectations pertaining to protection from harm are not prohibiting individual choice and freedom will proceed and is expected to continue into 2016, and will be reflected in changes to the provider manual to be completed by June 30, 2016. Additional changes in the waivers may be proposed as needed based on key learnings as the state moves forward with implementation of remediation strategies, in order to align incentives toward helping to support individual integrated employment at a competitive wage and integrated community living as the preferred outcomes for all program participants.

State Rules: In order to amend the state protocols, procedures, and policies, including the DIDD Provider Manual, the State must first amend the documents internally and then make the revised documents available to contractors and providers.

- The State has identified areas of non-compliance and areas to strengthen compliance in State rules across multiple departments as detailed above. The rulemaking process is lengthy, comprising a minimum of roughly six months from the notice of rulemaking to a final rule. TennCare will promulgate new rules, including collecting stakeholder input, by January 1, 2017. In addition, TennCare will collaborate to assist other state departments in revising their rules, as applicable, by January 1, 2017, or will take necessary steps to otherwise plan for transition if compliance cannot be achieved. Copies of memos to other state departments will be submitted to the CMS Regional Project Officer.

State Contracts: In order to amend the state contracts as detailed above, the State needed to include in its CRA with its contracted MCOs and its Interagency Agreement with DIDD HCBS Settings Rule language.

- The State amended its CRA with the MCOs to include the HCBS Settings Rule language detailed above in the CRA effective January 1, 2015 with additional amendments made effective July 1, 2015. The State monitors MCO compliance with the CRA through several quality mechanisms including routine audits, and these components have been incorporated into that compliance monitoring structure. Therefore, this contractual amendment has been made and is complete.https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf.
- The State amended its 1915(c) Waiver Interagency Agreement with DIDD to include the HCBS Settings Rule language detailed above effective July 1, 2015. The State monitors DIDD compliance with the Interagency Agreement through several quality mechanisms and these components have been incorporated into that compliance monitoring structure. Therefore, this contractual amendment has been made and is complete.
- The State will amend its DIDD Provider Agreement in 2016 to include reference to the HCBS Settings Rule. This contract will be effective January 1, 2017.
- The State required all MCOs to submit revised HCBS Provider Agreements to the State for review no later than August 15, 2015 to demonstrate that the MCOs have included the CRA requirement for providers to maintain compliance with the HCBS Settings Rule in these agreements. This includes review and approval by the TN Department of Commerce and Insurance (TDCI).

State Protocols, Procedures, and Policies: In order to amend the state protocols, procedures, and policies, including the DIDD Provider Manual, the State must first amend the documents internally and then make the revised documents available to contractors and providers.

- The State revised its Needs Assessment and Plan of Care protocols as detailed above and submitted these protocols to the MCOs on January 1, 2015. DIDD has revised the 6 protocols identified above and submitted them to the State for review. Approved protocols will be circulated to providers and posted to the DIDD website by December 31, 2015. Additionally, DIDD will revise its Provider Manual and circulate it to providers by June 30, 2016.

Section 3: Contracted Entity Internal Analysis, Outcomes and Remediation:
The Contracted Entity Internal Analysis Process:

During the TennCare self-assessment process, LTSS contracted entities, Managed Care Organizations (MCOs under the 1115 Waiver) and the Department of Intellectual and Developmental Disabilities (DIDD under the State's three 1915 (c) Waivers) were assigned the following tasks:

- The DIDD and MCOs were required to review all policies, procedures and practices (including Quality Management practices), training requirements, contracts, billing practices, person-centered planning requirements and documentation, and information systems to determine their compliance with the HCBS Settings Rule. Each entity was required to submit its assessment along with evidence of compliance to TennCare. Each entity was also required to identify any modifications needed to achieve compliance with the HCBS Settings Rule. TennCare reviewed each entity's self-assessment and evidence of compliance (100% review and validation) to ensure that all aspects of the system are congruent with CMS expectations and will allow the State to operate HCBS programs in a manner which comports with the HCBS Settings Rule.
- All revisions to contract language, policies, procedures, training requirements, etc. needed to achieve compliance with the new rule were submitted to TennCare for review and approval, and implementation will be tracked by the State in accordance with approved timeframes.
- Upon approval, final versions of revised documents will be completed and distributed to providers.
- Additional provider education/training sessions are being planned for the first quarter of 2016. All education and training sessions and materials will be led by or reviewed and approved by TennCare.
- Specific to DIDD, in instances where a change in rule or policy requires a public comment period, adjustments will be made accordingly to accommodate the timelines needed to process and respond to public input and incorporate such comments into document revisions.

Contracted Entity Internal Analysis Outcomes:

MCO Internal Analysis

To facilitate MCO internal analysis, TennCare conducted a readiness review of its MCOs for compliance with provisions of TennCare's Contractor Risk Agreement (CRA), which included assessing MCO compliance with the HCBS Settings Rule. TennCare required its MCOs to review, amend, and create policies, protocols, procedures, and training documents in the desk review portion of the readiness review to demonstrate that the MCOs had requirements "to ensure provider compliance with the HCBS Settings Rule during provider credentialing, care planning processes, and provider re-credentialing pursuant to CRA requirements." MCOs submitted amended and newly created policies, protocols, procedures, and training materials concerning the HCBS Settings Rule to TennCare on May 8, 2015. TennCare LTSS staff reviewed the documentation and responded with edits and comments on May 22, 2015. In response to TennCare feedback, MCOs resubmitted revised documentation on May 29, 2015, and TennCare reviewed and provided final approval of these documents on June 5, 2015.

Following the desk review portion of the readiness review, TennCare visited each MCO on-site during the week of June 8 – 12, 2015 and required as part of this on-site demonstration that MCOs present systems changes and supporting documentation to "demonstrate how the MCO will ensure initial and ongoing compliance from HCBS providers concerning the HCBS Settings Rule." All MCOs demonstrated that they had made system modifications and related changes to ensure HCBS provider compliance with the HCBS Settings Rule, and TennCare provided notice of successful completion of all readiness review activities to its MCOs on June 22, 2015.

In addition to the readiness review process, TennCare requested that all MCOs submit their revised HCBS provider agreements to the Tennessee Department of Commerce and Insurance by August 15, 2015 for TennCare review to ensure the agreements all contained requirements that HCBS providers comply with the HCBS Settings Rule as prescribed by the CRA and effective July 1, 2015. By August 15, 2015 all MCOs submitted evidence of amended HCBS Provider Agreements with language requiring the following: 1) Provider agrees to maintain compliance with the HCBS Settings Rule detailed in 42 C.F.R § 441.301(c)(4)-(5); and 2) MCO will verify that the provider is in compliance with the HCBS Settings Rule detailed in 42 C.F.R § 441.301(c)(4)-(5) prior to executing the Provider Agreement.

DIDD Internal Analysis

DIDD conducted an internal analysis and presented the findings to TennCare on March 30, 2015. As part of its analysis, DIDD reviewed its policies, provider manual, procedures and practices, contracts, billing practices, and information systems. As a result of its self-assessment, DIDD made the following determinations: 1) All of its policies relating to HCBS

Waiver Services are compliant with the HCBS Settings Rule; 2) Changes are needed to its Provider Manual; 3) Changes are needed to its medical necessity protocols and Quality Assurance tools; 4) All of its training requirements are compliant; however, DIDD added information to new provider training and orientation to include expectations concerning the HCBS Settings Rule, and conducted HCBS Settings Rule training for all Independent Support Coordinators and State Case Managers supporting members in 1915c Waivers by October 31, 2015; 5) All of its contracts and provider agreements contain language that does not contradict any HCBS Settings Rule requirements; however, DIDD determined that it could reinforce HCBS Settings Rule compliance with providers by adding an explicit requirement to maintain compliance with the HCBS Settings Rule in its Provider Agreement; 6) All of its billing practices are compliant but will be revised as described above; and 7) All of its information systems are compliant.

On September 30, 2015 DIDD submitted its revised Provider Manual to TennCare for review. DIDD added "Centers for Medicare and Medicaid Services HCBS Settings Final Rule Requirements" under the Training section to account for HCBS Settings Rule training created for new providers. Under Other Components of the QMS (Quality Management System), "Provider HCBS Final Rule Self-Assessments" has been added, as well as "Individual Experience Assessments (IEAs)." Under Residential, Employment and Day services, residential edits includes: 1) modifications to the final rule process and documentation requirements; 2) residential property can be rented, owned, or occupied by person supported under tenant law or a lease agreement; 3) the home and person's bedroom can be locked; 4) persons supported shall choose roommates in shared living arrangements; 5) persons shall have freedom to furnish and decorate their sleeping and living units; 6) persons will have freedom and are encouraged to control their own schedule and activities and have access to food at any time; persons can have visitors of their own choosing at any time; and 7) all residential settings must meet the individual accessibility and safety needs of the person. Under the same section, employment and day objectives includes: 1) exploring supported employment; 2) job shadowing; 3) exploring volunteer opportunities; 4) being an active community member; 5) taking a class in the community; 6) participating in experiences that coincide with interests; 7) training in a specific skill; 8) informational interviews; 9) participating in Discovery. Additionally, further guidance on Day Services Settings include: 1) the setting is integrated in and supports full access to the greater community; 2) is selected by the person; 3) ensures individual rights of privacy, dignity, respect, and freedom from coercion and restraint; 4) optimizes autonomy and independence in making life choices; and 5) facilitates choice regarding services and who provides them.

Contracted Entity Remediation Milestones and Timelines:

TennCare contracted MCOs

As detailed above, TennCare ensured that MCOs remediated all non-compliant processes during the readiness review.

To ensure compliance on an ongoing basis, pursuant to CRA requirements effective January 1, 2015, TennCare has worked with MCOs to ensure the HCBS Setting Rule is embedded in MCOs' contracting, credentialing, and monitoring processes for both new and current provider sites.

The effective CRA citations/contract language is below:

A.2.11.9.4.1.3. At a minimum, re-credentialing of HCBS providers shall include verification of continued licensure and/or certification (as applicable); compliance with policies and procedures identified during credentialing, including background checks and training requirements, critical incident reporting and management, and use of the EVV; and compliance with the HCBS Setting Rule detailed in 42 C.F.R § 441.301(c)(4)-(5).

A.2.12.11. Prior to executing a provider agreement with any CHOICES HCBS provider seeking Medicaid reimbursement for CHOICES HCBS, the CONTRACTOR shall certify that the provider is compliant with the HCBS Settings Rule detailed in 42 C.F.R § 441.301(c)(4)-(5). The provider agreement with a CHOICES HCBS provider shall meet the minimum requirements specified in Section A.2.12.9 and shall also include, at a minimum, the following requirements:

A.2.12.11.14. The contractor shall require that all CHOICES HCBS providers maintain compliance with the HCBS Settings Rule detailed in 42 C.F.R § 441.301(c)(4)-(5).

The State monitors MCO compliance with the CRA through several quality mechanisms including routine audits, and these components have been incorporated into that compliance monitoring structure. In addition, MCOs verify HCBS Settings compliance as part of credentialing and re-credentialing activities and during their annual audits of all providers.

TennCare's LTSS Audit & Compliance unit conducts annual HCBS credentialing audits as well.

DIDD

As detailed above, DIDD determined that its provider manual and medical necessity protocols contained non-compliant language. These documents have been submitted to TennCare and are currently under review for approval and will be distributed to providers no later than June 30, 2016.

Additionally, TennCare has identified one additional item for DIDD to remediate:

DIDD should add a provision to the DIDD Provider Agreement that requires providers maintain compliance with the HCBS Settings Rule. While this is already an expectation of DIDD HCBS providers included in TennCare's contract with DIDD, the requirement is not included in the provider agreement. Adding this provision will be accomplished by June 30, 2016.

The effective DIDD/TennCare Interagency Agreement language is below:*A.24. The Contractor shall ensure, prior to contracting with a new provider and as part of on-going monitoring of existing providers, that all HCBS settings where Medicaid-reimbursed services are provided are compliant with the CMS HCBS Settings Rule 42 C.F.R. § 441.301(c)(4)-(5) and in accordance with the state's approved transition plan.*

A.30. The Contractor shall comply with state and federal rules, laws and regulations, all applicable federal and state court orders including, but not limited to, those set forth in Grier v. Goetz, CMS HCBS Settings and Person-Centered Planning Rules in 42 C.F.R. § 441.301(c), and TennCare policies and procedures in the administration of the Waivers.

DIDD CQL accreditation:

Finally, as part of DIDDs ongoing partnership with The Council on Quality and Leadership, the Department has been working on network accreditation and has submitted a Personal Outcome Measure ® Plan (POM) in order to implement the POMs on an individual and systemic level by January 2016. The plan includes policy and process actions in the areas of: 1) People Exercise Rights; 2) People Choose Where and with Whom to Live; and 3) People Choose Personal Goals http://www.tn.gov/didd/news/7827.

In January 2015, DIDD received official Person-Centered Excellence network accreditation from the Council on Quality and Leadership (CQL) http://www.tn.gov/didd/topic/policy-innovation.

Section 4: Provider Self-Assessment, Outcomes and Remediation:

Provider Self-Assessment Process

Mandatory trainings were conducted via webinar for HCBS residential and day program service providers on the Provider Self-Assessment and Validation process. Six of these training webinars were conducted beginning on October 15, 2014 and were completed November 13, 2014. In addition, a recorded version was posted to the TennCare website for providers to access anytime.

The provider self-assessment process started October 15th, 2014 and concluded on March 31, 2015. The contracted entities then worked from April 1 through September 30, 2015 with providers on validating the self-assessment and approving any provider transition plan as applicable. The original Statewide Transition Plan detailed the process and is below:

- The State conducted statewide provider education and training sessions on how to complete the Provider Self-Assessment Tool. These training sessions were conducted October 15, 2014 through November 15, 2014.

- Providers received the applicable Provider Self-Assessment Tool with the Assessment Tool instructions and time lines. At a minimum, all HCBS residential, employment and day program provider settings were required to complete a self-assessment.
- Providers were required to include persons served, family members/representatives, advocates, and other stakeholders in their assessment process.
- Providers were required to include in their self-assessment a description of their self-assessment process, including participation of the aforementioned persons.
- Providers submitted their respective Self-Assessment along with ***specific evidence*** of compliance for further review by TennCare or its designee (DIDD or MCOs). Additional evidence was requested or additional reviews conducted as needed to further assess and validate compliance with these rules.
- Providers who self-reported or were assessed upon review and validation to be non-compliant with the HCBS Settings Rule were required to submit a Provider Transition Plan identifying the area(s) of non-compliance and describing their proposed plan for coming into compliance along with associated time lines. Information regarding Provider Transition Plans and specific timelines for achieving compliance is incorporated in this amended State Transition Plan.
- All completed and validated Provider Transition Plans were reviewed and approved by the DIDD or MCO as applicable, and implementation will be monitored based on approved timeframes, with oversight by TennCare.
- Providers needing assistance to achieve compliance requested such assistance from the entity with whom they are contracted (DIDD or MCO), another (compliant) provider of the same service type, and/or consumers and family members or advocates.
- Providers assessed to be unwilling or unable to come into compliance, will be required to cooperate with transition assistance to ensure all individuals served are transitioned to an appropriate provider type, maintaining continuity of services.
    I. TennCare, in conjunction with DIDD or the MCOs, as applicable, will oversee all necessary transition processes:
        i. A *minimum* of 30 days' notice will be given to all persons needing to transition between providers. Additional time will be provided to complete these transitions as needed and consistent with the State's approved Transition Plan. The State will ensure that sufficient time is permitted to safely transition individuals to another compliant setting of their choice, and to assure continuity of services. This will include instances where the person's new residential setting must be developed and/or modified to meet their needs.
        ii. A description of the process and choice of appropriate providers will be included with each notice. The person's ISC, case manager or care

coordinator, as appropriate, will conduct a face to face visit as soon as possible to discuss the transition process, and ensure that the person is making an informed choice of an alternate setting that meets the HCBS Settings Rule criteria, as well as ensuring that the person understands any applicable due process rights.

iii. The person's ISC, case manager, or care coordinator, as appropriate, will further ensure that any critical services and/or supports are in place in advance of the transition to the person's new residence.

Settings assessed:

Specific to settings, the provider assessment asks 48 questions in the areas of: physical location, community integration, residential rights, living arrangements, and policy enforcement. Each area contains probing questions based on the CMS Exploratory Questions and in total the assessment can be cross-walked to the CMS HCBS Final Rule requirements.

1915 (c) waiver settings assessed:

- Residential Habilitation
- Employment and Day (Community and Facility Based Day, In-home Day, and Supported Employment)
- Family Model Residential Support
- Medical Residential Services
- Supported Living

1115 CHOICES waiver settings assessed:

- Adult Day Care
- Assisted Care Living Facility
- Critical Adult Care Home

Validation Process:

TennCare has implemented a multi-layered validation processes to ensure responses from providers represent complete and accurate interpretations of the final rule requirements. First, each contracted entity was charged with reviewing and validating 100% of all provider self-assessments, supporting documentation and transition plans. Each contracted entity was required to identify a point of contact that would be responsible for tracking and reporting assessment progress on a monthly basis to TennCare. Documentation that supported the

provider's assessed compliance included: cross walk of supporting documentation, provider policies, training documentation, member materials, and any other pertinent information such as maps, pamphlets or photos and make-up and minutes from stakeholder meetings. If it was determined by the reviewer that the documentation submitted did not support compliance then the applicable indicator(s) was marked accordingly on the tracking mechanism and the provider received additional technical assistance in order to become compliant or revise the self-assessment and/or transition plan as appropriate to accurately reflect compliance.

Each contracted entity utilized staff that was familiar with the program to help with the validation process. For example, DIDD utilized its three regional offices to validate provider responses. The designated regional office staff were either part of the quality assurance monitoring or were in some way part of the larger quality management system. The review team consisted of: 1) one person from Quality Assurance, these are the regional QA directors who are involved in surveys for numerous providers; 2) one person from the Accreditation Team, these are people that are out in the field very frequently conducting Personal Outcomes Measures ® and Basic Assurances reviews at agencies; 3) one person from Operations, these are staff that are involved with ongoing monitoring, remediation of issues and technical assistance to providers; and 4) one person from Compliance; these are Compliance Directors and the organizers of information who are heavily involved in the Quality Management Committee process and routinely work with agencies and data storage.

TennCare strongly believed that providers should involve their stakeholders that are outside of the provider agency, but are directly impacted by the final rule, in the entire self-assessment process as a way to further ensure validity. TennCare required all providers establish a HCBS Setting compliance stakeholder group consisting of agency executive staff, direct support staff, individuals served, a family member or representative of individuals served, an advocate from an organization not associated with or receiving payment from the agency, and a support coordinator/care coordinator. Each provider was required to utilize this stakeholder group in the self-assessment and transition plan development process and submit documentation demonstrating stakeholder involvement, agreement with provider self-assessment and agreement with the provider transition plan.

The contracted entity's designated reviewers were all trained on the validation process and TennCare's expectations prior to the assessment process beginning. Additionally, providers were trained on the self-assessment process, including validation, prior to the begin date. TennCare required each contracted entity to submit three completed self-assessments as a quality oversight measure. TennCare reviewed and returned its findings to the reviewer prior to the contracted entity returning the validation documentation to the provider. The intent of this quality oversight was to inform the reviewer of TennCare's expectations and for the designated reviewer to then apply this broadly across all of their provider self-assessment reviews.

Designated reviewers were encouraged to reach out to TennCare throughout the validation process whenever assistance was needed to ensure consistency. Some contracted entities verified provider documentation through an on-site review prior to approving the self-assessment. For example, one MCO conducted on-site reviews of 6 Adult Day Care settings and 21 Assisted Living Facility settings. While this was not a requirement, TennCare encouraged each contracted entity to conduct on-site verification, as needed in the review and validation process.

Second, TennCare conducted a post review of completed provider self-assessments and approved transition plans. The intent for this oversight was not only to ensure that both the contracted entities and providers were interpreting the requirements accurately, but also to determine areas of systemic weakness that will inform future quality management process. In this post review TennCare asked each contracted entity to submit three approved provider self-assessments, all supporting documentation and accompanying approved transition plan if applicable. After reviewing all the documentation an analysis was developed that included strengths, weaknesses and remediation steps. The analyses were once again intended to inform the contracted entities of TennCare's expectations on interpreting the final rule. The remediation steps were built into the analysis to ensure each provider had a clear path for amending their provider transition plan.

An additional phase of TennCare's validation process will utilize the Individual Experience Assessment. TennCare will crosswalk responses from the provider self-assessment outcomes with the Individual Experience Assessment outcomes to form a base-line of how well the providers assessed their performance in meeting community integration expectations from the individual's perspective. A threshold will be developed for meeting expectations. If the provider fails to meet the threshold then the provider will be required to revise their self-assessment and transition plan. TennCare may desire to make changes to the IEA upon final data analysis. Any augmentation to this assessment and the implementation of this survey in the future would be made to ensure that each individual supported is comfortable sharing his/her true experience. Additionally, TennCare may utilize IEA survey results to compare with other survey tools (such as the Core Indictor Project) to find trends or variances.

<u>Heightened Scrutiny Process:</u>

TennCare has incorporated questions regarding the presumption of institutional characteristics in the provider level self-assessment. The physical location area and the indicators focus directly on presumed characteristics of an institution:

1. The setting is NOT located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment (a NF, IMD, ICF/IID, hospital).

2. The setting is NOT located in a building on the grounds of, or immediately adjacent to, a public institution.
3. The provider does NOT own or operate multiple homes located on the same street (excluding duplexes and multiplexes, unless there is more than one on the same street).
4. The setting is NOT located in a gated/secured 'community' for people with disabilities.
5. The setting or dwelling is NOT located in a farmstead or disability-specific community.
6. The setting is NOT designed specifically for people with disabilities.
7. Individuals who reside in the setting are NOT primarily or exclusively people with disabilities.

<u>The living arrangements area and many of its indicators focus on having the qualities of an institution:</u>

1. Do individuals in the setting have access to public transportation?
2. Is the setting free from gates, Velcro strips, locked doors, or other barriers preventing individuals' entrance to or exit from certain areas of the setting?
3. Do individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement?
4. Are cameras that are present inside the setting only utilized in direct relation to the person-centered plan of care?
5. Do individuals have access to food anytime, as appropriate?

Any negative responses to these indicators will be addressed by the assigned contracted entity reviewer and remediation steps will be captured in the provider transition plan.

As a final verification and validation step, TennCare has determined it is necessary to apply a "heightened scrutiny" review to specific services/settings. This Heightened Scrutiny review will be based on the CMS Heightened Scrutiny process: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/downloads/settings-that-isolate.pdf. This will help the State to determine whether such settings in fact should be "presumed to have the qualities of an institution," and if so, will require submission of evidence to CMS in order to demonstrate that the setting does not have the qualities of an institution and that it does have the qualities of a home and community-based setting. Tennessee does not intend to submit services/settings to CMS for application of Heightened Scrutiny unless the State believes that the setting in fact has the qualities of a home and community based setting, which may include steps that will be taken by the provider as part of an approved transition plan which the State believes are expected to achieve compliance. TennCare will work directly with providers and contracted partners to review specified settings for compliance with the HCBS Settings Rule using the process as defined by CMS. The State will also engage advocacy organizations in the review process. The intent is to further evaluate any setting that may be institutional in nature—by virtue of physical location,

or because it is designed specifically for people with disabilities and individuals in the setting are primarily or exclusively people with disabilities and the on-site staff that provide services to them. Tennessee is utilizing this process to clearly identify what it believes to be appropriate and sufficient in establishing and demonstrating that the settings meet the qualities for being home and community based settings. The settings that will be included in the Heightened Scrutiny review are:

- Adult Day Care
- Assisted Care Living Facilities
- Facility Based Day
- Residential Habilitation settings where more than 4 persons reside

In addition, while not included in the initial self-assessment process (because all settings were established after the rule became effective), Intensive Behavioral Residential Services will also be subject to this review to ensure full compliance with the HCBS final rule.

The Heightened Scrutiny review utilized by TennCare will include: review of data pertaining to services utilized by all persons receiving services in the specified setting—for example, for Facility-Based Day Services, a review of data to determine the number of individuals in the setting participating only in facility-based day services, those receiving a combination of facility-based and community-based day services, those receiving integrated employment, and the relative percentage of persons and time spent in each such setting; an on-site visit and assessment of physical location and practices; review of person-centered plans and individual experience assessments for individuals receiving services in the setting; interviews with service recipients; a secondary review of policies, training and other applicable service related documents; and 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. An assessment tool specific to each service/setting that will be utilized by the State will be provided to applicable providers prior to the State's on-site visit. The CMS Heightened Scrutiny process requires public input and as such will be incorporated into the State's review process.

Per CMS, evidence of how a setting overcomes its presumed institutional qualities should focus on the qualities of the setting and how it is integrated in and supports full access of individuals receiving HCBS into the greater community, not on the aspects and/or severity of the disabilities of the individuals served in the setting.

The TennCare Heightened Scrutiny review will begin April 1, 2016 and conclude by December 31, 2016.

Provider Self-Assessment Outcomes:

The following data was gleaned as a result of the provider self-assessment:

Total Number of Provider Settings Assessed: 1245
Total Residential Provider Settings: 704

- Residential Habilitation and Medical Residential: 170
- Family Model Residential: 290
- *Intensive Behavioral Residential Services: 0
- Supported Living: 144
- Assisted Care Living Facility: 99
- Adult Care Home: 1

*Note: IBRS was a new waiver service and a provider had not been established at the time of the provider self-assessment. The Department of Intellectual and Developmental Disabilities has certified 2 IBRS sites and are in the process of assessing each for HCBS compliance. TennCare will follow the DIDD review process with its own on-site review if DIDD findings result in non-compliance.

Total Non-Residential Settings: 541

- Community-Based Day: 167
- Facility-Based Day: 86
- Supported Employment: 99
- In-Home Day: 147
- Adult Day Care: 42

Compliance among Providers:

- Total number and percentage of provider settings deemed 100% compliant with the HCBS Settings Rule: 170 settings or 14%.
- Total number and percent of providers settings who have identified at least one area that is currently out of compliance with the HCBS Settings Rule and thus have submitted a transition plan in order to come into compliance: 1048 or 84%.
- Total number and percent of provider settings deemed non-compliant with HCBS Settings Rule and opting not to complete a provider level transition plan: 27 settings or 2%.
- Total number and percent of provider settings presumptively non-home and community based, but for which the state will provide justification that these settings do not have

the characteristics of an institution and do have the qualities of home and community-based settings: 0 or 0%.

1048 Transition Plans Received. Of the transition plans received, the number and percent requiring action in each of the following areas in order to come into compliance:

- 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%

Transition Plan Timelines: Number and percent transition plan approved to occur:

- Within 6-9 months of submitting the provider self-assessment (September 30, 2015 through December 31, 2015): 654 or 62%
- Within 1+ year of submitting the provider self-assessment (March 31, 2016 through March 30, 2017): 299 or 29%
- Within 2+ years of submitting the provider self-assessment (March 31, 2017 through March *30* 2018): 32 or 3%
- More than 3 years of submitting the provider self-assessment (beyond March 31, 2018): 63 or 6%

TennCare intends to target for further analysis any provider that has an approved transition plan with completion dates that extend beyond December 31, 2017. As a result of this analysis, if a provider's transition plan compliance activity completion dates can be shortened then TennCare will request an amended provider transition plan.

Contracted Entity Analysis:

The contracted entities were asked to summarize the assessment results. The CHOICES MCOs responses centered on community integration and transportation. Based on the back-up documentation submitted, community activities outside the setting, transportation resources and training on how to utilize transportation resources were all areas that needed more training and clear policy development and implementation.

Based on the DIDD analysis submitted community integration appeared to be one of the biggest opportunities for improvement. Facility-Based Day (FBD) service was mentioned multiple times in the summary. FBD neither encouraged community integration nor had developed ways to integrate the setting with non-disabled peers. Some did have parallel use for the building; such as club use or recreation for the community. There was one self-defined disability community.

Community integration was lacking personal community connection with non-disabled peers being promoted and supported by providers. Public transportation education was not being pursued due to providers having internal transportation and the cost of transportation being included in the rates for residential and day services.

Additionally individual rights and privacy stood out as an area that is lacking adequate provider understanding, lacking up to date policy, or lacking appropriate implementation. Rights were not well defined, in some cases differences in defined rights were noted for different services or sections of a program. Staff was not always receiving training regarding the rights of persons supported. There was little education on rights and member experience for volunteers. There appeared to be longstanding trend of placing restrictions for an extended amount of time rather than finding ways to phase out the plans and/or looking at least restrictive methods. DIDD found instances of both video and auditory monitoring in private area. Some providers had blanket policies in place that were restrictive in nature not offering flexibility to people supported and at times, imposed restrictions on a group of people with certain behavioral concerns without a Human Rights Committee review. Some residential settings, usually residential habilitation homes, which are larger and more congregate, did not have basic privacy mechanisms in place, such as locked bedroom doors.

Finally, legal lease or tenant agreements were not in place before this process for Family Model and they were inconsistently found for Residential Habilitation. Providers did begin to put these in place either while developing their assessments or through transition plans.

It was noted that a majority of DIDD providers believed the lack of flexibility in achieving community integration was due in part to the inflexible rate structure of day services. Some DIDD providers continue to feel that facility-based settings and services should be a choice regardless of the propensity to segregate. Providers, and some families and people supported, feel that if the person chooses this service from among other service options that the service should be an acceptable option. Also noted, some CHOICES providers believed that the HCBS Setting Rule and Person-Centered Planning flagged individuals receiving Medicaid and set them apart from other members receiving services.

Provider Self-Assessment Remediation Milestones and Timelines

Provider Transition Plan:

Provider level transition plans were required when there was a deficiency in any of the provider self-assessment compliance areas: physical location, community integration, resident rights,

living arrangements, or policy enforcement. For each of these sections there were specific indicators that need to be met at 100%. If these indicators were not met then the provider was required to address the deficiency in their provider transition plan. Each contracted entity reviewed these plans and either approved them or provided additional technical assistance in order to meet the September 30, 2015 deadline for submitting both final self-assessments and transition plans. Supporting documentation for compliance in each area was also required.

Tracking and Monitoring Provider Transition Plans:

Each contracted entity is responsible for ensuring provider transition plans are being implemented effectively. The process for tracking and monitoring transition plans is to be determined by the contracted entity. For example, DIDD will begin monitoring provider transition plans during routine provider visits. A tracking spreadsheet that identifies the provider transition plan milestones and deliverable dates will be used to help coordinate this effort. The regional office provider supports teams will monitor the plans on a monthly basis and roll their findings up into a quarterly summary for discussion and review. Quarterly meetings will be held to provide plan implementation updates. The quarterly meetings will take data that has been rolled up and determine if additional technical assistance is warranted. Technical assistance will be provided if there is a problem with the implementation of the transition plan, if an agency is not implementing the plan or if the agency decides to significantly change their plan or implementation of their plan. TennCare will require all contracted entities to submit transition plan monitoring updates on a quarterly basis.

MCO Credentialing and Re-credentialing:

The MCOs are in the process of developing or have already developed their HCBS Settings compliance tool and process for credentialing and re-credentialing providers. TennCare provided guidance on ensuring this process is tailored to the appropriate type of provider during its monthly MCO status call on October 19, 2015. For example, if a provider has been assessed by a different contracted entity for final rule compliance then the information requested would be different than for a new provider that has never been assessed for final rule compliance. The process for ensuring final rule compliance prior to credentialing and re-credentialing providers became effective on July 1, 2015.

DIDD Basic Assurances ®

As part of DIDD's ongoing partnership with The Council on Quality and Leadership, the Department has submitted a network accreditation Basic Assurances ® Plan in order to bring all Basic Assurances ®into alignment by January 2016. The Basic Assurances ® can be cross-walked

with the CMS final rule and is a tool utilized by a number of states to measure provider compliance or incorporated in standards and certification tools. DIDD has incorporated a number of the Basic Assurances ® in their Provider Manual that is currently under review. Some areas that were addressed in DIDD's Basic Assurance ® Plan include: 1) the organization supports people to exercise their rights and responsibilities; 2) staff recognize and honor people's rights; 3) the organization upholds due process; 4) decision-making supports are provided to people as needed; 5) people have meaningful work and activity choices; and 6) policies and practices facilitate continuity of natural support systems.

Targeted training

Now that phase one of the compliance process has been completed and TennCare has analyzed the provider self-assessments, targeted training will begin in areas that appear to be most critical. Targeted training will be provided to contracted entities in order to ensure that those responsible for training and credentialing fully understand how to operationalize the final rule. Targeted training will be provided to service providers in order to provide a deeper understanding of the final rule. Based on the final provider-self assessments, areas of community integration and living arrangement need further emphasis to ensure final rule compliance. TennCare will work with DIDD and the MCOs to develop and conduct these targeted trainings as well as facilitate focus groups described in section E below. Additionally, provider training will look at how the providers assessed themselves versus how the contracted entity's assessed the provider. This will shed light on the possible gaps in truly understanding the intent of the final rule and will provide opportunities for more specialized education. Finally, targeted training will be provided to persons supported and their family. TennCare wants to ensure that persons supported and their family understands the reason for changes in the way HCBS are rendered. It is also important for this target audience to know that services and supports will still be available; however these services and supports may look different.

Targeted trainings will begin by the end of the first quarter of calendar year 2016.

Relocation of Beneficiaries:

Currently, TennCare does not foresee a scenario where it will need to submit to CMS evidence for the heightened scrutiny process. If a provider site is not in full compliance with the HCBS Setting Rule, then the expectation is that the provider will come into compliance as evidenced by an approved transition plan with reasonable timelines for achieving compliance deliverables and a clear mechanism in place for the contracted entity to provide on-going support (as necessary) to ensure providers are implementing the approved plan. If the provider cannot or

refuses to come into compliance then TennCare will use its process for transitioning people from the non-compliant setting to a setting that meets all requirements.

TennCare has worked with the contracted entities to collect data regarding providers that will not come into compliance with the final rule and the people that will be impacted. A number of the providers that chose not to comply did not have Medicaid recipients receiving services. However, it will be necessary to move some people. Currently there are 25 people that will be relocating due to their provider choosing to not comply with the final rule. TennCare's process for relocation is outlined below. A relocation letter has been drafted for the individuals impacted and their family if applicable, as well as a letter to the provider. Specific guidance has been described in the provider letter to ensure continuity of services. Due to the proximity of the holiday season, TennCare expects that the relocation process will begin January 1, 2016. TennCare will monitor the relocation process during its monthly status calls.

TennCare, in conjunction with DIDD or the MCOs, as applicable, will oversee all necessary transitions. The relocation process instructions provided to the MCOs and DIDD is as followed:

- *The state will ensure that reasonable notice and due process is provided to anyone needing to relocate. At least a 30 day advance notice will be the minimum. Upon determining the need to relocate a person, the contracted entity's care coordinator will make a face-to-face visit to the person and if applicable caregiver/guardian/conservator to discuss the specific reason(s) for the need to relocate the person and to officially begin the notification of relocation process. Please invite caregivers, family members, friends, and anyone else that is important to this person. This face-to-face meeting should reflect everyone's sincere desire to ensure continuity of services while meeting the person's needs during this relocation process.*
- *A formal notification letter that outlines the specific reason for the relocation and the due process procedure and timeline available to the person and if applicable his/her caregiver/guardian/conservator will be sent to no less than 30 days prior to relocation. The general language will be provided by TennCare. The specific reason(s) for relocation and due process procedure will be added by the MCO.*
- *The contracted entity will send the current provider of service a formal notification letter indicating the intent to relocate the person supported. Again, this notification should occur no less than 30 days prior to relocation. The current provider should be directed to participate with TennCare, contracted entities, advocates or ombudsman, and other agencies, as applicable, in activities related to the relocation of person. This includes, but is not limited to, participation in planning meetings, ongoing provision of information, and other activities as directed. The general language will be provided by TennCare. The specific reason(s) for relocation requirement will be added by the MCO. The two notifications (to the person supported and the provider) should be sent simultaneously to ensure both parties are aware of the need to relocate at the same time.*

- *The contracted entity will ensure that the person is given ample opportunity to learn about the variety of settings that are available and are compliant with the HCBS Settings Rule. The person should be afforded the opportunity to select from non-disability specific settings and select their roommates if applicable. Supports will be provided to the person to assist in relocation choice and the caregiver's schedule will be accommodated to support the person in making an informed decision about an alternate setting. Care Coordinators should be researching all possible relocation settings for this person including, but not limited to, CLS homes, living with a relative or loved one, alternative assisted living facility, living with a friend, or exploring living on his/her own with supports.*
- *Once a new location has been selected, a person centered planning meeting will take place to define the timelines for relocation, as well as identify specific supports and services needed in order to make a safe transition. Additional time should be built into the relocation plan to ensure safety, continuity of services, for development of or modifications to existing settings, and to assure that all supports and services will be in place prior to the person relocating.*
- *The contracted entity will ensure that all supports and services are in place prior to the person moving. This should be done through an on-site visit 7-10 days prior to the person relocating and should include at a minimum the person, caregiver/guardian/conservator (if applicable), the MCO Care Coordinator/DIDD Individual Supports Coordinator, a contracted entity advocate or ombudsman, and the new provider. Any modifications or changes identified during the on-site visit as necessary for the person's health, safety, or welfare will be addressed prior to the relocation.*
- *After relocations, the contracted entity will ensure that the MCO Care Coordinator/DIDD Individual Supports Coordinator first three (3) monthly contacts will occur face-to-face.*
- *Contracted entities will provide TennCare transition updates as defined by the State.*

Part D. Individual Experience Assessment

- Individual Experience Assessment process: February 1, 2015 through January 31, 2016
    I. Each individual's ISC, case manager or care coordinator, as applicable, will assist the individual and his/her family member/representative, as appropriate, in completing an initial Individual Experience Assessment. Service provider staff may participate as requested by the individual and his/her family member/representative.
    II. Such assessments will be conducted during the individual's annual person-centered plan review, or sooner if an amendment or plan review is conducted prior to the annual review.
    III. This initial assessment period will be ongoing for one year to allow each ISC, case manager and care coordinator the opportunity to conduct the Individual

Experience Assessment while completing a scheduled annual review or needed amendment.

IV. For provider owned/controlled settings, any proposed modification of requirements set forth in the HCBS Settings Rule for the individual shall be reviewed to confirm that:
    i. There is a specific individualized assessed need for such modifications;
    ii. Prior interventions and supports including less intrusive methods have been tried and demonstrated to be unsuccessful;
    iii. The proposed modification is appropriate based on the specific need identified; and
    iv. The proposed modification, including interventions and support will not cause harm to the individual.

V. Each of the above items (i.-iv.) shall be documented in the person-centered plan, along with:
    i. The method of collecting data on an ongoing basis to measure the effectiveness of the modification; and
    ii. A specific time limit for periodic review of the data and the effectiveness of the modification to ensure it continues to be appropriate.
    iii. The individual shall provide informed consent of the proposed modification.

VI. If a modification to the HCBS Settings Rule is determined to be inappropriate based on the person's individualized needs (and in accordance with the requirements above), the area identified as non-compliant will trigger a new assessment of the provider, as applicable, and a Transition Plan developed by the provider to address any issues of non-compliance will be submitted to the contracting entity for review, approval and monitoring of implementation.

Part E. Achieving Initial Compliance

No later than December 31, 2015, upon review and validation of State, contracted entity, and provider self-assessments and internal analyses, the State will submit this amendment to the originally proposed Statewide Transition Plan with setting specific outcomes, remediation activities and milestones for achieving compliance with the HCBS Settings Rule and new public comments with a summary of comments received and explanation of revisions made as a result of public comments.

In addition, no later than December 31, 2015, the State will submit an amendment to its three 1915 (c) waivers that will include the fully developed Statewide Transition Plan, with timelines

and milestones for achieving compliance with the HCBS settings requirements in the final rule, as well as incorporation of waiver revisions based on public comments where appropriate.

For providers needing assistance to come into compliance the state proposes to implement the following strategies, January 1, 2016 through December 31, 2016:

- Facilitate focus groups of non-compliant and compliant providers who can talk through provider specific issues and problem-solve how to achieve compliance together. Participation will be voluntary and can include consumers and family members who may aid in the problem solving process. The primary focus will be on residential settings in the living arrangements category and on non-residential settings in regards to facility based day and sheltered workshop services.
- Provide one-on-one technical assistance (TA) (TA will be provided upon request by the DIDD, MCO and or TennCare as appropriate)

Part F. Assuring Ongoing Compliance

Once overall compliance is achieved, strategies to ensure ongoing compliance will include:

- Incorporating the Individual Experience Assessment (as described above) into all initial and annual person-centered plan reviews. This means each person served will have an opportunity upon enrollment in a program and annually to provide information on his/her experience with supports provided in Medicaid reimbursed HCBS settings.
- Current Quality Assurance monitoring methodologies will incorporate the addition of monitoring performance measures that ensure compliance with HCBS Settings and PCP Rules. TennCare has expanded the role of an existing Care Coordination Unit to monitor and ensure PCP practices are implemented effectively and a person's experience with HCBS settings is congruent with the intent of the final rule.
- The Plan of Care document utilized by the MCOs is being revised to a standardized template that aids in facilitating person-centered planning practices.
- Annual consumer/family satisfaction surveys that include questions relevant to the HCBS Settings and PCP Rules. TennCare previously participated in the National Core Indicators for individuals with I/DD and has begun participation for seniors and adults with physical disabilities beginning with face-to-face surveys in 2015.
- The State will also explore the use of national accreditation standards to support its ongoing compliance monitoring efforts.
- TennCare Audit & Compliance staff and the LTSS Care Coordination Unit staff will be trained in Person-Centered Thinking, Planning and Practices to ensure staff are knowledgeable on how to ensure the final rule is being adhered to.

Amended Statewide Transition Plan Public Comments

Comments on the Amended Statewide Transition Plan:
HOLD

Summary of the Comment on Amended Statewide Transition Plan and Changes Made:
HOLD

Comments on the Waiver-Specific Transition Plan

The State received 35 online comments, 21 comments via mail, and 4 comments via email, totaling 60 written public comments. (These were written comments from 60 submitting entities; most entities submitted multiple comments/recommendations.) These included three letters from advocacy groups: one from The Arc Tennessee; another from the Tennessee Parent Coalition encompassing parents of individuals with I/DD across the state, including Nashville, Memphis, and Chattanooga; and the third from the TennesseeWorks Partnership Team and Employers and Providers Workgroup. The vast majority of comments received were from family members, conservators, or representatives of individuals with disabilities served in the state's HCBS programs.

Of the 60 written comments received, 5 were not applicable to the Transition Plan or Assessment documents, and 21 were specific to concerns about the potential elimination of facility based day services under the new HCBS setting regulation. Comments were also received during face-to-face meetings with various provider groups and during statewide informational calls targeted to individuals with I/DD and their family members or conservators. A summary of the comments pertaining directly to the Proposed Transition Plan and changes to the Transition Plan based on those comments is below.

Summary of Comments on Waiver-Specific Transition Plan and Changes Made

In order to help organize comments for incorporation into the Transition Plan, the State asked entities submitting comments to answer certain questions regarding the Transition Plan. Entities were also encouraged to submit any other comments or recommendations beyond the scope of these questions.

1. Are the suggested timelines appropriate?

- Almost all of the commenters focused on the timeline set forth in the regulation for achieving compliance with the HCBS Setting Rule, rather than the specific timelines

proposed in Tennessee's Transition Plan. The majority of these commenters stated that they believe the full 5 years will be necessary for transition and 3 years at minimum. *(The State has not yet established a deadline for achieving full compliance, and recognizes that any proposed date is subject to CMS approval. This date will be determined based on state, contracted entity, and provider self-assessments, as well as action steps and timelines for achieving compliance, but will occur no later than March 17, 2019.)*

Concerns were expressed, however, with the proposed timeframes for completing provider self-assessments and contracted entity self-assessments. Based on these comments, the State modified the Transition Plan to extend the timelines for submission of these self-assessments, incorporating a training period for providers on the new tool, as further described below. These changes in the Transition Plan are addressed in Part B, 2 and Part C, 3 with the extension of Contracted Entity Self-Assessment and Provider Self-Assessment activities, respectively, from December 31, 2014 to March 31, 2015.

2. The best methodology/process for completing the assessments?

- The majority of commenters declined to make specific recommendations regarding the process.

- Several commenters recommended training for providers on the self-assessment process prior to its implementation. (*This comment was addressed in Part C, 3) with the addition of "a. The State will conduct statewide provider education and training sessions on how to complete the Provider Self-Assessment Tool. These training sessions will be conducted between October 15, 2014 – November 15, 2014.")*

- Several commenters also affirmed the importance of self-advocate and family involvement in all aspects of the assessment process, and recommended that the Transition Plan reflect ways to ensure that their perspective would be included in the assessment of compliance with the new rule. (*This comment resulted in a change in Part C, 3, c. Providers will be required to include persons served, family members/ representatives, advocates, and other stakeholders in their assessment process.)*

- Some commenters expressed concern regarding individuals who may be required to transition to new providers should their current providers not come into compliance with the new rule. (*This comment resulted in the addition of a new i. under Part C, 3 ,i.,*

reflecting the oversight of the SMA, in conjunction with DIDD or the MCO, as applicable, in all necessary transition processes.)

3. Strategies for initial achievement of compliance and assurance of ongoing compliance?

The majority of commenters responded that they need more guidance from CMS, particularly on non-residential services. Providers and families expressed significant concern regarding the potential impact of the new rule on facility-based day services, and whether such services will continue to be permitted under HCBS programs. *(TennCare received verbal guidance from CMS on non-residential service compliance which will be addressed in provider training, and is proceeding accordingly. The State will incorporate into its Transition Plan assessment and compliance processes any additional written guidance that may be issued by CMS, as it becomes available.)*

Many commenters expressed satisfaction with the current services provided in Tennessee, affirming their belief that programs are person-centered and operating in compliance with the new rule, and are concerned that changes related to the rule will disrupt services for members—in particular, facility-based day services.

- There were recommendations that the State also consider other ways of measuring ongoing compliance in addition to the individual experience assessments. *(This resulted in the addition of a 4th bullet under Part F, exploring the use of Core Indicators data and national accreditation to support ongoing compliance monitoring efforts.)*

4. OTHER comments

- The overwhelming majority of commenters again expressed concern about the effect the HCBS Setting Rule will have on facility-based day services. Most of these commenters are concerned that Tennessee will do away with facility-based day programs in part or altogether, and strongly oppose such changes. *(This comment did not impact changes necessary to the Proposed Transition Plan; verbal guidance received from CMS will be addressed in provider training and ongoing communication with stakeholder groups.)*

Other comments requested changes in certain language, e.g., not using "plan of care." *("Plan of care" has been changed to "person-centered plan" throughout the Transition Plan.)*

Summary of *Additional* Comments on Statewide Transition Plan and Changes Made

Since Section G is the only substantial difference between the initial proposed waiver-specific Transition Plan and the proposed Statewide Transition Plan, the State asked entities submitting comments to address their comments specifically to Section G of the proposed Statewide Transition Plan, while also providing additional opportunity for comment on portions of the Statewide Transition Plan that were previously posted for public comment, i.e.,

1. Please provide any comments/suggestions on Section G of the proposed Statewide Transition Plan

2. OTHER comments

Summary of Additional Comments on Statewide Transition Plan

The state received 25 additional online comments in response to the posted Statewide Transition Plan. This included one comment from a family member, 3 comments from Independent Support Coordinators (ISCs, contracted to provide Independent Support Coordination or case management under two of the State's HCBS waivers) and 21 comments from non-ISC HCBS providers, one of whom indicated they were also a family member.

A summary of these additional comments received and changes to the Statewide Transition Plan based on those comments are as follows:

- The first commenter (an ISC) expressed concern that not all families were aware of public meetings and materials posted on the TennCare website and questioned whether persons submitting comments are representative of the broader population served under the waivers. The ISC also expressed concern regarding community-based day services and support for facility-based day services as a "well-rounded option" for many individuals. Other concerns included ample time for transition if an agency is unable to come into compliance, and additional time for completion of Individual Experience Assessments since they have not yet commenced. *(The Individual Experience Assessment Tool is being revised per feedback received after training sessions were provided and will begin February 1, 2015.)*

- The timeline for completion of the Individual Experience Assessment was also the focus of a second ISC's comments, noting that the assessments have not yet begun and recommending that the dates be adjusted to provide for additional time to complete these assessments.

- 2 commenters (an ISC and a non-ISC HCBS provider) had questions about the provider self-assessment process, and one specifically asked about assessments for non-residential providers. *(Comprehensive provider training was conducted and each provider was assigned to a designated reviewer entity, DIDD or an MCO. Each designated reviewer has been in contact with providers to explain their submission process and provide access to the online assessment tool. Representatives from each designated reviewer are available to providers, and individual follow up is conducted on a regular basis with providers. All provider questions will be addressed by designated reviewers. Guidance on the non-residential provider assessment was provided during the provider training sessions and is embedded within the assessment tool as well. Additionally, the "Exploratory Questions to Assist States in Assessment of Non-Residential HCBS Settings" provided by CMS is posted on the state's website and was distributed to HCBS providers and the link was also included by DIDD in their weekly provider newsletter, Open Line.)*

- 17 comments (all from non-ISC HCBS providers) were identical, with one offering additional detail on the otherwise consistent responses. Each indicated that CMS guidance on the HCB setting rule—in particular, guidance pertaining to non-residential services "lacks clarity." They reiterated concerns previously expressed in response to the waiver-specific Transition Plan, i.e., *"It is still a concern that 'an overwhelming majority of commenters again expressed concern about the effect the HCBS Setting Rule will have on facility-based day services' this was not really addressed in the transition plan."* Similar concern was also expressed in 3 additional comments from non-ISC HCBS providers, reiterating their support for facility-based programs as a continued choice for individuals receiving HCBS. A few went so far as to say that the new rules will actually constrain the choice of individuals receiving HCBS by making people *"do things they do not want to do"* and *"taking away the CHOICE [sic] of where they want to be and what makes them happy." (Facility Based Day (FBD) settings were specifically addressed in the comprehensive provider trainings that were conducted by the state, guidance on completing the self-assessment for FBD settings was provided during the training and is also embedded within the assessment tool).*

  The 17 identical comments (plus 1 additional comment) from non-ISC HCBS providers requested additional training in the assessment of compliance with the new HCB setting rules for providers in non-residential settings.

- These same 18 comments voiced concern that the March 31, 2015 deadline for completion of provider self-assessments is proving to be more challenging than anticipated. *(6 months was provided for completion of these self-assessments. The timeline is necessary in order to allow time for review and validation, and development of corrective actions by the end of 2015. The state and designated reviewers are tracking provider progress and will work individually with agencies struggling to meet the imposed deadline.)*

- The 17 identical comments requested that a FAQ document regarding the provider self-assessment process be posted on state websites. *(A FAQ document will be developed in partnership with the designated reviewers and posted to the TennCare, DIDD and MCO websites by February 6, 2015).*

- These 17 identical comments (plus one from another non-ISC HCBS provider) requested the opportunity to review and provide input on any revisions in state law, rules and regulations, policies, protocols, and practices that might result from state or contracted entity self-assessments. All but one also requested review of any changes in the provider agreement. 17 of the 18 comments expressed appreciation that, as indicated in Part G.2 above, there will be public notice period prior to the implementation of revisions in state rules and regulations.

- The opportunity for public input on any changes in implementing regulations and appreciation for the indication of such in the Transition Plan was the subject of the only additional comment received from a Family Member on the Statewide Transition Plan.

In response to these comments, in addition to ongoing efforts to ensure opportunity for public input and ongoing support and assistance to providers, including a FAQ document regarding the self-assessment process, several adjustments (or clarifications) were made in the Statewide Transition Plan.

First, in Section 2, Part D, 4, the date for completing Individual Experience Assessments has been modified to reflect that such assessments will now commence on February 1, 2015 and continue through January 1, 2016.

Second, in Section 2, Part C, 3.i.i.1., we have emphasized that 30 days advance notice is the *minimum* amount of notice that will be required in instances where a person must transition from a non-compliant provider to a new compliant provider, and that "[a]dditional time will be

provided to complete these transitions as needed and consistent with the State's approved Transition Plan. The State will ensure that sufficient time is permitted to safely transition individuals to another compliant setting of their choice, and to assure continuity of services. This will include instances where the person's new residential setting must be developed and/or modified to meet their needs."

Finally, Section 2, Part C, 3.b. was modified to clarify that Provider Self-Assessments are applicable to all residential, employment and day program providers in a Section 1915(c) waiver or the State's MLTSS programs and to delete PA providers from the list of providers required to complete a self-assessment. This is based on guidance in a Questions and Answers document developed by CMS which advises that states are not required to assess services provided in a person's private home. Consistent with CMS guidance, we will nonetheless utilize the person-centered planning process to ensure that all services are being provided in a way that supports the person's opportunities for employment and integration into the broader community.