Department of Medical Assistance Services
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MEDICAID MEMO

TO: All Providers of Group Home Residential Services, Sponsored Residential Services, Supported Living Services, Group Day Services and Group Supported Employment Services available in the Developmental Disabilities (DD) Waivers

FROM: Cynthia B. Jones, Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 5/25/2017

SUBJECT: Mandatory 2017 Provider Self-Assessment for Compliance with the Centers for Medicare and Medicaid Services (CMS) Home and Community-Based Services (HCBS) Settings Regulations

This memorandum is to inform providers of group home residential, sponsored residential, supported living, group day and group supported employment services of the provider self-assessment requirements related to the 2014 CMS HCBS settings regulations. Providers of these services are required to complete a HCBS provider self-assessment for EACH unique setting in which services are provided.

If you completed a provider self-assessment in 2015 you **MUST** still complete the 2017 Provider Self-Assessment for Compliance with the Centers for Medicare and Medicaid Services (CMS) Home and Community-Based Services (HCBS) Settings Regulations. Failure to comply with the provider self-assessment requirement will result in the termination of enrollment as a Medicaid provider.

BACKGROUND

In March 2014, CMS issued federal regulations to ensure that individuals receiving HCBS services under 1915(c) Medicaid waiver authority have full access to the benefits of community living and the opportunity to receive services in the most integrated setting appropriate. CMS is requiring states to review and evaluate current HCBS settings, including residential and non-residential settings, to determine the setting's compliance status with the HCBS regulations.

Each state that operates a 1915(c) waiver that was in effect on or before March 17, 2014 was required to file a Statewide Transition Plan (STP) to describe how the state will bring all pre-existing settings into full compliance with the home and community-based (HCB) settings requirements in 42 CFR 441.301 (c)(4)(5). Virginia has received initial approval from CMS for its STP, which requires providers of group home residential, sponsored residential, supported

living, group day and group supported employment services to complete a provider self-assessment for EACH unique setting where HCBS services are provided. For example, if a provider operates eight group homes, each individual group home is considered a separate setting.

On May 9, 2017, CMS issued an informational bulletin informing states that it will extend the transition period for states to demonstrate compliance with the home and community based settings criteria until March 17, 2022 for settings in which a transition period applies. CMS encourages states to maintain their current timeline to the degree possible and to rigorously continue assessment and remediation activities.

Please note that the transition period for HCBS compliance is for currently operating settings only. New settings are required to be fully HCBS compliant prior to providing Medicaid HCBS. **New settings are NOT eligible for a transition period to demonstrate compliance.**

MANDATORY PROVIDER SELF-ASSESSMENT OF SETTINGS

The provider self-assessment will be the method through which Virginia meets this CMS requirement.

The provider self-assessment will be conducted using a secure web-based portal. Providers will be notified that they can access the portal and complete the self-assessment in late May/early June 2017. Each provider will have unique log-in credentials. Providers will have approximately four weeks to complete and submit the provider self-assessment for each setting where HCBS services are provided. The provider self-assessment will include the following elements:

- General provider information;
- Provider organizational compliance;
- A series of questions addressing HCBS requirements for ALL settings (day/non-residential and residential services); and
- A series of questions addressing HCBS additional requirements for provider owned or operated residential setting.

Provider self-assessment questions and a companion document designed to be used as a side-by-side tool for the completion of the provider self-assessment are available on the DMAS website. If you are a provider, you are **STRONGLY encouraged to begin your self-assessment process** and gathering of evidence. You do not need wait until the provider self-assessment portal is available to begin your assessment(s) of settings. **With the self-assessment questions and companion documents available you can begin your provider self-assessment of settings**. You will have four weeks to enter self-assessment results into the secure portal.

There are two different sets of questions and companion documents for providers to review specific to the settings being assessed. These are:

1. Provider Self-Assessment Questions & Companion Document *for group home residential, sponsored residential, supported living, group day services*
2. Provider Self-Assessment Questions & Companion Document for *group supported employment services*

This approach addresses the unique nature of group supported employment services and ensures a meaningful assessment of those settings.

Providers that do not complete a HCBS provider self-assessment *for each unique setting* will be notified of: 1) non-compliance with the provider self-assessment requirement; and 2) Virginia may initiate disenrollment actions. Providers that do not complete the provider self-assessment will be disenrolled as a Medicaid provider of DD Waiver HCBS. Disenrollment determinations will be managed on a case-by-case basis.

There is not an expectation that all providers/settings are in full compliance with HCBS settings requirements when the provider self-assessment is completed. The completion of the provider self-assessment will assist providers in identifying gaps and developing remediation strategies. The Virginia Departments of Medical Assistance Services (DMAS) and Behavioral Health and Developmental Services (DBHDS) will provide technical assistance and guidance to support bringing non-compliant settings into full compliance.

PROVIDER PREPARATION TO COMPLETE THE SELF-ASSESSMENT

DMAS and DBHDS will conduct a webinar in coordination with the notification to providers that the provider self-assessment portal is open (anticipated for late May/early June 2017). The webinar will provide information on the provider self-assessment and a demonstration of the web-based portal and process for providers to access the portal, create log-in credentials and complete the provider self-assessment. The webinar will be recorded and posted to the DBHDS and DMAS websites.

Providers should take the initiative to become educated on the CMS HCBS regulations' settings provisions and requirements. There are many resources and technical assistance documents available on CMS and DMAS websites. Some providers have informally assessed their settings and have begun implementing actions to come into compliance. Those efforts can be reflected in provider self-assessments.

Providers are strongly encouraged to include individuals and families in their provider self-assessment process. The experience of the individual receiving HCBS is an important factor in determining that a setting is an integrated community setting with full access to the benefits of community living. For example, this could be accomplished through a survey or telephone interviews and/or focus group discussions with individuals and families. In addition, feedback from community partners, direct support professionals, neighbors, support coordinators, and other community connections could be sought to gain meaningful insight and input for the

provider self-assessment. The engagement of stakeholders when completing the provider self-assessment may serve as evidence of compliance.

To reiterate, providers will have approximately four weeks to enter and submit provider self-assessment responses and evidence once the self-assessment portal is open. Providers are encouraged to start planning now how they will structure their internal process for assessment of compliance with the HCBS settings requirements and completing the provider self-assessment.

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 3.0, Commonwealth Coordinated Care (CCC), Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0:
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Commonwealth Coordinated Care (CCC):
  http://www.dmas.virginia.gov/Content_pgs/mmfa-isp.aspx
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE):
  http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.