



of Wisconsin Disability Organizations

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August 29, 2014

Department of Health Services  
Secretary Kitty Rhoades  
1 W. Wilson St.  
Madison, WI 53703

Dear Secretary Rhoades,

Thank you for your Department's efforts to develop a state plan that will implement the vision and intent of the recent changes to the federal CMS Home and Community Based Settings (HCBS) administrative rule. We believe there are many positive elements in this rule that can improve inclusion, access, participation, and contributions of people living with disability in their communities. Most importantly, change is critically necessary in Wisconsin. The status quo for some service settings is unacceptable for a variety of reasons.

In addition, we believe the HCBS rule is aligned with revisions to federal law made in the Workforce Innovation Opportunity Act (WIOA),<sup>1</sup> which codifies a federal definition of competitive integrated employment<sup>2</sup> that includes requirements for employment settings, requires transition services for youth with disabilities, and requires completion of multiple actions designed to successfully transition people with disabilities into integrated competitive employment.

We believe full implementation of the new HCBS integrated settings requirements have the potential to result in the most significant shift in public policy for people with disabilities that advocates have seen in the past two decades. This rule, in combination with other federal policy changes, moves us toward fully realizing the intent of the 1999 Supreme Court Olmstead decision: that people with disabilities should be able to live, work and make choices about their lives just like people without disabilities. Such change is essential given Wisconsin data demonstrating non-alignment with the Olmstead decision.

In comparison to other states that have faced scrutiny by US Department of Justice for compliance with the Olmstead ruling, Wisconsin data indicates an imbalance towards segregated HCBS funded settings to an equal or greater degree than those states that have already been directed to change practices. This plan provides an opportunity for Wisconsin to further its efforts to come into full compliance with the Olmstead decision prior to any federal intervention or scrutiny.

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<sup>1</sup> Signed into law 7/22/2014

<sup>2</sup> 29 U.S.C. 705 Section 404, Section (7), Subsection (5)

The HCBS rule is a tremendously exciting opportunity for Wisconsin, but we recognize the five year transition period will have challenges. We believe successful transition to new expectations and provider business models depends on visionary leadership from the Department, full engagement of participants and stakeholders, and technical assistance to build provider capacity and implement best practices. DHS must also address concerns of families and participants to provide assurances that service levels currently aligned with individual needs will not change or be decreased.

Sincerely,

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## Executive Summary

As a cross disability coalition of more than 30 organizations, Survival Coalition has thoroughly discussed the new HCBS rule requirements, and the transition plan proposed by DHS. We have summarized below the priority issues we would like to see reflected in a revised transition plan.

- **Stakeholder Engagement throughout the transition process (see page 5)**

Create a Stakeholder Implementation Task Force with specific charges, tasks, and membership that is time-limited to the full implementation of the HCBS settings rule.

- **Lead a public education campaign on HCBS rule and transition process for participants, stakeholders, providers, and MCOs (see page 7)**

DHS can address many concerns expressed by participants, stakeholders, providers, and MCOs through a public education campaign, and also use this as an opportunity to emphasize the intent of the rule—to provide people with disabilities the full range of opportunities that people without disabilities can access.

In addition to the actual settings, the way services are delivered may have isolating qualities. The settings and delivery system cannot be decoupled and should be addressed at the same time

- **Hire an Independent Quality Reviewer to conduct statewide independent assessments of all HCBS settings (see page 11)**

Use a non-provider independent quality reviewer to conduct a uniform statewide assessment of all HCBS settings and service delivery practices. The independent assessor should conduct on-site visits, participant interviews, analysis, prepare recommendations for the full report which will be provided to DHS and shared with the Implementation Task Force (see page 5).

- **Non-disability specific settings must be options in all areas of the state (see page 9)**

DHS should assess community capacity and increase integrated setting options; ensure at least one non-disability specific setting is always available in all areas of the state without wait lists; assist transition of all existing providers to a different business model to expand community capacity.

- **Build Provider Capacity (see page 10)**

Qualified individuals are needed to provide services and supports. DHS should develop standardized training and technical assistance that is available. Technical assistance is an ongoing need beyond transition to maintain best practices in the future; an annual appropriation line should be dedicated specifically to this effort.

- **Establish ongoing monitoring, and enforcement processes (see pages 14 and 16)**

Ongoing monitoring of providers— through a standardized scheduled audit process and a randomized on-site inspection process—will continue to be necessary after the five year transition period. DHS must establish policies and procedures that address the need for various enforcement actions, outline a process whereby violations of HCBS settings and service delivery can be reported and investigated, and establish an enforcement process that clearly communicates corrective action steps to providers and clearly communicates to MCOs when they must suspend payments or terminate a subcontractor for non-compliance.

## Engagement of Stakeholders and Participants

### Stakeholder engagement throughout transition process

Stakeholder engagement is necessary at all stages of the plan including; assessment, development and implementation of technical assistance, development of processes to implement the rule, rule implementation, compliance monitoring, and enforcement of the rule. Stakeholders should be identified as partners in Wisconsin's successful transitions to HCBS compliant settings and service delivery. The proposed plan can be strengthened to ensure a stronger and necessary commitment to stakeholder engagement. CMS is clear in its January 2014 regulation that some settings may involve heightened scrutiny by CMS and states will be required to provide strong evidence that the setting meets HCBS requirements. CMS review of settings with heightened scrutiny will include direct input with stakeholders. Therefore we suggest including stakeholders upfront in Wisconsin's process.

### *Create Transition Implementation Task Force*

We recommend a Transition Implementation Task Force be created, and that the existence of the body be time-limited to the full implementation of the HCBS settings rule. This body should be equal partners in the following:

- Developing assessment criteria and standards for residential and non-residential settings
- Developing assessment surveys for participants, self-advocates, and providers.
- Developing specific indicators for HCBS compliance
- Reviewing the independent assessment (see page 11), assist the department with the development of training, technical assistance, and participant communications.
- Establishing benchmarks by which outcomes are measured, outcome targets to gauge progress, and an implementation plan with specific measurable goals and timelines.
- Development and oversight of a non-compliance mediation process, remediation steps to mitigate non-compliance, re-evaluation of compliance, and tiered enforcement process when non-compliance has not been mediated
- Development and oversight of the implementation of a person centered planning process
- Reviewing of relevant DHS internal agency policies to ensure they align with spirit of HCBS rule
- Receiving, reviewing, and making recommendation on Department reports to the Body on benchmarks

We further recommend the membership of the stakeholder committee include:

- The State Medicaid Director or representative
- A representative from the Office of Inspector General

- A representative from the Independent Living Centers
- A representative from the state designated Protection and Advocacy group
- A representative from the state Developmental Disability Board
- A representative from the Aging Advocate community
- At least five participants who are older adults, people with physical disabilities, people with developmental disabilities, people with mental health issues, and an IRIS participant.
- A Legacy Waiver representative
- An IRIS Waiver representative
- Children’s Waiver representative
- ADRC representative
- A representative of a Managed Care Organization
- A residential service provider
- A non-residential service provider

*This approach resolves the following potential issues:*

- Stakeholder engagement will assist the Department by problem-solving transition challenges before they occur. Limiting stakeholder involvement to review of items already created or collected by the department—as proposed in the current plan—is insufficient input.
- Stakeholder engagement informs the development of multiple processes that need to be established and applied consistently to further rule implementation.
- Stakeholder engagement enables the department to access and utilize local knowledge that may identify specific services or geographical areas that are in most need of technical assistance and capacity building.
- A stakeholder body is a mechanism that establishes a working relationship that will make further Technical Assistance, educational outreach and awareness, and the overall transition process easier for DHS.

Previously with other new initiatives, DHS has established an implementation task force. The HCBS settings rule is a shift in public policy that is large enough to require its own implementation task force. No existing advisory council has the membership or charge to adequately address statewide transition to HCBS settings.

## Transition education and awareness for participants, stakeholders, providers, and MCOs

### *Send clear message that all HCBS settings will be reviewed within a set timeframe*

This offers the Department an opportunity to provide standardized technical assistance to providers and participants to educate them on the rule's content and requirements. A set timeframe for evaluation accompanied by robust technical assistance by the Department may help facilities identify changes they need to make, and implement self-corrections to resolve compliance issues prior to the assessment deadline.

### *Send clear transition education messages to stakeholders and participants*

The HCBS settings rule will bring changes. Uncertainty without clear information from the department fosters fear of these changes by participants and their families. Unfortunately, confusion about the rule has enabled misinformation and factual inaccuracies to spread among participants, family members, and providers. DHS can address many concerns through a public education campaign, and also use this as an opportunity to emphasize the intent of the rule—to provide people with disabilities the full range of opportunities that people without disabilities can access.

Themes of topics that are causing distress for participants and family members have emerged. Public education efforts should include reassurances from DHS in these core areas.

- **Participants will not lose services.**

Supports will continue to be based upon individual needs identified in their plan. The plan acts as a contract for services between the individual and the state. The state long term care program must ensure continued supports to facilitate achievement of the goals in each individual's plan. An individual's needs and levels of services based on those needs should not change or be reduced.

- **The HCBS rule does not force certain providers to close.**

The HCBS rule does not force any provider to close and does not include any proposals to reduce funding. Some providers may have to shift their business model. DHS's plan gives providers 5 years, plus technical support to help them meet this federally required change.

- **People will not be forced to sit at home with nothing to do.**

The intent of the federal rule change that DHS is responding to is to provide people with disabilities the full range of opportunities that people without disabilities can access. All providers of long-term supports will have the opportunity to change and expand the supports they offer to meet federal expectations for more community-based options.

- **The rule does not take choices away nor reduces choices.**

Currently, there is a significant lack of choice exists in Wisconsin communities for people with disabilities who want integrated employment and living supports. In many parts of the state,

waiting lists exist for integrated employment and community supported living options. The direction DHS is taking will expand choice for families and individuals who have been waiting for new options in their communities.

- **The transition process itself is clear and thoughtfully planned.**

Clear timelines are outlined in the transition plan. Time is built into the plan so that all providers can adjust their settings to come into compliance with the new rule before the federal deadline. All providers have the opportunity to shift their business model so that it meets HCBS requirements. Providers that make a choice to close rather than come into compliance with federal regulation will be identified by September 9, 2016. If the need arises, participants will be notified as early as possible and MCOs will work to transition members into a compliant setting that is the least disruptive to the participant's daily life.

***Provider self-assessment used as an educational tool to prepare providers for DHS Technical Assistance and transition***

Use of self-assessments is one tool to train providers and get them up to speed. Additional technical assistance for providers and training for staff will also be necessary.

Self-assessments should not be a determining factor in a regulatory or oversight purposes. The Department is the final determinant of compliance.

Self-assessments can be used as an educational and self-analysis tool that serves as an internal guide or screening for providers. As they learn the requirements of the new rule, a self-assessment can help providers gauge their organization's readiness for transition and examine their current operational practices. Adequate knowledge of the rule coupled with accurate self-assessment may result in providers voluntarily changing practices that will meet the Department's expectations for compliance with the rule. Self-assessments need to include input from all LTC program participants.



## Provider Capacity Building

### *Assure a full range of community options exist in every part of the state.*

The premise of the HCBS rule is to positively improve outcomes in people's daily lives. Building a full week and a full life requires a menu of supports that can help people with disabilities live, work, be actively engaged in their communities, and make decisions just like people without disabilities. Change in Wisconsin is critically necessary to ensure integrated options.

We are hearing from families across the state that most of the current options for HCBS funded employment, day services, and residential services have segregating and isolating qualities that are unlikely to be compliant with HCBS rules. Specifically:

- The only options in many communities are settings that have segregating and isolating qualities;
- Families and individuals indicate they want community based options;
- Integrated services are not available statewide, and wait lists exist in many areas for integrated options.
- While all setting options receiving HCBS funds must meet integrated settings requirements, the Department should ensure:
  - At least one of the settings offered is always a non-disability-specific setting;
  - Existing providers transition to a different business model, if necessary;
  - Community capacity is assessed and developed to increase integrated setting options.

These steps will also help Wisconsin ensure Olmstead compliance for all HCBS long term care services

### *Ascertain true picture of provider capacity*

The HCBS rule is based on the premise that all individuals are able to access integrated settings (including residential, transportation, employment etc.) no matter where in the state they receive these services.

An assessment of current settings—many of which we presume will not meet the HCBS standards—will give DHS important information about the type and number of choices available by location. This geographic information may reveal areas of the state with few or no choices that meet HCBS settings standards; some areas may have several providers that are running their business in a manner that complies with HCBS standards.

Assessment results (see page 11) should be used to identify areas that have no or limited HCBS compliant choices. Targeted capacity building strategies should be conducted so that expansion of integrated settings occurs in a geographically equitable manner. The goal of this transition plan should be to increase the number of integrated settings to all areas of the state every year of the transition plan, with all providers being in full compliance by the end of the five year plan.

### ***Invest in technical assistance and implementation training***

Nationally, building provider capacity is an issue facing many if not all states<sup>3</sup>. Investing in a multi-strategy, multi-level approach must occur over the course of this five year transition period and beyond to build and maintain the capacity necessary to achieve systems change. Qualified individuals are needed to provide services and supports, and staff needs standardized training and technical assistance available at all times. This is an important ongoing need for successful transition and maintenance of best practices in the future; an annual appropriation line should be dedicated specifically to this effort. Survival Coalition supports increased funding for the Department for this purpose.

### ***Build capacity for Integrated Day Services***

Nationally, there is increasing recognition that current approaches to Day Services are insufficient. As the service system continues to advance the goal of full inclusion for adults with disabilities and focuses on the importance of employment in the community as a key strategy to support inclusion, it is also important to provide supports help adults to access community integrated activities and resources when individuals are not at work. As an example, in the June 2013 US Department of Justice settlement with the state of Rhode Island<sup>4</sup>, the state has begun developing Integrated Day Services that are:

- Individualized, flexible, purposeful, and productive daytime activities; individually tailored to a person's interests, abilities, and goals; and that afford individuals the services and supports necessary to interact with non-disabled individuals to the fullest extent possible during the day.
- Include an array of group and non-group activities and facilitate meaningful choice by individuals with I/DD between group and non-group activities.
- Are not services provided as part of a sheltered workshop, day services, group home, or residential service provider's on-site program.

Supports in Wisconsin's Day Services should be cross disability and these services should be in integrated settings.

Nationally, a set of best practices for states and providers is emerging. Survival has included a summary of these best practices in Appendix A (page 29), and would welcome the opportunity to work with the department on developing an Integrated Day Services model for Wisconsin.

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<sup>3</sup> Several states invest specifically in enhancing provider capacity through training. Washington State's WISE was created as an entity within state government. Alaska funds capacity building as a driver of employment policy change. Missouri and Iowa have purchased the College of Employment Services, which these states believe will offer consistent and on-demand training to state agency personnel and employment providers. The state of Tennessee is using Relias Learning systems.

<sup>4</sup> USDOJ Rhode Island Interim Settlement Agreement filed June 13, 2013.

## Transition Process—who does what, when, and how

### Assessment of Settings

Uniform, comprehensive, and independent assessment of all HCBS settings and service delivery practices is the foundation for successful transition and HCBS rule compliance.

The two fundamental requirements of the HCBS rule are:

1. The setting is selected by the individual from among setting options that include non-disability specific settings.
2. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

#### *Use independent quality review to conduct statewide independent assessment*

Using a non-provider independent quality reviewer to conduct an assessment of all settings ensures that all providers are being uniformly evaluated across the state by the same personnel who have received similar training and who are using standardized criteria. An independent quality reviewer does not have a financial interest in a facility being assessed and can provide an objective assessment that is rooted in the participant experience in the setting. This objectivity and independence is an asset to the Department, and informs all the steps of the transition plan.

DHS has successfully used independent contractors in the past to conduct statewide quality reviews of statewide programs. A task of this scope and statewide scale—evaluation of all settings receiving HCBS funds—is worthy of issuing a comprehensive Request For Proposal (RFP) for one entity to do all assessments, on-site visits, participant interviews, analysis, recommendations, and reporting back to DHS Implementation Task Force (see page 5). Independent assessments will continue to be an ongoing need after transition, and should routinely be conducted on an ongoing and cyclical basis.

All the following elements are considered to be essential for entities responding to an RFP for HCBS setting assessment and evaluation:

- Has the capacity to do statewide comprehensive evaluation.
- Is independent from providers that manage HCBS settings or receive HCBS funds
- Is experienced with comprehensive quality review of Long Term Care programs

Any entity the Department contracts with for HCBS setting assessment and evaluation purposes should:

- Have no contracts with the Department or with regulated providers that may give the perception of a conflict of interest or jeopardize the independence/objectivity of the final assessment.

- Is not a recipient of HCBS funds, and has no potential for direct or indirect financial gain if a setting is found in or out of compliance with HCBS settings requirements.

All of the following deliverables are necessary for the independent quality reviewer to complete:

- Statewide assessment of all settings, specify all settings will be assessed within a timeframe.
- Requirement that assessments be conducted in an audit format.
- Requirements for the process and documentation the Independent Quality Reviewer utilizes for each assessment.
- Each assessment includes an on-site visit of setting, interviews with staff, interviews with LTC participants receiving HCBS services, and interviews with provider leadership.
- Each assessment includes review of provider governance, internal policies and procedures, review of the fidelity of the person-centered planning process.
- Each assessment includes a quantitative and qualitative evaluation of the setting against HCBS settings criteria, with a recommendation on overall compliance or non-compliance with the criteria. The Department is the final determinant of compliance.
- The assessment includes, as appropriate, recommendations for technical assistance follow up.

***Using an independent assessor resolves the following concerns:***

- **Minimizes State Liability**
  - *DHS incurs financial risk and potential conflict of interest by not using an independent assessor. The current transition plan delegates assessment, review of providers, submission of provider compliance plans, and evaluation of provider compliance to Managed Care Organizations (MCOs).*
  - *DHS is the entity that is ultimately responsible for ensuring that Wisconsin is in compliance with federal Medicaid law.*
  - *Violations of the HCBS rule could have fiscal consequences for state taxpayers, and result in CMS suspending Medicaid reimbursements or other actions that may have a fiscal impact for the state.*
- **Protects MCOs and Providers**
  - *Under the current transition plan, provider self-assessment and MCO evaluation of provider compliance is the foundation of the process that transitions settings into HCBS compliance.*
  - *The provider self-assessment approach puts the provider in the position of determining whether or not investments in facility infrastructure or changes in practice are necessary.*
  - *Given the complexity and newness of the rule, the numbers of providers, and varying size/capacity of providers, accurate self-assessment may be challenging.*
  - *Some providers may incorrectly self-assess compliance or non-compliance based on incomplete knowledge or understanding of the requirements.*

- *Some providers may choose to self-assess compliance when that is not the case because of a perceived or actual financial advantage to their business; self-assessed compliance may result in avoided investments or continuing of practices that are violations of the new CMS rule.*
- *MCOs have a contractual relationship with the state to provide overall administration and coordination of long term care services for individuals receiving HCBS services; they have not been required by the state to be an evaluator or enforcer of federal policy.*
- *A regulator role is fundamentally different from administrative, coordination, and direct service supervisory roles. Regulation and oversight demands a different set of skills. MCOs should not take on a regulatory role.*
- *MCOs have an inherent conflict of interest, as the providers they subcontract with are the regulated entities. The Transition plan eventually prohibits MCOs from contracting with non-compliant providers, but MCOs are given responsibility for assessment and evaluation of compliance which determines who they can contract with. This structure sets up a scenario that could be subject to abuse, fail to identify non-compliant settings, or enable MCOs to use non-compliance as a punitive measure or threat against providers.*
- *An independent assessment would identify where MCOs do not have a full provider network, as required.*
- *MCOs may incur additional liability if a subcontracted provider setting is not in fact compliant and member or participant sues because the setting is not HCBS compliant.*
- **Uniform statewide assessment preferable to using multiple MCOs with different and/or overlapping geographic service regions**
  - *The current transition plan calls for a representative sample of providers to be assessed. This will result in some settings not being assessed, unequal treatment of providers, and potentially a failure to identify settings that are not in compliance.*
  - *Wisconsin has multiple MCOs, each with its own leadership and staff. Assessment, evaluation, remediation, evaluation of provider compliance may vary between MCOs. The goal of HCBS requirements is to ensure all people with disabilities have equitable access to the community no matter where they live.*
  - *The size of MCOs, their geographic coverage areas, and the number of providers providing services within the MCO's region varies; some MCOs will have a greater workload than others.*
  - *The same providers may have subcontracts with multiple MCOs or counties, leading to multiple entities conducting reviews (which could lead to conflicting assessment results).*
  - *15 counties do not currently have Family Care/IRIS, and should not be responsible for assessment of providers for the same reasons stated above. Under the proposed plan, we assume counties would be responsible for assessing providers with which they subcontract.*
  - *Especially because the state has three concurrently operating Long Term Care programs, a uniform independent assessment ensures that all providers in all parts of the state are treated consistently and fairly.*

## Compliance monitoring and process for achieving compliance

### *Ongoing Monitoring process and Reporting Requirements*

Ongoing monitoring of providers—whether through a standardized scheduled audit process or randomized on-site inspection process—will continue to be necessary after the five year transition period. Turnover of staff, provider, and MCO leadership will occur and continual training and education will be needed. As new best practices are established, the department will need a mechanism to continue improving services and measuring success. The Transition Plan is an opportunity to build-in reporting requirements that will help DHS evaluate services as well as indicate performance of individual providers and MCOs.

There should be a continual expectation of assessment and ongoing monitoring on the part of providers and facilities, and that it is a matter of fairness to all providers that their peers are equally measured and evaluated based on providers and facility characteristics, practices, and outcomes.

### *DHS administers all compliance, remediation, and enforcement of HCBS requirements*

DHS should position itself solidly as the entity that is determining non-compliance, directing the remediation process, and conducting rule enforcement. DHS will need project staff devoted to this purpose for the limited time period of the transition (5 years), and may need to retain some positions to continue the ongoing monitoring that will be necessary, provide technical assistance, and conduct any enforcement actions. We support increasing DHS's capacity and additional funding as necessary to do this work.

### *DHS should direct remediation process for non-compliant providers*

DHS should be the entity directing non-compliant providers on the development of their remediation plan, evaluating the remediation plan, directing providers on the appropriate steps they should include in their remediation plan, approving the remediation plan, and evaluating whether the provider is compliant.

The Department should establish a process to review remediation plans and build in ability to amend or include additional requirements of the facility upon review. The process should specify a re-inspection process.

### *This approach addresses the following issues:*

- Clarifies expectations for providers, provides a process for implementing best practices and maintaining eligibility for HCBS funds.
- Establishes due process and remediation requirements for settings that are found out of compliance.
  - *This includes an appeal process for providers if they feel they have been inaccurately assessed to be out of compliance.*
  - *This includes an appeal process for participants to use if they feel a provider has been inaccurately assessed to be in compliance.*

***Participant initiated mechanism for reporting non-compliant settings***

Participants in long term care programs should have an independent mechanism to access if they believe that HCBS settings requirements are not being followed by a provider or MCO. The same entity—independent from providers—should serve participants across all HCBS funded LTC programs.

Participants have expressed concerns about their ability to question providers or complain about provider actions because of fears that services will be changed, interrupted, or that other consequences will result.

## Enforcement of requirements

### *Establish reporting requirements and process for enforcement*

The current transition plan does not contain any details about how HCBS settings requirements will be enforced. The five year transition period is intended to ensure all current providers shift business practices to meet the HCBS settings and community based service delivery expectations. Like ongoing monitoring, enforcement of the HCBS rule will be an ongoing need during and after transition<sup>5</sup>.

DHS must establish policies and procedures that anticipate the need for various enforcement actions, outline a process whereby violations of HCBS settings and service delivery can be reported and investigated, and establish an enforcement process that clearly communicates corrective action steps to providers and clearly communicates to MCOs when they must suspend payments or terminate a subcontractor for non-compliance.

The following elements should be included in DHS enforcement policies and procedures:

- Specific mechanism for participants to file anonymous complaints about HCBS settings or service deliver.
- Mechanism to independently investigate complaints, such as an Ombudsman program.
- A certain number of complaints should trigger an automatic investigation of an entire organization/provider. This investigation should be comprehensive and involve Ombudsman investigation of all individual complaints. If a pattern arises—for example, the same types of complaints from different individuals—this information should be reported to DHS for further enforcement action.
- Enforcement actions should include the following:
  - *Specific corrective action steps required by DHS that must be implemented within a six month timeframe.*
  - *Requiring the MCO/provider to develop a corrective action or remediation plan that must be approved by the Department. An approved corrective action plan would enable continuation of funding for six months while the plan is being implemented.*
  - *Termination of provider as an eligible recipient of HCBS funds in absence of remediation or corrective action plan, and notice sent to MCOs of providers no longer eligible to be subcontractors.*
  - *Temporary withholding of HCBS payments.*
  - *Non-renewal of operating approvals.*
  - *Suspension and limitations on operating certificates or certifications.*
  - *Fines and other fiscal sanctions, including restitution.*
  - *Stepped enforcement (tiered sanctions of increasing severity) for repeat violators.*

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<sup>5</sup> New provider businesses may be started during or after the transition period. MCO, providers, and the state will experience leadership and staff turnover. Without continual technical assistance, ongoing monitoring, and enforcement HCBS rule compliance may attrition and put the state at risk of CMS sanctions.



- *Allowance for MCOs to suspend or terminate provider subcontracts immediately if HCBS settings or service delivery does not meet requirements.*
- *Review and re-inspection of providers 12 months after being found in violation to confirm full compliance.*

## Person-centered planning

### *Establish clear statewide definition of person centered planning*

A uniform statewide definition of person centered planning should be adopted and applied statewide by all providers and MCOs. This definition should have fidelity to the language of the rule and clearly expect that services will result in integrated full access to the community<sup>6</sup>.

### *Establish clear conflict of interest policies*

consistent with the new regulations, Wisconsin long-term care programs should develop and issue clear and complete conflict of interest guidelines for all participants in person-centered service planning processes. This should include service providers, care and case managers, parents, guardians and other service providers who may be involved in the planning process with an individual.

Wisconsin long-term care programs should maintain existing policies which permit the exclusion of service providers from certain aspects of the person-centered service planning process in order to address situations where significant conflict of interest exists and to ensure an individual:

- Always has free choice of provider and can choose to change providers at any time without undue influence from an existing provider;
- Has a confidential opportunity to freely discuss issues and concerns regarding providers with his/her case manager, care manager, nurse, or broker (depending on the specific long-term care program); and
- Can freely decide his/her goals and outcomes, without undue influence from one or more providers who could benefit if certain goals or outcomes are chosen.
- Includes a clear expectation that the LTC participant is fully engaged and actively involved in their plan development.

In addition, the following elements must be central to the Department's expectations for the person-centered planning process:

- The participant should have the authority to request meetings and revise the plan whenever necessary, and that meeting occur at times and locations of convenience to the person
- The participant or representative must be central in determining what available HCBS are appropriate and will be used.
- A strengths-based approach to identifying the positive attributes of the person must be used.
- There must be mechanisms for solving conflict and disagreement within the process including clear conflict of interest guidelines

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<sup>6</sup> See June 6, 2014, CMS guidance, "Section 2402(a) of the Affordable Care Act—Guidance for Implementing Standards for Person-Centered Planning and Self-Direction in Home and Community-Based Service Programs."  
<http://www.acl.gov/Programs/CDAP/OIP/docs/2402-a-Guidance.pdf>

- The plan should not be constrained by any pre-conceived limits on the person’s ability to make choices.
- Goals must be documented in the person’s and/or representative’s own words.
- Non-paid supports and items needed to achieve the goals must be documented.
- All persons directly involved in the planning process must receive a copy of the plan. The plan should be discussed with family/friends/caregivers designated by the individual so that they fully understand it and their roles.

***Ensure monitoring of person-centered planning processes and document the method of monitoring that will occur.***

While CMS outlined required components of person-centered planning, they also indicate that “the degree to which the process achieves the goal of person-centeredness can only be known with appropriate quality monitoring by the state, which should include substantial feedback provided by individuals who received or are receiving services.”

***Provide support for individuals with guardians to realize integration and participate fully in the execution of their right to an integrated setting.***

People with intellectual and developmental disabilities are often placed under guardianship and lose the capacity to fully participate in choice-making about integrated options. The Administration on Community Living and other national organizations are discussing how to promote the concept of Supported Decision-Making for individuals with guardians. In June the Administration on Intellectual and Developmental Disabilities (AIDD) and the Administration on Aging (AoA) published a Request for Proposals for a training and technical assistance/resource center on supported decision making. The Center will collect and disseminate materials on supported decision-making, including the experiences of people with intellectual and developmental disabilities in making informed decisions with the use of supports.

Wisconsin’s transition plan should specifically reference its intention to explore the development of Supported Decision-Making options and establish a targeted workgroup (including self-advocates) to develop recommendations on this topic to be issued within a specified timeframe.

## Non-disability specific residential settings:

### Guidance needed to clarify expectations for providers

The HCBS rule articulates characteristics of integrated settings and expectations of areas where individuals have choices and protections. The state plan should offer further guidance for providers on operationalizing the requirements of the rule. CMS has been clear in its negotiations with other states as to its expectations.

#### *Monitor the following indicators that illustrate operational expectations<sup>7</sup>*

- **Food, Meal(s), and Storage of Food Access**
  - *Individuals have access to food, meal(s), and storage of food (e.g., individuals are allowed to purchase and store their own snacks or special food and keep food for themselves; kitchens, refrigerators, and pantries are not locked and if any safety considerations need to be implemented for a particular individual, the other residents have a means of ready access).*
  - *Individuals have input on food options provided (e.g., choices are offered for meals and/or in menus).*
  - *While it is recognized that mealtimes occur at routine times as is the case in most households, an individual may choose to eat at a different time or may choose to eat their meals alone if desired.*
- **Access to Areas of the Home:**
  - *Individuals have access to areas of their home such as kitchens, laundry rooms, cabinets, closets and other rooms of the house. Such rooms do not have posted hours of operation and are not locked. If any safety considerations need to be implemented for a particular individual, the other residents have a means of ready access. Rules may not be posted unless the individuals residing in the home agree to a schedule that enables everyone equal access.*
- **Visitors and Freedom of Association:**
  - *Individual freedom of association, initiative, and autonomy regarding with whom to interact and when to interact is optimized and not regimented.*
  - *Individuals may have visitors of their choice at any reasonable time without facility approval and individuals have the right to privacy with their visitor(s). This also means that individuals have access to the internet and telephone at any time and may choose to have private telephone numbers in their rooms and/or private cell phones for use at any time.*
  - *The facility may require visitors to sign in and/or notify the facility administrator that they are in the facility or other such policies/procedures to ensure the safety and welfare of residents and staff as long as such policies and procedures do not unnecessarily restrict visitors for the convenience of staff and/or regiment freedom of association.*
- **Roommates:**
  - *Individuals are provided with opportunities to work with the facility to achieve the closest optimal roommate situation. Individuals that have issues with their roommates are encouraged and*

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<sup>7</sup> New York negotiated an MOU with CMS that contained the standards listed in this section.

- supported to work things out with their roommates and/or to receive assistance from the facility staff/facility/provider in coming up with alternatives.*
- *The facility has a mechanism to assess roommate satisfaction/dissatisfaction and provides individuals with a confidential opportunity to discuss issues or concerns regarding their roommates. The facility also provides education to individuals on self-advocacy and supports them in resolving these issues and/or in moving to another room or residence if the person chooses to do so.*
  - **Personal Space and Privacy:**
    - **Privacy:** *Individuals have the ability to lock their rooms for personal privacy and to control access from unwanted external entry. The locking mechanisms will allow for the entry of support or help in an emergency.*
    - *Individuals may keep their own key and may lock the door to their private space. Individuals are allowed to have keys to the house they live in.*
    - **Personal Items and Decorations:** *Individuals are encouraged and supported to decorate and keep personal items in their rooms (decorations must conform to building/fire safety codes and licensure requirements/rules in certified settings and must not violate the law).*

***Require providers to adopt internal policies and governance that are consistent with Department standards***

Internal governance policies and procedures are essential to fidelity of HCBS rule implementation. CMS has been clear with other states with its expectations, and has negotiated MOUs that specify internal policies that CMS expects each organization receiving HCBS funds to include. A recent MOU negotiated between CMS and the state of New York was finalized in 2013 just before the final HCBS rule was published. Internal policies required under that MOU are included in Appendix A, and we recommend DHS require the same of Wisconsin MCOs and providers.

***Include HCBS requirements for settings in licensing and certification standards; and reference in all HCBS waiver service descriptions and in MCO contract language***

HCBS Regulatory Requirements for HCBS Settings (see Appendix C, page 31) should be incorporated into CBRF Licensing Standards, AFH Certification Standards for 1-4 Bed Corporate Homes, and AFH Certification Standards for 1-2 Bed Owner Occupied Homes. For any modification of the requirements described (see Appendix D, page 32), justification and documentation of the specific assessed need as described in Appendix C (page 31) should be required of providers.

Including a reference to HCBS setting requirements in each waiver service definition and provider qualification standard will ensure conformity across providers and communicate expectations for payment.

Managed Care Organizations indicate the MCO contract document is the main source they reference for clarification of Department expectations, therefore, necessary integrated settings language should be included to clarify newly expected changes in service delivery.

***Specify how individuals will be ensured that they can select residential settings from among setting options, including non-disability specific settings***

The intention of the HCBS rule implies that non-disability settings will be present and can be freely chosen by individuals. “Informed choice” is contingent upon non-disability settings being present and in sufficient number that any individual who wants to make that informed choice may do so no matter where they live in the state (see page 9). It is important that participants fully understand and have the opportunity to experience different types of settings and do so independently from entities that may have a vested or personal interest in the outcome of the participant’s choice.

***Require the opportunity for all participants to actively experience non-disability specific settings***

The state plan should require participants to be provided opportunities to visit all different types of settings, including non-disability specific settings, and to meet with individuals who receive support in such settings; and to receive information in understandable formats on the specific settings as part of the “informed choice” process. “Informed choice” should be distinguishable from “choice” in that it emphasizes provision of information about all possibilities from which an individual can choose, as well as the consequences of those choices in a manner that is meaningful. According to CMS, the process of informed choice must be documented.

Annual review of the person centered plan should not assume that a person’s initial choice of a setting remains the same, and should offer opportunities for individuals to explore and experience other options. The state transition plan should require documentation on how the individual has been provided information, where/when/and with whom the participant has visited different settings, comments from participants about each setting choice, and documentation of the choice selected by the participant with a statement from the participant on why they chose that option.

The federal Workforce Investment Opportunities Act (WIOA) now requires youth be afforded experiential employment opportunities as part of the required informed choice process. This model is applicable to persons with disabilities of all ages and to other HCBS funded settings. WIOA’s approach aligns with and complements the HCBS rule and furthers the Department’s vision on self-determination and person-centered planning.

***Provide a transparent manner by which individuals can assess the performance of a provider and make an informed choice***

In addition to experiencing non-disability specific settings, informed choice is also facilitated by providing participants with the tools to compare and contrast provider options.

Washington State shares existing data about provider performance through a participant-friendly tool that allows comparison across providers. Specifically, the WA-DDD Employment Supports Performance Outcome Information System summarizes data that is reported monthly<sup>8</sup>. Users can compare providers by employment outcomes achieved for individuals by gross pay, average hours worked; monthly wages; supports provided and other factors. Such a tool would be an excellent means by which to standardize informed choice and to supplement experiences by the individual and other information provided to

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<sup>8</sup> <http://www.statedata.info/washington-ddd/>

participants. Developing a similar tool would facilitate more informed decision-making by participants and further implement the intent of the HCBS rule.

Lack of provider capacity may limit an individual's choices. Currently, participants do not know whether a provider they are interested in using is accepting new participants for certain services. The best choice for an individual may not be available, and participants may be moved to a place or provider that can provide the service but may cause disruption or lack of access to community opportunities in other areas of the individual's life.

Evaluating provider performance is important, but should be done in the context of the individual's full life, needs, and values. Proximity to public transportation, family, medical centers, retail centers, community buildings, employment options or current employer, rural or urban environment, may all be important considerations for individuals selecting a residence or provider of employment services. Including the ability for participants to see the full context of their decisions enhances person centered planning and informed choice.

### ***Include Community Supported Living as a service within all waivers***

The Department has telegraphed that Community Supported Living will be defined and proposed as a service category in upcoming waiver renewals. We support inclusion of CSL in all waivers, including the self-directed waiver, and the billing mechanism for this service should consistent and accessible across waivers. We believe CSL—similar to Aging in Place—can be an effective mechanism to create support within homes that meet HCBS settings standards and develop provider capacity (see page 9). CSL is a strong and viable option to enable people to live in homes of their own (one way of offering people a non-disability specific setting), with individuals they choose. We believe that capacity should be expanded so that this type of non-disability setting is available across the state, and is required to be among the options of non-disability settings presented to participants when making informed choices. We request active stakeholder involvement in review of the CSL definition and accompanying requirements within the waiver renewals.

## Pre-Vocational & day service settings

These settings have many of the qualities CMS considers isolating and segregating under HCBS rule requirements including:

- The setting is designed specifically for people with disabilities, and often even for people with a certain type of disability.
- The individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them.
- The setting is designed to provide people with disabilities multiple types of services and activities on-site, including day services, medical, behavioral and therapeutic services, prevocational and/or social and recreational activities.
- People attending the setting have limited interaction with the broader community while attending the setting.
- “Outings” to the community are pre-planned rather than chosen by individuals, typically involve large groups and the use of special buses for transportation. Time spent at community venues may typically be times reserved for disabled people (e.g. at the bowling alley or pool).
- People attending the service are transported to and from the service in special vehicles that transport only people with disabilities.
- The service delivered typically involves remaining in the setting rather than routinely participating in community activities that take place in integrated, community settings.
- People take breaks and eat lunch on site, alongside of other individuals with disabilities and staff supervises during these times.

Prevocational and day service settings that are located in industrial parks or similarly situated on the outskirts of towns, on relatively large lots that are located a distance from most other typical community venues open to the public (e.g. community centers, libraries, YMCAs/YWCAs, schools, colleges, shopping areas, etc.) are settings that isolate by virtue of their location and should not be approved settings for HCB services. Not all prevocational and day service settings will fall into this category; but those that do should not be settings where HCB services can be delivered after the transition period for compliance has been completed.

Reverse integration (bringing people without disabilities into the setting) is an unacceptable strategy for meeting the new HCB settings regulations because:

- such an approach does not provide people with opportunities to seek employment and work in competitive integrated settings,
- such an approach does not provide opportunities for people to engage in community life,



- such an approach does not allow people to receive specific types of services (e.g. employment services, therapies, recreation opportunities, etc.) in the places where people not receiving HCBS typically go to get those services.

### *Make changes to Pre-Vocational waiver services definition*

Individuals with plans indicating prevocational services as a component should be required to have an integrated employment goal with defined progress benchmarks toward that goal

- If the individual has not successfully achieved and maintained integrated employment within two years, although demonstrable, reasonable and continued progress has been made, the interdisciplinary care planning team must meet to determine what actions have been taken and which have been successful or unsuccessful and a new action plan must be developed that reflects the discussion.
- After applying for assistance from vocational rehabilitation services, and after two years with no demonstrable, reasonable and continued progress toward integrated employment, the presumption is that the individual should, with the support of the interdisciplinary care planning team (IDT), be transferred to a service category providing meaningful, community-based, integrated activities that are similar to those engaged in by their non-disabled peers . This presumption can be rebutted by evidence that more time, up to one year, will result in meeting the integrated employment goal. Examples of such evidence might include that DRV will be assisting with vehicle modifications so that the individual can travel to and from work, or the individual is completing a degree or certification.
- The service should specify that individuals who continue to make progress toward integrated employment benchmarks but who have not achieved integrated employment goals within five years and the individual should, with the support of the interdisciplinary care planning team (IDT), be transferred to a service category providing meaningful, community-based, integrated activities. These activities should be aligned with the individual’s required person-centered plan.
- This service definition should reference “informed choice” requirements and define the informed choice process for this service as including provision of information (to the individual – or guardian if applicable) about the benefits of integrated settings; facilitating visits or other experiences in such settings; explanation of all options and the services that can be provided to support each choice; and offering opportunities to meet with other individuals with disabilities who are working and receiving services in integrated settings, with their families, and with community providers.
- The service definition should emphasize adherence to CMS regulation regarding payment of individuals above 50% of minimum wage who are also receiving HCBS funded prevocational services, as well as the relationship to vocational versus prevocational supports. Specifically, participants receiving compensation exceeding 50 percent of minimum wage should “trigger” a review of the necessity and adequacy of the prevocational, segregated employment service with mandatory referral to supported, integrated employment services In order to comply with the HCBS settings rule, DHS should set a goal that 75% of these individuals would choose integrated employment/supported employment within the first year of the Department’s transition plan.

To ensure adequate focus on integrated employment as the desired outcome for an individual, each approved prevocational services provider should be required to also offer supported employment services.

DHS should assess provider rate structure (average cost/unit) and make recommendations to MCOs about ways to create tiered incentives to increased supported employment provider capacity statewide during the five-year transition timeframe.

***Establish a no-new-entrant policy to HCBS noncompliant facility-based day and prevocational settings***

Create a no-new-entrant policy to HCBS noncompliant facility-based day and prevocational settings within the first year after the federal sub-regulatory guidance on non-residential HCBS settings is released by CMS to ensure transitions directly to fully compliant HCB settings.<sup>9</sup> The Workforce Investment Opportunity Act (WIOA) already supports a no new entrant policy for youth.

In Wisconsin pre-vocational services have been being billed in perpetuity for the same individuals without any employment outcomes being reached.

The transition plan should identify tiers of populations currently receiving pre-vocational services that should be prioritized to be transitioned into community integrated employment settings. Those populations might include:

- People who want to leave facility based settings
- People earning 50% or more of minimum wage
- People who are currently working part-time in competitive integrated employment

***Provide guidance to schools on HCBS settings to assist transition into compliant settings***

Provide guidance (preferably developed collaboratively with Department of Public Instruction) to school districts that define and provide specific examples of settings that meet the new CMS regulatory standards to inform the development and implementation of IDEA transition plans, goals and services that can be subsequently supported by the adult long-term care system. Guidance should address the necessity of schools providing complete and accurate information to families about future Medicaid Home and Community-Based funded service options and settings available in Wisconsin and how the state's HCBS transition plan is expected to change future options for HCBS-eligible youth. This is also an opportunity to inform parents at earlier stages (Wisconsin special education law mandate transition planning at age 14) about available supports to enhance success of integrated employment, e.g. vocational rehabilitation; supported employment available through CLTS; vocational futures planning, community integration services in CLTS; MAPP; work incentive benefits counseling.)

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<sup>9</sup> This policy would also be consistent with the Workforce Innovation and Opportunity Act signed into law July 22, 2014.

***State defined benchmarks for incremental improvement for providers***

Providers will need DHS guidance that clearly indicate expectations and define benchmarks and timelines for incremental improvement toward increased numbers of individuals in acceptable HCB employment and day service settings each year of the state's transition plan. Specific targets for constant, demonstrable improvement in integrated employment rates should be set, reviewed and monitored.



# Appendix A

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## Internal policies and governance required for MCOs and providers receiving HCBS funds

Suggested internal policies to require for each organization include the following<sup>10</sup>:

1. **Governance:** The Board of Directors or leadership of each organization has appropriate oversight of the organization's commitment to these standards and the organization's continuous quality improvement plans and strategies involving these principles.
2. All organizational policies and procedures, training materials, and other applicable documents should be consistent with these standards and ensure that the organization implements policies, procedures, and practices that clearly define its commitment to the promotion and protection of individual rights.
3. Organizational self-assessment practices that review the degree to which the organization is embracing and exhibiting these quality standards in day to day operations and strategies for continuous quality improvement as a result of the self-assessment should be undertaken.
4. Agency training, orientation, and other applicable and ongoing communication, training, and learning mechanisms should be reflective of these expectations including teaching and encouraging respect for each individual supported as a unique individual with unique preferences, interests, and goals— teach listening, learning and responding in ways that honor individuals and increase individual control teach about individual rights, dignity, and self-determination and how to support individuals to exercise control and choice in their own lives.
5. Communication with stakeholders including staff and individuals served on these principles and soliciting feedback from individuals served and their advocates on how to do better through satisfaction surveys, focus groups, residence meetings, and other applicable forums should be undertaken.
6. Practices should be undertaken that make clear that the needs and preferences of people supported determine the types of supports provided. Promote practices that enhance individual decision making e.g., over schedules, activities, and staff hiring, training, supervising, evaluation, and firing, and in other areas where individual input and autonomy can be promoted and facilitated.

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<sup>10</sup> New York negotiated an MOU with CMS that contained the policies listed in this section.

# Appendix B

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## Provider practices and procedures expectations for individualized supports for people during the day

- These expectations include:
  - *Encouraging presence and participation in the community*
  - *Developing social capital, friendships, and networks*
  - *Supporting participation in community leadership roles*
- The individual receives services personalized to their interests and needs, decides how they will spend their time, and is provided with the level of support they require.
- Individualized schedules are developed that allow for consistent participation in each activity. The schedules are matched to the individual's interests and support needs, not to a provider's schedule.
- The personalization of services should yield ratios of 1:1 support per individual and no more than 1:3, to maintain the focus on individualization. The person's need for paid support should also be re-evaluated as they gain skills and competencies through CBNW activities.
- The decision about whether to spend time with other people with developmental disabilities is based on the preferences of the individual—not the service provider, family, or residential services provider.
- Case management services focus on an intensive person-centered process that begins with the individual's goals and desires, not with the available services. Case management staff supports the team to identify both paid supports (e.g., service providers) and natural supports (e.g., family, friends, neighbors, religious community, co-workers, managers).
- Transportation is arranged on a personal basis to accommodate the individual's choices throughout their day, and supports a realistic mix of employment, leisure, and overall life activities.
- Service providers function as community connectors. Just as integrated employment providers need opportunities to develop community employment networks, service providers need opportunities to identify community resources and develop individualized supports for participation in community life.

# Appendix C

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## Requirements for Home and Community-Based Settings Residential Providers<sup>11</sup>

1. The setting supports full access of individuals to the greater community to the same degree of access as individuals not receiving Medicaid HCBS.
2. The setting is physically accessible to the individual.
3. Each individual in the setting either owns the place or has a signed lease or written legally enforceable agreement with tenant/landlord protection to document protections that address eviction processes and appeals comparable to those provided under Wisconsin's landlord tenant law.
4. The setting ensures each individual's rights of privacy, dignity and respect, and freedom so that each individual
  - *has, if sharing a unit, the right to choose a roommate;*
  - *has a unit with entrance doors lockable by the individual, with only appropriate staff having keys to doors;*
  - *has access to make private calls, text, email at his or her own preference and convenience;*
  - *is free from coercion and restraint;*
  - *has the freedom to decorate sleeping or living units within the lease or other agreement;*
  - *can control personal resources.*
5. The setting optimizes but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment and with whom to interact so that each individual can
  - *engage in community life with family, friends and others;*
  - *have visitors of their choosing at any time, with access to private areas for visiting;*
  - *choose when and where to eat, have access to food at any time, and choose with whom to eat or to eat alone;*
  - *have support to control their own schedules and activities, including engaging spontaneously in unscheduled activities.*

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<sup>11</sup> These requirements are those for which HCBS service providers are to be held accountable. They are taken from 42 CFR 441.301(c)(4), and do not include related requirements that are the responsibility of the State or agencies with which the state contracts for the administration of HCBS (e.g., Counties and MCOs).

# Appendix D

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## Modification of Requirements for HCBS Residential Services

Any modification of the conditions specified in Appendix A, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:<sup>12</sup>

- A. Identify a specific and individualized assessed need.
- B. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- C. Document less intrusive methods of meeting the need that have been tried but did not work.
- D. Include a clear description of the condition that is directly proportionate to the specific assessed need.
- E. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- F. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- G. Include the informed consent of the individual.
- H. Include an assurance that interventions and supports will cause no harm to the individual.

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<sup>12</sup> from 42 CFR 441.301(c)(2)(xiii) (A-H)