



Process to Ensure Compliance with the 2014 Medicaid Home and Community-Based Services Settings Regulation

Requirement

The Department of Health Services (Department) is requiring operators of provider-owned or controlled residential settings to complete an on-line provider self-assessment in order to continue to provide services to people in Wisconsin's Medicaid home and community-based waiver programs. If a provider does not complete the self-assessment for a setting, the Department will assume that setting will not be utilized for Medicaid waiver participants. This document provides background on the reason the Department is requiring this self-assessment and describes how it fits into a process of verifying compliance and providing opportunities for providers to become compliant through a remediation process.

Background

States that operate Medicaid home and community-based services (HCBS) waivers under Sections 1915(c) and/or 1915(i) of the Social Security Act are required to comply with new provisions of federal rule at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2) by March 17, 2019. More information on the final federal rule can be found on the Centers for Medicare and Medicaid Services (CMS) website at www.medicaid.gov/hcbs. Each state that operates waiver programs is required to submit a Statewide Transition Plan that describes how the state will ensure that all Medicaid HCBS waiver services are provided in settings that have the community-based qualities described in the regulation. Wisconsin submitted its [Statewide Transition Plan](#) on January 30, 2015.

The Medicaid HCBS waiver programs in Wisconsin that must ensure compliance with the settings requirements are:

- Family Care;
- Family Care Partnership;
- IRIS (Include, Respect, I Self-Direct);
- Community Options Program Waiver (includes CIP II);
- Community Integration Program Waiver (includes CIP 1A and CIP 1B); and
- Children's Long-Term Support (CLTS) waivers.

The federal rule requires all home and community-based settings in which services are delivered to meet certain qualifications. The rule specifies that, to be home and community-based, the setting:

- Is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The federal rule includes additional requirements for provider-owned or controlled residential settings. These requirements are:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Wisconsin's Plan for Compliance

The Statewide Transition Plan submitted by Wisconsin establishes a multi-phase process to assess the current status of provider-owned or controlled residential settings with regard to the HCBS settings requirements to ensure full compliance by March 17, 2019. This process includes:

- Provider self-assessment;
- Validation of the self-assessment response by waiver agencies¹ or other agents of the State;
- Implementation of a remediation process for providers who are not compliant per the self-assessment or based on the validation;
- Relocation of waiver participants from settings that are not able to be or interested in becoming compliant; and
- On-going monitoring and re-evaluation of settings by waiver agencies.

Only providers who are currently serving, or intend to serve, Medicaid home and community-based waiver program participants are required to complete the provider self-assessment. A self-assessment must be completed for each setting even if operated by a single provider. The following residential settings must complete a self-assessment:

- Community-based residential facilities (CBRFs);
- Licensed 3-4 bed Adult Family Homes (AFHs);
- Certified 1-2 bed AFHs; and
- Certified Residential Care Apartment Complexes (RCACs).

Purpose of the Self-Assessment

The self-assessment asks questions that will help providers and the state to determine the extent to which settings currently comply with the requirements of the federal rule and to identify the areas where changes are needed to ensure compliance. The intent of the self-assessment is not to disqualify settings, but to help providers and the waiver agency(ies) they work with to determine actions needed to meet the requirements under the federal rule. Providers are encouraged to complete the assessment accurately based on the current practice in the setting. A non-compliant response will not disqualify a provider at this point in the process.

¹ Waiver agencies are the entities that operate HCBS waiver programs locally. These vary by waiver program and include county agencies, managed care organizations and other contracted agencies.

When all providers have completed the self-assessment, the Department will select a sample of settings that will have on-site visits by a waiver agency or other entity selected by the Department. This validation process is intended to determine if the responses provided are supported by evidence. Evidence that will be considered includes policies and procedures, physical characteristics of the setting, individual plans, conversations with waiver participants who live in the setting and other relevant information provided by the setting. This validation process will alert the Department to areas where providers may have misunderstood the self-assessment questions or the requirements of the federal rule.

All settings, regardless of whether they receive a validation visit, will need to make changes to meet the requirements of the federal rule if they want to continue to provide services to HCBS waiver participants. Waiver agencies and the Department will work together with operators of non-compliant settings to develop remediation plans and verify that any changes needed are implemented by December 31, 2017. If a setting does not come into compliance, waiver agencies will work with each person living in that setting to select a different living setting.

The provider self-assessment will only be used as part of this process and will not be used to affect licensure, certification or qualification as a setting for programs that are not operated under HCBS waivers. Documentation that a setting is compliant either based on the self-assessment or implementation of a remediation plan will be maintained separate from licensure or certification records.

Settings Requiring Additional Review

The federal rule makes a presumption that certain settings are not home and community-based. These include:

- Settings in a publicly or privately-owned facility providing inpatient treatment;
- Settings on grounds of, or adjacent to, a public institution; and
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS waiver services.

States are able to present evidence to the federal Centers for Medicare and Medicaid Services (CMS) to justify that some settings that meet the criteria above are home and community-based. CMS will make a determination based on the evidence. The Department will determine on a case-by-case basis whether it will request CMS review or not. Settings that meet the above definition and want to provide evidence that it is home and community-based must complete the provider self-assessment in order for the Department to consider whether or not it will request CMS review. The Department will conduct a site visit for each such setting using the same protocols that will be used for other providers. If the Department agrees with the provider that the evidence indicates that the setting is home and community-based, the Department will provide the evidence to CMS for review and determination. Settings will be subject to periodic reviews of continuing compliance.