Federal HCBS Setting Requirements

Is integrated in and supports access to the greater community

Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources

Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS

Is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting

Ensures an individual's rights of privacy, respect, and freedom from coercion and restraint

Optimizes individual initiative, autonomy, and independence in making life choices

Facilitates individual choice regarding services and supports and who provides them

*Additional Requirements for Provider-Controlled or Controlled Residential Settings**

Institutional Model
Issues Persist in Current HCBS Infrastructure

- Normal relationships/natural supports v. paid relationships/supports

- Dependency

- Limited choices, often not based on exposure to more individualized, inclusive options

- Artificial environments

- Not within public view

- Becomes the provider's/agency's source of continued revenue

HCBS should be aligned with preserving and improving social determinants of health among beneficiaries

Social Determinants of Health as Cost Control

- Enlightened cost control strategy—not just for Medicaid, but health care system overall

- Increase efficiency while also improving health of enrollees

- Interventions for targeted populations have demonstrated cost savings, such as:
  - Intensive case management for super-utilizers
  - Coordinating access to safe, affordable housing for individuals who are homeless or housing-insecure

Housing/ Transportation

Employment/ Contributing

Social Inclusion

Improved Health Outcomes
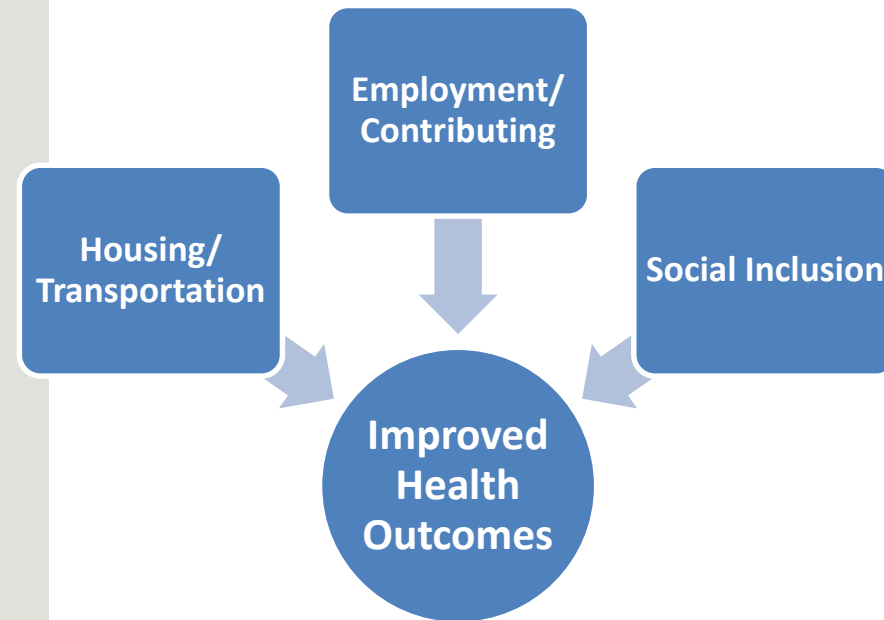
HCBS should also support individuals to….

Live in their own home with the people they choose to live with

Enjoy the support and engagement of family and friends

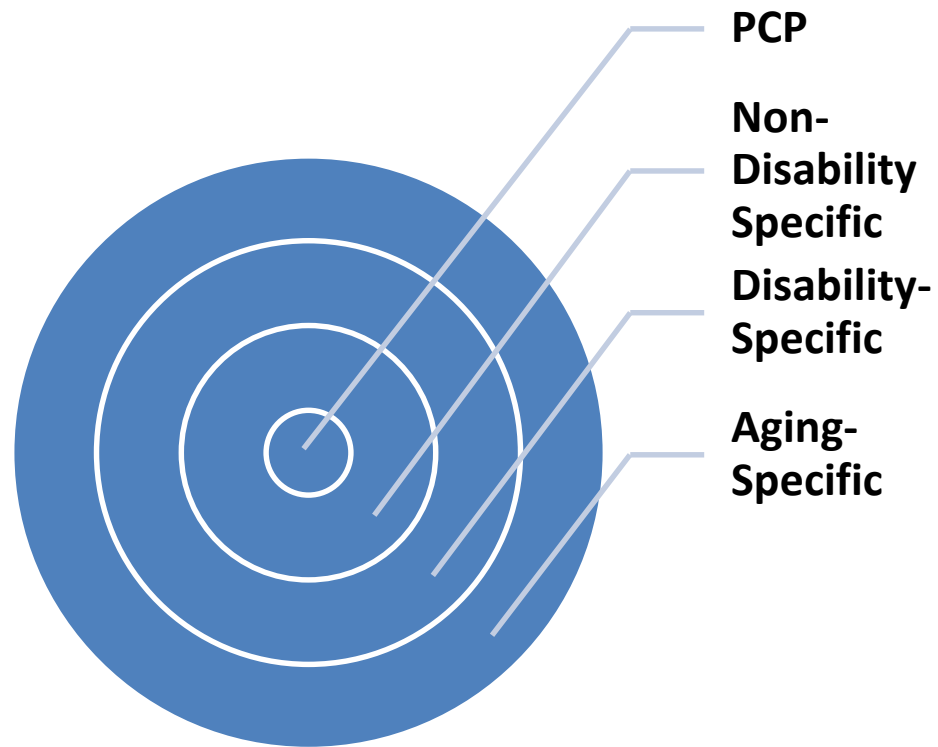Get a job, volunteer, or retire but continue to engage

Enjoy good health

Be a meaningful part of and contribute to their community

Achieve their personal potential for independence, inclusion and self sufficiency

How to Approach HCBS Systems-Change to Improve Community Integration

PCP

Non-Disability Specific

Disability-Specific

Aging-Specific

Policy

Practice

Payment

Community Integration

Strong Stakeholder Engagement, with Greatest Emphasis on Consumer

Person Centered Planning in the Context of HCBS
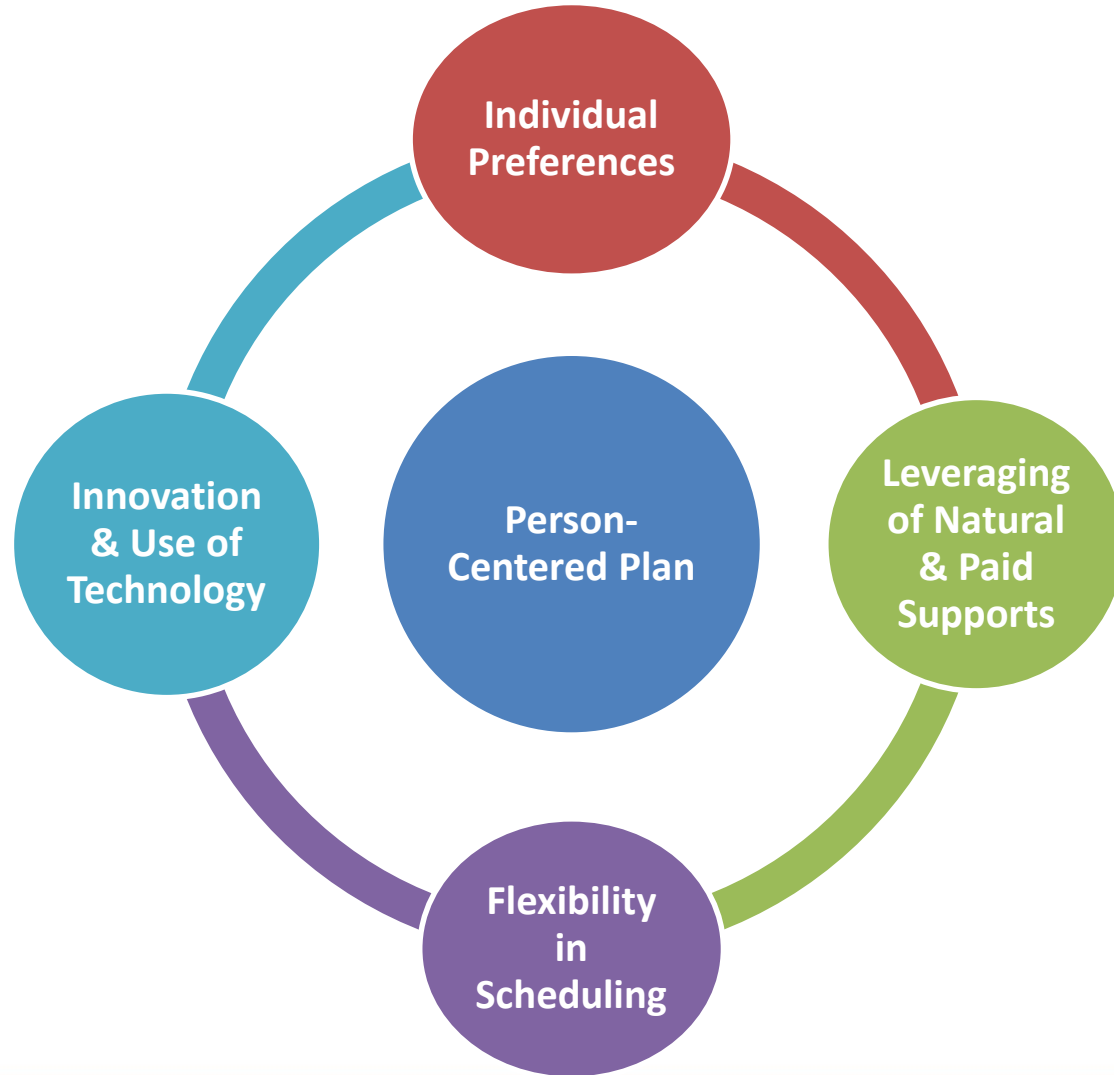
Person-Centered Planning

- A Planning Process for LTSS needs:
  - Plans describe the preferences and interests that make up a desired life and the supports (paid and unpaid) needed to achieve it.
  - Plans are directed by the person along with independent facilitation support as needed.
  - Planning with federal, state systems, communities, and families is necessary for people with LTSS needs live their desired life.

Interactions: Person-Centered Planning, Assessments, Service Authorization

- Distinct functions that are often conflated in practice
  - Person centered planning: driven by the person and reflects his/her perspective
  - Assessments: judgments made by professionals (e.g. diagnosis, functioning, service needs)
  - Service Authorizations: the final determination of what services are provided for what purpose

Strategies for Promoting Provider Transformation to Spur Increased Community Integration among Medicaid HCBS Beneficiaries

PROVIDER TRANSFORMATION

Modernizing HCBS Settings: Provider Capacity Building (1)

Expanding Non-Traditional Partnerships

Exhausting Available Generic Community-Based Resources

Provider Transformation

Rethink Human Resource/ Staffing Models

Create, Test, Validate, Scale New Ideas based on Individualization
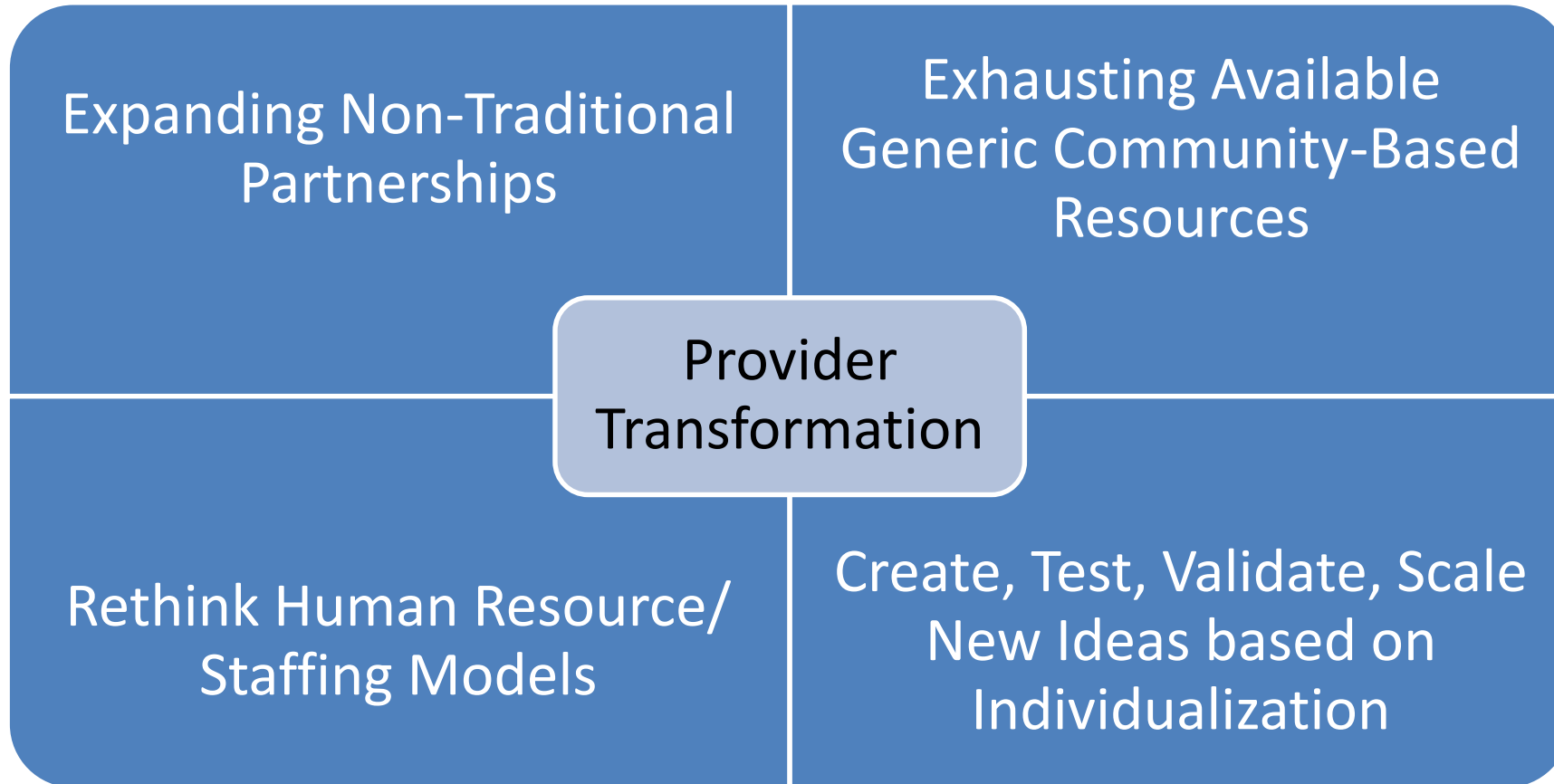
Modernizing HCBS Settings:
Provider Capacity Building (2)

Innovative Provider Service Principles

- The best places to learn how to live and work in the community are in the community.
- Our buildings should be places for people to come and go – not to stay.
- We shouldn't provide things here that exist naturally in the community.
- We should never make the people we support look incompetent in the community.
- We must balance preservation of safety with the dignity of risk....there is room for both, just as there is for all other adults that do not have disabilities. The key is in striking the right balance *on an individual basis.*

Provider-to-Provider Tips on Making the Shift to Community Integration

- Invest time and resources into effective practices.
- Build your social capital at all levels.
- Explore traditional and non-traditional revenue sources.
- Do it one person at a time, and do it a lot of times until you're done. You'll get better at what you do.
- Start small – clear the path. Don't get stuck in planning, processing and waiting for the right "time" for change.
- Hire for who you want to become, not for who you are.

Decentralization of CRP Business Models

Operationalizing Decentralization

- Many current agency business models based on people coming to agency facility (centralized)

- Community integration – individualized and everywhere in the community

- Agency support provided to people where they are – no longer at centralized places

- A significant change in business structure – any type of business would have significant retooling to accommodate new approach

Resource Allocation to Accommodate Changes

- Moving resources out of a centralized location and out to where people are being supported

- Involves resources such as:
  - Staff
  - Communication and electronic record keeping devices
  - Transportation
  - Management support

- Facility consolidation and/or liquidation - one of the tough choices

Assuring Optimal Community Integration in HCBS:
Promising Practices for Providers – Community Engagement

- *Spending time with HCBS beneficiaries in natural environments and exposing beneficiaries to a number of community-based experiences as a way to better inform the person-centered planning and follow-along assessment processes.*

- *Developing partnerships and alliances with generic, community-based entities that result in mainstream inclusion of HCBS beneficiaries in activities available within the broader community.*

- *Establishing a public relations programs that highlight and incentivize stronger engagement of community-based partners directly with HCBS beneficiaries.*

- *Establishing a community-based advisory group to help identify and design new models and strategies for the setting to expand its individualized service offerings and increase greater access to activities in the broader community.*

Assuring Optimal Community Integration in HCBS:
Promising Practices for Providers – Generic & Natural Supports

- *Reaching out to local businesses and community partners to request program/activity/event discounts and free memberships for individuals receiving HCBS similar to offerings provided to aging Americans, military service personnel/veterans, and other special populations.*

- *Exhausting public transportation options (including ride shares, taxi services, public metro or bus systems, trains, virtual transportation services, and offer) to promote optimal individualization of scheduling and activities.*

- *Fostering access to technology, virtual applications, and other innovations as a way to stimulate natural supports and provide solutions-oriented strategies to facilitate greater participation in activities by HCBS beneficiaries in the broader community.*

- *Offering activities and programs that encourage families and friends to participate regularly and that promote greater independence and autonomy on the part of HCBS beneficiaries.*

Assuring Optimal Community Integration in HCBS:
Promising Practices for Providers – Staffing

- *Assuring the level of support required, appropriate staffing levels , and adequate transportation options needed to offer both group and individualized options that facilitate optimal community engagement.*

- *Decentralizing staff structures so as to promote greater flexibility and encouragement of community-based staffing over facility-based staff structures.*

- *Hiring of logistics coordinator or purchasing of logistics software to help facilitate and promote increased individualization and small group activity scheduling.*

- *Encourage staff through incentives, rewards systems, or other promotional strategies for the development of new or expanded community-based partnerships, creation of new or expanded community-based activities, and fostering of natural supports for HCBS beneficiaries.*

Assuring Optimal Community Integration in HCBS:
Promising Practices for Providers – Sustainability

- *Collaborating with providers of similar settings to share administrative functions and leverage resources focused on training and ongoing capacity building of managers and front-line staff in the implementation of effective practices that result optimal community integration of HCBS beneficiaries.*

- *Designing activities that may begin as a small group endeavor but allow for some individualization and individual personal growth and development as part of the activity.*

- *Emphasizing community-based activities that promote the development of skills and facilitate training and educational opportunities among HCBS beneficiaries that could lead to attaining and expanding volunteering and competitive, integrated employment opportunities.*

- *Facilitating skills-building workshops and activities that encourage greater control over personal resources and promote increased independence and personal autonomy of HCBS beneficiaries.*

- *Look at non-traditional funding streams to support sustainability work.*

HCBS & Non-Disability Specific Settings: *Strategies for States*

- *Invest in capacity building activities of existing and new providers to assure the development of multiple non-disability specific setting options across all categories of home and community-based services offered by the state.*

- *Provide ongoing in the training and technical assistance needed to help address systems-wide modification requirements of specific settings.*

- *Disseminate information to existing and potential provider entities about any local or state tax or other financial incentives available for establishing no-disability specific HCBS setting options in the state.*

- *Review existing HCBS service definitions, policies, and rate structures to assure outcome-oriented, incentives-based approach to HCBS, including but not limited to promoting innovative transportation <u>and</u> natural support strategies that facilitate individual community integration.*

Stakeholder Engagement: How

- Ongoing (from design to implementation to oversight)
- Robust and meaningful
- Responsive
- Transparent
- Timely, accessible notice of meetings, public comment & other opportunities for meaningful input
- Updates/summary of policy changes and ideas in clear, easy-to-digest language
- Meetings at times convenient for all
- Multiple vehicles for input

Systems Change to Transition Service Delivery Models

Lessons Learned from D.C. and Beyond

Laura Nuss – New Editions Consulting

The Goal: *Meeting the Principles of Inclusion*

- *The players:*

  People receiving HCBS services and their network of support
    - State HCBS Program(s) and Executive leadership
    - Providers of HCBS services and supports
    - Advocacy organizations
    - The broader community

- *Will need leadership from all.*

Systems Change

- Can start with a premise, that social problems are the product of networks of cause and effect.

- In evaluating how HCBS is achieving a particular goal, what are the drivers of cause and effect?
  - Leaders
  - Policy
  - Resources
  - Operational design and effectiveness
  - Values and norms
  - Public attitudes

Policy to Practice

- The HCBS Settings Rule sets the bar, the state changes statutes, regulations and policy to comport with the rule, now what?
  - Engage multiple stakeholders and find the leaders for change
  - Training in values, principles and strategies
  - Person-centered planning and practices
  - Financial support – incentives and disincentives
  - Critically evaluate operations for barriers and conflicts with values
  - Engage outside the "system" to change attitudes and garner support

- Timing – each change you hope will have an effect, but when, what order and, most importantly, can not be a one-time initiative.

- Changing the rules by itself will probably not get us from here to there.

Stakeholders: *All Needed at the Table*

- People receiving HCBS and their support network
  - Know best what they want, barriers and fears
- Providers
  - Need their leaders to be part of the solution, to try first, to reevaluate and provide respected and honest feedback
- State HCBS Agencies and Leadership
  - Need their own leaders and support from Executive branch
- Advocacy organizations
  - Need their support with state leadership, Executive and Legislative branches
- The community
  - Need support of employers, community civic organizations, local public resources

Training: *More Than a Session*

- Evaluate attitudes and cultural norms of stakeholders.

- Foster a learning culture.

- Invest in building subject matter expert capacity within systems.

- Involve and include recipients of services and supports.

- Invest in person-centered thinking training for all.
  - Provide tools, and methods to evaluate effectiveness of using the tools.
  - Create and support Communities of Practice to create space to learn together, make adjustments.

Person-Centered Planning and Practices

- Person-centered planning compliance vs. effective person-centered planning and practices to advance the Settings Rule can be very different!
  - *Enhancing care management focus of aging systems or in managed care*
  - *Pushing past traditional IDD models of care*
  - *Supporting the case management/support coordinator wherever it is located within the system*
    - --State, county, local entity, private, MCO
  - *Supporting the provider to be part of the solution*
  - *Supporting individuals and families to be part of the solution*

D.C.'s Person-Centered Planning and Thinking Initiatives

Started in 2013 in the IDD agency to shift from heavy health and safety focus. The Medicaid EPD system joined in 2014 as it addressed conflict-free case management requirements. Blended in NWD initiatives.

New Employee PCT Orientation video for all IDD staff.

2 Day PCT Training for all IDD staff.

Additional multi-course intensives for IDD support coordinators.

Person-centered counseling training for EPD staff and case managers and NWD staff.

Revisions to PCP assessment tools and plan formats including guided conversations to identify a pathway to employment or increased community inclusion.

Expanding D.C. PCT Initiatives

- Critical to expand the values, knowledge and ultimately control beyond the state and case management functions.
  - Self-advocate People Planning Together Train the Trainers.
  - Including family members as PCT trainers and supporting training to family networks.
  - On-going PCT training for provider staff.
  - Require CEO's to attend PCT training in regulations.
  - Support year-long facilitated PCT provider transformation.
  - Engage in state-level PCT organizational transformation.

Strong Person-Centered Practices and the HCBS Settings Criteria

- Establishes expectation and on-going training and systemic support for placing choice and control in the hands of the person receiving services and supports and families.

- Expands methods and skills for exploration of interests and growth of community-focused discovery.

- Reinforce the role of the case manager/support coordinator to ensure robust assessment and exploration occurs for PC planning.

- CM/SC Monitoring tools evaluate community engagement/integration and satisfaction with services, settings and providers.

Supporting a Life in the Community

- Flexible and supportive HCBS options:
  - Residential support options for smaller settings, inclusion services, shared staff, non-traditional staffing hours, shared living, support/supervision through technology, self-directed support, etc.
  - Non-residential wrap around support, non-traditional hours, career planning, inclusion services, joint vocational rehab providers, etc.
  - Non-medical transportation – options for public and private, ride share, take off the name, natural supports.
  - People and families know what to expect from services and providers and the system has viable options for people to make changes.

Providers Making the Transition

- Board and leadership must be fully informed and engaged.

- Expand and target board recruitment to increase social capital.

- Develop a strategic plan, anticipate and identify alternative uses for bricks and mortar, evaluate the organization top to bottom for alignment and support of advancing inclusion.

- Include people receiving supports at every turn.

- Hire *differently*.

- Recognize staff supervision is different and critical. Invest in training, communication and technology

Incentives and Disincentives

- State investments in on-going training, communities of practice and technical assistance for all stakeholders.

- State investments to assist providers with transitioning from large to small settings.

- Service options with lower staff ratios.

- Limits in regulation on number of days, hours or years people can use a particular service.

- Higher reimbursement rates for inclusive services.

- Housing investments.

- Value based or outcome based reimbursement.

Supporting the Community

- Cross systems education, training and support – all levels of government to support HCBS participants and providers to access typical community resources.

- Public relations campaigns.

- Work with state and local workforce investment, adult education, Chambers of Commerce, communities of faith.

- Housing – access, renovations, multi-generational.

Using Innovative Reimbursement Methodologies and Rate Structures to Advance
HCBS Settings Rule Intent and Compliance

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National HCBS Conference

August, 2018

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Promoting Community Integration and Person-Centered Supports

❑Can't achieve goals by only changing policy and practice expectations

❑Must look at how reimbursement rates and methodologies are supporting (or not) community integration and person-centered supports

❑May be obvious or subtle disincentives that need to be addressed

❑Rebalancing of rates/funding may be critical for ensuring alignment of financial incentives with the standards in the HCBS Settings Rule

Example #1: Promoting Community Integration and Person-Centered Supports

Personal Assistance: Tennessee CHOICES MLTSS Program

❑Typically takes place in the home but can also support participation in the community

❑One rate does not incentivize use of this service for community integration

❑Convert existing dollars to two tiered rates:

<p style="text-align:center;color:red;">Lower rate for in-home personal assistance</p>

<p style="text-align:center;color:red;">Higher rate for community-based personal assistance</p>

❑Justifiable in terms of actual costs to deliver service & appropriate use of value-based purchasing

Example #2: Promoting Community Integration and Person-Centered Supports

Residential Services: Wisconsin Managed Care Organization

❑Introduced Pay-for-Performance for residential providers to increase quality, person-centered service delivery

❑Providers are able to focus on supporting individuals with community contribution, reciprocity, and gaining valued roles within their communities as key outcomes of residential supports

❑To date, providers have received outcome payments for supporting members to find jobs and volunteer in their local communities. The focus is supporting **all** members to be more involved in their communities, "in the ways they wanted to do it".

Example #3: Promoting Community Integration and Person-Centered Supports

Day/Employment Services: Michigan Managed Care

❑ Goal: increase opportunities for competitive integrated employment (CIE) and community participation

❑ Revised all day/employment service rates – rebalanced funding to better support and incentivize CIE and community-based service models

❑ Removed incentives in facility-based and congregate service (e.g. Group Supported Employment) models

❑ Created incentives for CIE and community-based service delivery

❑ In first six months, saw 13% increase in service delivery in community

Example #4: Promoting Community Integration and Person-Centered Supports

Integrated Day Services: District of Columbia DD Agency

❑Recognized need for separate waiver service for community-based service delivery

❑Establishing separate service allowed for distinct definition, service limitations, provider qualifications and reimbursement rate model

❑Allowed new/different providers to be approved to offer community-based service as alternative to traditional facility-based model

❑Ensured increased investment in service provision was directly tied to increased community integration (not just a hope of this occurring as a result of the increased investment)

Final Thoughts

Forget what hurt you in the past. But never forget what it taught you.

❑ All rate structures in LTSS programs include incentives and disincentives

❑ Need to make sure the intrinsic incentives and disincentives in a rate structure truly **support valued and desired service delivery models and outcomes**

❑ Community integration and person-centered supports are valued and desired outcomes **not because the HCBS Settings Rule say so**, but <u>because they are evidence-based approaches</u> that increase and preserve:

Health

Safety

Skills for Independence

Access to Natural Supports

Access to Valued Social Roles

Increased Self-Esteem

Increased Personal Control