

## **Disabled & Elderly Health Programs Group**

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October 8, 2015

Kevin Moore  
Medicaid Director  
State of Wisconsin, Department of Health Services  
1 West Wilson Street, Room 350 PO Box 309  
Madison, WI 53701-0309

Dear Mr. Moore,

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Wisconsin's Statewide Transition Plan (STP) to bring state standards and settings into compliance with new federal home and community-based settings requirements. CMS previously sent Wisconsin a letter on March 18, 2015 requesting that information be added to the STP. Wisconsin submitted a revised draft STP for CMS to review on July 22, 2015. CMS reviewed this draft and requests some additional detail regarding settings included in the STP, assessment processes and outcomes, ongoing monitoring, remedial action processes, and heightened scrutiny. These issues are summarized below.

### **Scope of Settings Included in the STP:**

- As requested in CMS' March letter, the revised STP identifies setting types in the state's 1915(c) waivers and describes the activities to assess compliance for these settings. Please provide additional information on the following:
  - Wisconsin's waivers include the following services that were not discussed in the STP: "vocational and futures planning," "counseling and therapeutic services," "consultative behavioral intervention services," "early intensive behavioral intervention services," and "consumer education and training." Please update the STP to describe in what setting types these services are rendered.
  - Please define "private residences that are not regulated residential settings for persons with disabilities" (p. 4 of the STP).
  - Please further define "prevocational service settings" (p. 4 of the STP).
- CMS requests that the state ensure that all detail in the waiver-specific transition plans is included in the STP, including dates and methodology. For example, the plan for the Self-Directed Support Waiver contains dates for completion of remedial activities that are different than the dates in the STP.
- The STP indicates that the state will convert the Community Recovery Services (CRS) program under the 1915 (i) HCBS authority to a 1905 (a) State Plan authority. If the state does not complete this conversion within six months from the date of this letter, the state must include the settings in which CRS 1915(i) benefits are provided in the STP.

### **Systemic Assessment:**

- As an attachment to the STP, Wisconsin provided a helpful crosswalk that displays specific qualities from the federal requirements and where relevant language is located in state standards for residential settings serving adults.
  - Please also provide an analysis indicating how each state regulation excerpt supports, is silent on or conflicts with each of the qualities in the federal regulation.
  - Please explain in the STP or crosswalk if “no conflict, either direct or indirect, between the home and community-based services final rule and state statute and code” description means that the specific state statute and code is silent on or reinforces the federal regulation.
- Please provide similar crosswalks comparing the federal requirements to the related state standards for residential and non-residential settings serving children and non-residential settings serving adults. The revised STP indicates that these reviews were completed in July (children’s residential and non-residential settings) and September 2015 (adult non-residential settings).
- Page 5 of the revised STP explains, "Some of the HCBS standards found in the federal rule, such as choice of setting, choice of roommate, and access to activities in the community, are the responsibility of the entity providing care management or consultation, not the service provider...." While a care management entity may have a significant role in assuring that each setting complies with the federal rule, each setting itself and the service provider providing services in each setting must fully comply with the federal requirements. Please clarify how the setting will comport with the federal regulation.
- The revised STP states on p. 6, “Wisconsin regulations and other policies address important principles of the rule, such as provider agreements, participant choice and rights and basic accessibility, but those policies do not address some of the specific tests of these principles that CMS has suggested in its guidance. Therefore, provider assessments will be performed to determine whether requirements of the federal rule that are not addressed through state regulations and policies are met by individual providers.” Please explain which “specific tests of these principles” are not addressed in Wisconsin’s regulations and other policies.

### **Site-Specific Assessments:**

- Please clarify the methodology of the preliminary review of settings. How did the state conduct the review and determine that each setting type is considered to meet the requirements? How did the state determine that no additional assessment is needed?
- The STP states that providers "must complete the self-assessment for each site that they operate" (p. 8) and "any current waiver provider that fails to submit a self-assessment for a setting may be subject to a site visit or other follow-up" by the state. Please clarify what action the state will take to verify that settings comport with the regulation when a provider does not complete a self-assessment and the state does not conduct a site visit.

- The STP states that the State Medicaid Agency (SMA) or contracted staff under the direction of the SMA will conduct the site visits. Please describe how the state assures that there will be no conflict of interest between the contracted entity that conducts site visits and the service providers. The STP notes that the results of the provider self-assessment process will be analyzed by August 2016 (p. 16). Once Wisconsin has compiled this information, the state will need to amend the STP to provide the outcomes of all site-specific assessments of both residential and non-residential settings. Please provide estimates of the number of settings by waiver that 1) fully comply with the federal requirements, 2) do not comply and require modifications, 3) will not comply and require relocation of beneficiaries, and 4) are presumed not to be home and community-based and will require heightened scrutiny. The amended STP will need to go through the public input process prior to submission to CMS.

### **Monitoring of Settings:**

Please provide additional information on how the existing monitoring processes will be updated given the new home and community-based settings requirements. The state has indicated that some requirements will be addressed in state regulations while others will be addressed through provider contracts. Please indicate how these requirements will be monitored.

### **Remedial Actions:**

- The STP states on p. 10 that "there is no need to propose changes to regulations or certification standards" for certified and licensed settings as "none of the HCBS requirements are conflicted in the statutes or licensing regulations." The state explains that both licensed and certified providers also serve people who do not receive Medicaid HCBS so rather than changing the standards for all settings, "the HCBS settings rule can be accommodated through requirements specific to HCBS waiver providers." The state notes that it will change home and community-based services waivers and accompanying program guidance (e.g. service descriptions and provider standards, contracts) as needed to ensure waiver providers comply with setting requirements. Please explain how this process will work, who is responsible for enforcing the provider contracts and other waiver requirements, and how ongoing compliance will be monitored when specific waiver requirements necessary for compliance with the federal rule are not in sync with broader state regulations.
- The state notes in the STP that a provider that does not wish to comply with the setting requirements can notify the state at any time and the state will relocate any waiver participants in that setting. Please explain how any such notification by a provider to the state will afford an ample period of time for beneficiaries to select other alternate settings, with all services and supports in place at the time of relocation. The STP says that provider remediation activities must be completed by June 2017 and the state will validate provider remediation by August 2017 (p. 11, 16). Please provide more information on the monitoring/oversight process (and associated milestones) to ensure that providers meet the deadline for completing remediation activities.

### **Relocation of Beneficiaries**

Please provide a more detailed description of the timeline for relocating individuals, an estimate of the number of beneficiaries that may need to be relocated, a process to assure that critical services/supports are in place in advance of any individual's transition, and that the individual had ample time to select an alternate setting.

### **Heightened Scrutiny:**

- On p. 12-13 of the STP, Wisconsin outlines its heightened scrutiny process including how the state will identify settings that are presumed to be “institution-like,” notify providers of the state’s determination, collect information from providers and on-site assessments, and ultimately decide which evidence to submit to CMS. Please clarify the state’s methodology for determining which settings are presumed to have institutional qualities and specific milestones (with timelines) related to the heightened scrutiny process described by the state.
- CMS would also like to note that it is the state’s responsibility to ensure that all settings demonstrate the characteristics of a home and community-based setting. If the state is operating with a presumption that an individual’s private home or private family home is meeting this requirement, the state needs to confirm that none of these settings were purchased or established in a manner that isolates the individual from the community of individuals not receiving Medicaid-funded home and community-based services. Information available in CMS’ Toolkit on settings that isolate may be helpful in this regard. It is not CMS’ expectation that a state would presume a setting’s compliance with regulatory requirements where all or the majority of services are rendered in or on the grounds of that setting, or where a group of individuals with disabilities or a specific type of disability (or their families) have purchased and reside in the setting.

CMS would like to have a call with the state to discuss these issues and to answer any questions the state may have. The state should resubmit its revised STP, in accordance with additional information requested above, within 75 days following the call. The STP will have to undergo a public comment process prior to submission. For this second public comment period, the state should note the concerns expressed by CMS in the March 18 letter about the first public comment period. A representative from CMS’ contractor, NORC, will be in touch shortly to schedule the call. Please contact Lynell Sanderson in the CMS Central Office at (410) 786-2050 or at [Lynell.Sanderson@cms.hhs.gov](mailto:Lynell.Sanderson@cms.hhs.gov), with any questions related to this letter.

Sincerely,

Ralph F. Lollar, Director  
Division of Long Term Services and Supports

cc; Ruth Hughes, ARA