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December 22, 2022

Ms. Ondrea Richardson
Division of Long-Term Services and Supports
Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Dear Ms. Richardson:

I am pleased to submit Wisconsin's Statewide Transition Plan (STP) to CMS for review and consideration of final approval.

The technical feedback previously received from CMS has been incorporated into the final draft of Wisconsin's statewide plan to bring settings into compliance with the federal home and community-based services (HCBS) regulations found at 42 CFR Section 441.301(c)(4)(5) and Section 441.710(a)(1)(2).

The updated STP was made available in a 30-day public comment period from October 10, 2022 through November 18, 2022 for feedback from stakeholders and the public. Outreach efforts included 16 newspaper announcements throughout the state, listserv notices, and publication on the Department of Health Services website. This final submission of Wisconsin's STP reflects the CMS-requested updates and clarifications, as well as a summary of the public comments received.

If you have questions regarding the statewide transition plan, please contact Christian Moran at Christian.Moran@dhs.wisconsin.gov.

Based on an 12/08/22 communication from CMS all states are to provide the following information to CMS to document state and provider compliance with the regulatory criteria. This information is also included in our statewide transition plan:

Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations;

Some of the HCBS standards found in the federal rule, such as choice of setting, choice of providers, and financial support for access to activities in the community, are the responsibility of the entity providing care management or consultation, not the service provider.

Other standards such as preference for a private room or choice of roommate and access to activities in the community are a joint responsibility of the setting and the waiver agency. For example, if a setting does not have private rooms or none are available, the waiver agency should assist the participant to consider another setting with private rooms. While all settings must allow access to the community, an individual may need more support to engage in an activity than the setting can provide. In such cases, the waiver agency is responsible for working with the participant and the setting to identify resources. This is true across all HCBS waiver programs in Wisconsin. Monitoring the quality of person-centered planning by the SMA is an ongoing process in all these programs.

Person-Centered Planning

All of Wisconsin's HCBS waivers require that the waiver agencies support person-centered planning. Care managers and support and service coordinators in Family Care and the CLTS waiver work with the participant, family and other parties as preferred by the participant to develop a person-centered plan and provide services that implement the plan. In the IRIS program, the participant develops his or her own plan and is supported to implement that plan by the IRIS consultant and fiscal-employer agency. In all cases, participants are given the choice of services in non-disability specific settings.

Contracts

Waiver agencies ensure that providers meet the standards as defined in the respective approved waivers, including requirements of the HCBS settings rule. Waiver agencies are required by contract to ensure compliance with the requirements of the HCBS settings rule through their contracts and agreements with waiver providers. As part of the SMA's review of waiver agency compliance with contract and waiver standards, the SMA will validate waiver agency compliance with these requirements.

In-Person Meetings with Participants

MCO care managers and IRIS consultants must meet with program participants face-to-face every 3 months. At least one meeting per year must be in the person's home. Other meetings may occur in other locations including day program settings. CLTS support and service coordinators must have contact with program participants every 3 months, which may be completed by any of the following: in-person meeting, meeting using both audio and video technology, meeting using audio-only (telephone), or written/email exchanges. When meeting with the participant, residential and nonresidential settings are observed to ensure health and safety and continuing compliance with the HCBS settings rule. This does not replace monitoring and compliance determination by the credentialing authority but provides an important supplemental check on compliance. In the event a setting appears to no longer be compliant with the HCBS settings rule, the waiver agency will inform the SMA who can make a request to the credentialing authority or to SMA staff, as appropriate, to conduct a site visit to further determine compliance with the rule.

State Statutes and Regulations

For residential settings, the service standards in Wisconsin's waivers are based upon and reference applicable state statutes and regulations. The SMA conducted an analysis of the regulatory requirements for the residential settings that serve adults and identified those that align with and meet specific requirements of the HCBS regulations and guidelines for these residential settings. The analysis indicated that most of the requirements included in the federal rule are already covered by Wisconsin's statutes and regulations that govern certain licensed or certified residential settings.

The SMA used the same process for systemic assessment of nonresidential settings. As not all day and vocational settings are covered by state law, regulation, or certification standards, the SMA analyzed program policies as articulated in Wisconsin's waivers, policy documents, and contract requirements to determine the degree of compliance with the HCBS settings rules.

Because contracting and direct oversight of providers differs across Wisconsin's HCBS waiver programs and generally involves local waiver agencies, remediation strategies have program-level variation. The SMA has analyzed regulations that govern certified and licensed settings and determined that there is no need to propose changes to regulations or certification standards for those programs. Both licensed and certified providers also serve people who do not receive Medicaid HCBS and any instances where additional criteria must be met for compliance with the HCBS settings rule can be accommodated through requirements specific to HCBS waiver providers. The SMA imposed additional requirements on licensed or certified providers above those required in statute and rule in order for the provider to serve HCBS program participants.

SMA Policies, Contracts and Other Documents

Wisconsin laws, regulations, standards, and other policies addressed most of the requirements of the rule, including provider agreements, participant choice, participant rights, and accessibility. In some cases, however, the policies did not address all the criteria that CMS has suggested in its toolkits and other sub-regulatory guidance. In addition, Wisconsin policies are silent on some aspects of the rule. Based on CMS guidance, areas where the SMA determined additional information was needed include:

- Location of the setting—characteristics of surrounding area
- Access to transportation
- Opportunities to receive services in an integrated community setting
- Opportunities to engage in competitive integrated employment
- Lockable entrances to individual living spaces
- Opportunities for privacy
- Nature of ability to make individual choices, such as access to food and money
- Access to certain areas in the setting

As necessary, additional requirements were incorporated into SMA policies, contracts, and other documents, e.g., benchmarks, compliance reviews and other oversight materials used to articulate program requirements.

Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance; and

All settings are subject to the ongoing regulatory process for their setting type. Any areas of non-compliance that may not have been identified during the initial review process are being identified through the ongoing compliance and regulatory process. This process is conducted by DQA for CBRFs, 3-4 bed AFHs, RCACs, and ADCs. For 1-2 bed AFHs, the process is conducted by MCOs for managed long-term care (LTC) and SMA contracted staff employed on behalf of the SMA for the IRIS program. For nonresidential settings that are not otherwise regulated, the process is conducted by contracted staff employed on behalf of the SMA.

HCBS Compliance Review Request and Periodic Compliance Site Visits

Wisconsin will use several methods for ongoing assessment and monitoring of settings: DQA will continue to assess the compliance of any new licensed settings that are certified by DQA (CBRFs, 3-4 bed AFHs, RCACs, and adult day care providers) requesting HCBS compliance by reviewing the [HCBS Compliance Review Request, F-02138](#) and the required supporting documentation. Licensed settings and settings that are certified by the state licensing authority (DQA) (CBRFs, 3-4 bed AFHs, RCACs, and adult day care providers) are subject to periodic compliance site visits (at least every 3 years for CBRFs, 3-4 bed AFHs, and RCACs and at least every 5 years for adult day care providers) by DQA. As part of these periodic licensing or certification reviews, DQA also reviews the setting for continued HCBS compliance. Settings found to have deficiencies in licensing or certification requirements are required to implement corrective actions and can lose their license or certification when noncompliance continues or is egregious. Any provider that loses its license or certification cannot continue to be a qualified waiver service provider regardless of their HCBS compliance status. Providers are required to address any HCBS rule deficiencies. Failure to adequately remediate results in removal as an HCBS waiver provider. New providers who are licensed or certified by DQA are reviewed for HCBS compliance if they intend to serve HCBS waiver participants. Information about which residential settings are HCBS compliant and standard or abbreviated surveys completed in the past three years are listed on DQA's public-facing [Provider Search](#).

Annual 1-2 bed AFH Recertification Process

Certified 1-2 bed AFHs are certified by MCOs for Family Care and Family Care Partnership members and contracted staff employed on behalf of the SMA for IRIS participants. The HCBS requirements have been incorporated into the [Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes](#). The certification entities are required to review compliance with the state standards for any setting that intends to serve HCBS waiver participants. These settings must be recertified on an annual basis. HCBS compliance requirements are part of the initial review and the recertification process. Settings that are not compliant with all AFH standards, must implement corrective actions within 45 days and will have their application for certification or recertification denied if they fail to successfully remediate the areas with which they are non-compliant within the designated time frame. If an AFH application for certification or recertification has been denied or if an AFH certification has been revoked, the AFH is no longer eligible to serve as an HCBS waiver provider.

The contracted staff currently conducting the compliance reviews of nonresidential settings will continue to be employed to assess the compliance of any new nonresidential settings and to

conduct ongoing compliance reviews of existing settings. The SMA will complete an updated review process to ensure compliance at least every three years, similar to DQA-regulated residential settings. Certifiers use the [Benchmark Guide for Home and Community-Based Services Settings Rule: Nonresidential Provider Settings](#) as a reference of state benchmarks and to provide justification to support the certifying agency's determination of compliance. The review process for all new and existing providers will include an off-site review of provider documents and an onsite visit. Settings that are not found to be compliant with the HCBS settings rule, are required to submit acceptable remediation plans within 45 days and to implement the accepted plans within 6 months. If the non-residential provider fails to achieve compliance with the HCBS settings rule within the designated timeframe, the provider is no longer eligible to serve as an HCBS waiver provider.

Description of a beneficiary's recourse to notify the state of provider non-compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback

Beneficiary recourse to notify the state of provider non-compliance: In addition to monitoring or compliance by waiver agencies, beneficiaries have several options to report provider non-compliance to the SMA. The Division of Quality Assurance has a [complaint process](#) in place for state licensed and certified providers. If any individual believes that a caregiver or DQA regulated health care provider has violated State or Federal laws, that individual has the right to file a complaint with DQA. The Bureaus of Health Services, Assisted Living, and Nursing Home Resident Care are responsible for conducting complaint investigations of health and residential care facilities. Individuals can file a complaint or report by calling a toll-free number, filing a report, submitting a concern, or submitting a complaint. Individuals can also contact the Ombudsman Program which responds to complaints and problems of residents or recipients of long-term care, such as community-based residential facilities and services provided by managed care organizations.

HCBS programs have grievance processes, including notification of care managers and IRIS consultants, that are followed if someone has concerns regarding the quality of their care or services. Waiver agencies identify whether specific providers are the subject of grievances or appeals and have protocols to take appropriate corrective action. The SMA reviews grievance and appeal information as part of its ongoing monitoring procedures and overall quality management strategies.

Sincerely,



Lisa Olson
Medicaid Director

cc: Curtis Cunningham, Assistant Administrator for Benefits and Service Delivery
Christian Moran, Director, Bureau of Programs and Policy
Kimberly Schindler, Project Manager, Bureau of Programs and Policy
Michele MacKenzie, CMS