HCBS HCB Settings Quality Review Process Webinars, June 5 and 7

Question and Answer Sections

June 5 Webinar Q & A

Q: We haven't been notified yet of acceptance or approval of CAP plan. Is that being subsumed into the notification?

A: It's forthcoming. It's not necessarily subsumed but in conjunction with. DDSN is working behind the scenes on getting plans ready to talk with providers. It's all going to happen concurrently.

Q: When will we be notified if we are subject to heightened scrutiny?

A: We are hoping to do it sooner rather than later. DDSN and I have not confirmed a specific timeline on that, but in the next couple of weeks hopefully.

Q: For category 3 settings, what was the rationale behind the first bullet point in the presentation instead of any CRCF that had been ICF/IID, why the proximity requirement?

A: We're looking at because the buildings didn't change, and for all intents and purposes, the people may not have changed, but the licensure changed. We wanted to make sure that even though the license changed and the name had changed, that also the programming changed in those residential homes. That how the staff assists and support the people that live there changed. That it's appropriate and in line with waiver expectations. And the folks are being supported in a way that is in line with their person-centered plan. We want to make sure there wasn't any residual effects of it formerly being an institution still in place with how people live their lives day to day.

Q: Is there scrutiny necessary for any CRCF that was formerly an ICF/IID?

A: For the single CRCFs, current CRCFs that used to be ICFs, it was our goal that through those settings that were formerly ICFs that are single CRCFs currently in the community, that looking at their compliance action plan, making sure that the appropriate technical assistance is in place and they have a good robust compliance action plan in place to make sure that not only programming changed, training for staff changed, and looking at those things, that those steps are in place that are appropriate and monitored. We're hoping that through intense technical assistance, that those settings that are single CRCF will be able to reach compliance through that and not necessarily subject to the heightened scrutiny piece.

Q: How much time will be provided between provider notification of whether or not, you know, they have settings and resident notification to allow providers time to discuss prior to when we send letters to the resident or participant?

A: We have not formalized that timeline. I would anticipate probably within a month.

Q: Will conflict free case management make any impact? It seems like an opportunity for providers to assert undue influence, if not.

A: Conflict free case management is a requirement of the regulation. That's something we're working on to see how we can best implement that with little to no adverse impact, of course, to our participants. We want to make sure they receive the case management they need. As far as influence, I am not sure because conflict free case management is not in place yet with our state, and CMS is well aware of that, I'm not stating anything that CMS doesn't know. I'm not sure there's a place for influence there. That process is almost being handled separately. It is a little bit on a delay because, again, we're working out the logistics behind the scenes to make sure that as participants may need to transition case managers in the future, because they're currently in conflict, that they don't feel any adverse impact to that. So that process is kind of being kept separate from the heightened scrutiny process. We hope providers act appropriately and make sure they encourage participants and residents to share their thoughts and feedback to help everybody improve, and to receive the services and supports that are appropriate for them to make this a really even better HCBS system. But we're hoping there will not be any undue influence there.

Q: I understand the point and provided an answer. In the absence of conflict free case management, there is more room for providers to skew any communication even though it's part of the final rule and enforcement action. I want to make sure it's heard it doesn't support the individual being able to make their own choices without influence from providers in conflict.

A: I think there's concerns that for people who receive case management and direct services all from the same provider that the provider may, in fact, try to influence how either participants or residents answer questions when folks come to interview them. And I hope that would not be the case but knowing, again, that we communicate directly with the residents and participants making it available directly from DHHS that there would be a pre-done presentation that they could listen to at any time that explains the process participants and families absolutely can directly reach out to state office DDSN or to me to submit any concerns or feedback they have and we'll absolutely include that in the review process. So know that is available to folks. WE don't want to make sure -- we want to make sure that people are not cut off or influenced in any way inappropriately to either give information or not give information because, again, the system doesn't get better for our folks that we serve and support if we don't allow them to have a voice in it. They're the ones receiving services, they're the ones receiving supports. They're the ones we're doing this for. So I want to make sure they absolutely have a voice and a seat at this table and in this process.

June 7 Webinar Q & A

Q: Will the stakeholder advisory group provide input on the 117 category 3 settings that DHHS and DDSN not come to consensus on? And the 10 settings in category 2 automatically go to CMS for heightened scrutiny?

A: To answer the second part first, yes, the 10 settings under category 2 automatically go to CMS for heightened scrutiny. We have to submit them. Again, when we submit these settings, we have to go through a public notice process, so that stakeholder advisory group as a whole or as independent entities – the organization that you represent – can absolutely provide comment to that. And we will take public comment on, and take comment from, that group as well on any settings that even if we do come to consensus on, you can submit comment to that. I think that I understand the first part of the question which was will the advisory group provide input on the 117 category 3 settings -- any category that we don't come to consensus on, whether it be category 2 or category 3, we are going to send to the stakeholder advisory group.

Q: How many cloud settings? What are cloud settings?

A: These are the little bit more independent settings. It was an acronym, and the CIRS acronym stands for Community Inclusive Residential Settings. And those can be apartments, can be homes, but those are settings that participants, they choose on their own. They decide who they are going to live with on their own. They will work with that through a provider to help locate settings, but they do a lot of that on their own. You can find descriptions of the whole CIRS licensing standards and process on the DDSN website. I think that most people may tend to live with at least a couple of roommates in those settings and so they are sort of like CTH IIs in that way, but they are more independent as far as the supports that are provided to people who live there. So it was…15 of those settings.

Q: Did DHHS or DDSN consider opportunities for the interaction of the broader community as defined by the regulation as characteristics of a setting that isolates and how is this category considered?

A: The entirety of category 3 settings, which is looking at the settings that have the effect of isolating, drives towards how do people have the opportunity to interact with the broader community as an opportunity for settings to isolate. So that helped us come up with our four bullet points that we listed below. So that is incorporated in that category 3 setting definition.

Regardless, if the setting did not make this heightened scrutiny list or not, all of our waiver settings, in the DDSN network and in adult day health care settings that contract directly with our division of long term living at DHHS, they all have to be compliant with all of the characteristics as far as integration with the community. So if a setting does or does not go through this specific part of the process, all settings must make sure they provide that opportunity for interaction as defined by the regulation.

Q: CMS provided guidance on the settings review tool rubric. Is DHHS/DDSN considering data points that go beyond the guidance provided, and if so, what data points might be considered in the rubric?

A: I am assuming that this person is referring to guidance that was issued in the new frequently asked questions in March. What we are looking at is basically, all of the data points that we are looking at are going back to: how is it aligned with the HCBS requirements? So, for example, the big five that all settings must require: integration in the community, autonomy, et cetera. Almost all of those are broken down into individual categories that we are looking at to make sure, and that includes the residential as well when applicable, that all of those criteria are being met to be compliant with the regulation.

Q: The QIO, the quality improvement organization, that is being utilized (this is the one that is currently under contract with the Department of Disabilities and Special Needs which is Alliant), the question is, are they only carrying out individual interviews or will other organizations interview individuals?

A: We are utilizing them because they have already received the training and are familiar with the observation tool. They will obviously get training on the tool that has been revised and make sure they understand the data points that we are looking for, and so we will utilize the organization to interview folks, because they will be out there doing that in addition to gathering the data on the setting itself.

Q: Have providers pushed back against their heightened scrutiny designation and how do we manage that?

A: I am sure that the providers are telling you that they don't know. Again, as we are going out with this process, we have not communicated yet to the providers if they are being part of the process or what settings they have in this process, but that information is coming soon. We just want to make sure that everybody is informed about what the process would look like. And so, they will know, but I know that the providers are anxiously awaiting and the reason that we have not communicated yet is of course, because we were going to contact them sooner, but then CMS came out with the guidance literally two weeks before we were going to be doing this public webinar in April and they came out with the guidance in March. So we had to stop, go back, re-adjust, and so we had to revise all of that before we could communicate with the providers or participants.

Q: What has been the most common element to settings selected for heightened scrutiny?

A: It goes back to just looking at the criteria that's provided. So, for category 2, was it on the grounds of or adjacent to a public institution like an ICF? That's a pretty easy one. Category three, we looked at all those criteria as far as how do we designate settings? And then looking within that, once we designate the settings, we're going to explore: how are they providing

access to, and making sure that the folks are integrated into, the communities in accordance with their person-centered service plan.

Q: Why are CTH IIs most commonly subject to heightened scrutiny?

A: They just have it in numbers. We have a large number of settings, residential settings, that are CTH II. There are 734 in total with those. That's a large number. And so, just by numbers, they're naturally going to have more represented.

Q: What feedback would be most helpful to us regarding this process?

A: If you see something that does not seem logical as we have talked through it, or if you think, you know what would be good data point for us to consider for us to look at when we are reviewing this, I think that information would be helpful for us.

Q: Will this presentation available on the DHHS or the DDSN website?

A: Yes. So once we have the recordings done, what will be posted is a copy of the slide deck. There will also be a transcript available, and also what I will do to make it easy from the transcript I will cull out the questions Wednesday and today and put them in one separate document so everybody can see all of the questions and the answers provided for both.

Q: With the visits being announced how do you ensure that the residents won't be encouraged on what to say or how to act? I worry you won't see or get an accurate view of what occurs or how individuals truly feel.

A: You are right, there is no way to know that people won't be coached on answering. We just hope that, we encourage everyone to participate in this process with integrity and fidelity knowing that at end of the day, our goal really is to truly submit all of the settings to heightened scrutiny review, because we want to make sure that they are serving our participants in the way that is truly integrated and best supports them in accordance with their person- centered service plan. That's not going give us accurate data if a provider coaches a participant in how to answer questions, so we hope that would not occur. We also know that should a participant or the family want to provide us feedback privately and separately, they can reach out to us and do that on their own, knowing that we can absolutely consider that data separate from a visit that is done with a formal interview. So if they wanted to do that, they absolutely could.

Q: How do we define community exposure or settings? Are individuals getting a say in where and how much community integration they're given?

A: Well, certainly, people -they are the ones who define community integration. They are the ones who tell the people who they are serving and supporting them, this is how I want to be involved in my community. Whether it be, I am content with-maybe they have a faith-based organization they go to or volunteer twice a week, and content to go run their errands when they choose, and that is fine. If there are other people who want more integration, then as long as they - that is how they communicate that to the provider and the provider works with

them to determine how to facilitate that, and just like every single one of us on the call has different levels of community integration that we desire, so do all the people we serve and support. And so it is going back to, how we are supporting them in accordance with their person-centered service plan?

Q: Have people with disabilities been included in the process so far? Establishing criteria is hard to do without consulting the people it serves.

A: This is the point where we are consulting all of the stakeholders we think are key, which would include people with disabilities. I am not just doing the two webinars. To make sure that we get good stakeholder feedback, I will be presenting at IMPACT-South Carolina, which is the statewide self-advocacy group, next week. I wanted to do that presentation in person. It will cover this process to get their feedback and they, too, will have the opportunity to provide feedback on that. And to define the criteria, and CMS has provided that and the state has to define that, but how we do our process to make sure that we get all of the voices at the table, this is the way that we have gone forward and thought that we will make sure that we will get all of the input that we need and is appropriate and important.