Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Changes to the current program that are proposed in this renewal request include:
-Updated references of “county waiver agencies” to “locally-contracted waiver agencies,” where appropriate
-Removed references to the program’s name
-Removed or revised outdated language throughout the application
-Revised and clarified quality improvement strategies throughout the application to reflect the current updated waiver quality strategy, policies, and processes

Appendix A – Removed local non-state entity’s responsibility for waiver enrollment managed against approved limits and waiver expenditures managed against approved levels to reflect changes with the state-level budget and enrollment process

Appendix B.1.c – Outlined required discussions and document sharing for locally-contracted waiver agencies during the transition process

Appendix B.3.f – Updated processes to select entrants to the waiver to reflect changes with the state-level budget and enrollment process

Appendix B.6 – Updated the qualifications of the screener and the components of the Functional Screen

Appendix C1/C3 – Nursing Services has been removed per CMS direction.

Appendix C1/C3 – Consumer Education and Training renamed to Empowerment and Self-Determination Supports

Appendix C1/C3 – Supported Employment Individual and Small Group combined into Community/Competitive Integrated Employment

Appendix C1/C3 – Supportive Home Care renamed to Personal Supports

Appendix C1/C3 – Housing Counseling and Relocation Services combined into Housing Support Services

Appendix C1/C3 – Training for Parents/Guardians and Families of Children with Disabilities renamed to Family/Unpaid Caregiver Supports and Services

Appendix C1/C3 – added 8 new services: Discovery and Career Planning; Grief and Bereavement Counseling; Health and Wellness; Participant And Family-Directed Goods and Services; Participant and Family-Direction Broker Services; Remote Supports and Equipment; Safety Planning and Prevention; and Translation and Interpretation Services

Appendix C.2a and C.2.b – Removed references to the Wisconsin Provider Management system and updated these sections to reflect current practices

Appendix C.2.e – Changed that the State makes payments to relatives/legal guardians under specific services to whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3

Appendix C.2.f – Revised the open enrollment of providers section to reflect the enhanced provider registry and directory processes

Appendix D – Updated the ISP development processes, safeguards, implementation, and monitoring activities

Appendix D.1 – Corrected the responsibility for service plan development to qualified case managers only

Appendix D.1 – Removed references that Support and Service Coordination could be declined by a family

Appendix D.1- Changed the service plan review and update from every twelve months to every six months or more frequently when necessary

Appendix E – Clarified the intent and goals of the participant and family-directed model, delineated the roles and responsibilities of locally-contracted waiver agencies and other service providers, and revised the participant-directed budget methodology to align with the rate schedule

Appendix F – Revised notice of action and notice of rights requirements

Appendix G.1 – Redefined the types of reportable incidents and oversight activities DHS conducts for reportable incidents

Appendix G.2 – Prohibited restrictive interventions and seclusion and updated safeguards and oversight activities

Appendix H - Updated to reflect current practices, system design changes and strategies

Appendix I - Updated to reflect current and anticipated practices and procedures

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Wisconsin** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Original Base Waiver Number: WI.0414
Draft ID: WI.036.04.00

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

01/01/22

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be

reimbursed under the approved Medicaid state plan (*check each that applies*):

☒ **Hospital**

Select applicable level of care

◉ **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Children from birth through age 21 years.

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Children from birth through age 21 years.

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

Children from birth through age 21.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

☒ **Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

A § 1915(b)(4) Fee-for-Service Selective Contracting Program application has been submitted concurrent with the § 1915(c) renewal application for the purpose of obtaining approval for locally-contracted waiver agencies to be the sole provider delivering Support and Service Coordination (case management) services to participants.

Specify the §1915(b) authorities under which this program operates *(check each that applies):*

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☒ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The purpose of this waiver is to provide necessary supports and services to children and youth from birth through age 21 in Wisconsin who have substantial limitations in their daily activities, need support to remain in their home communities, meet functional, Medicaid financial and non-financial requirements, and reside in allowable living situations within the community. The goal of the waiver program is to support children with substantial needs, as well as their parents/guardians, by delivering services to assure the child's health, safety, and welfare needs in an inclusive home and community setting.

This waiver is guided by the following principles:
-Every child should be supported to live their best possible life now and into the future.
-Focus on the strengths and resiliencies of children and families.
-Children are best served within the context of their family and community.
-Equitable and inclusive access, systems, services, and supports.
-High-quality service coordination supports, culturally competent practices, and innovative approaches to engaging children and families in their community.
-Participants and families have a voice and are an equal partner at every step.

The Wisconsin Department of Health Services (DHS) is the single state agency for Medicaid. DHS' Division of Medicaid Services (DMS) is responsible for ensuring compliance with federal and state laws and regulations. Locally-contracted waiver agencies are responsible for operating the waiver program. DHS may contract with waiver agencies, including county human/social/community departments, the waiver agency's sub-contracted case management entity, or a tribal waiver agency (abbreviated to locally-contracted waiver agencies for the purpose of this application).

The locally-contracted waiver agency's Support and Service Coordinator provides case management services. Support and Service Coordinators coordinate and facilitate access to all services and supports, both formal and informal, which are needed by the child and family to meet their identified outcomes. Support and Service Coordinators assist the child or youth and the family to achieve an inclusive, interdependent, and self-empowered life. The Support and Service Coordinator combines the knowledge the family has as the expert of the child with their knowledge of available programs, resources, and services to create an Individual Service Plan that best supports the child and family in pursuit of their desired outcomes.

Services are delivered by qualified providers throughout the State under the Participant and Family-Directed Service Delivery Model or the Traditional Service Delivery Model. Services are provided based on each waiver participant's Individual Service Plan to enhance the participant and family's quality of life as identified during the step-by-step decision-making process.

Waiver services are coordinated as the payer of last resort with services that are covered under the IDEA Part B Special Education Program through Wisconsin's Department of Public Instruction, and services covered under the Rehabilitation Act of 1973 through Wisconsin's Department of Workforce Development's Division of Rehabilitation (DVR), as well as coordination with the child's private health insurance, and economic support programs, as applicable. DHS monitors the locally-contracted waiver agencies' compliance with the waiver program's payer of last resort and coordination of benefit requirements through a comprehensive quality management and review system.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who

direct their services. (*Select one*):

- ◉ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ○ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ○ **Not Applicable**
- ◉ **No**
- ○ **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- ◉ **No**
- ○ **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a

Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Cunningham

First Name: Curtis

Title: Assistant Administrator for Benefits and Service Delivery

Agency: Department of Health Services, Division of Medicaid Services

Address: 1 West Wilson St. Room 550

Address 2: PO Box 7851

City: Madison

State: **Wisconsin**

Zip: 53707-7851

Phone: (608) 261-7810 **Ext:** ☐ **TTY**

Fax: (608) 266-2713

E-mail: Curtis.Cunningham@dhs.wisconsin.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Rathermel

First Name: Deborah

Title:

Director

Agency:
Department of Health Services, Division of Medicaid Services, Bureau of Children's Services

Address:
1 West Wilson St. Room 418

Address 2:
PO Box 7851

City:
Madison

State: **Wisconsin**

Zip:
53707-7851

Phone:
(608) 266-9366 **Ext:** ☐ **TTY**

Fax:
(608) 267-2713

E-mail:
Deborah.Rathermel@dhs.wisconsin.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wisconsin**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☐ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

This application is renews the existing waiver and incorporates the changes outlined in the "Major Changes" section.

Housing Counseling and Relocation Services have been merged into one service category. The merge does not narrow any support covered previously under either service category. Therefore, there is no anticipation that any services will be reduced or lost. Participants will be notified of the change during the next required meeting with their Support and Service Coordinator, after the new waiver start date of January 1, 2022.

Supported Employment – Individual and Supported Employment – Small Group have been merged into one service category. The merge does not narrow any support covered previously under either service category. Therefore, there is no anticipation that any services will be reduced or lost. Participants will be notified of the change during the next required meeting with their Support and Service Coordinator, after the new waiver start date of January 1, 2022.

Several other service titles have been changed, but the name change does not narrow any support covered under the service. Therefore, there is no anticipation that any services will be reduced or lost. Participants will be notified of the change during the next required meeting with their Support and Service Coordinator, after the new waiver start date of January 1, 2022.

The Wisconsin Department of Health Services was directed by the Centers for Medicare & Medicaid Services to transition coverage of nursing services authorized through the waiver program to the Medicaid State Plan benefit. Effective July 1, 2020, nursing services were no longer funded through the waiver program. They are now accessed through Medicaid programs that use the ForwardHealth card. This transition is complete.

DHS has added a limitation to all services that only services or items covered that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met. Policy and procedures will be updated in the first half of 2022 and relevant stakeholders will be notified.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

All portions of the Wisconsin Statewide Transition Plan apply to the WI waiver #0414.

The State assures that this waiver renewal will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The State will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

○ **The Medical Assistance Unit.**

Specify the unit name:

(Do not complete item A-2)

◉ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

The Division of Medicaid Services

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

The Department of Health Services (DHS) is the Wisconsin State Medicaid Agency. The Governor appoints the DHS Secretary, and the Department utilizes a Division structure under the authority of the Secretary to carry out the Department's mission and to assure compliance with federal and state regulations as they relate to the administration of programs within the Department.

The DHS Secretary has designated the Administrator of the Division of Medicaid Services as the State Medicaid Director. The State Medicaid Director is responsible for the overall policy direction of Wisconsin's Medicaid programs, including HCBS waiver programs and securing the financial accountability of all Medicaid programs. The State Medicaid Director is accountable to the Department Secretary. This includes coordinating the decision-making for all policies that affect Wisconsin's Medicaid State Plan and HCBS waiver services.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

○ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

◉ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

☒ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

In Wisconsin, designated locally-contracted waiver agencies perform some of the functions of the State Medicaid Agency on behalf of, and under the administrative guidance and supervision of, the Department. A locally-contracted waiver agency may include counties, tribes, and designees of the county. The Department enters into contracts with the designated waiver agencies to operationalize the waiver program.

Under the Wisconsin Constitution, a county department serves as an arm or political subdivision of the State, primarily performing delegated state operational functions at the local level. The Department may contract with federally-recognized tribal governments in Wisconsin to perform delegated state operational functions. The functions of Wisconsin's waiver agencies to operate the approved HCBS Waiver Program's operations are specified in Wisconsin statutes and administrative rules and are consistent with the approved waivers.

Contracts with waiver agencies reference the Department's Medicaid Home and Community-Based Services Waiver Manual, numbered memos, and other documents which detail the approved policies, procedures, and standards, as established by DHS, to which waiver agencies must adhere.

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Department of Health Services—the State Medicaid Agency—maintains direct administrative oversight of the waiver program consistent with 42 CFR§431.10(e). DHS maintains the sole authority to provide administrative direction and issue policies, rules and regulations. Locally-contracted waiver agencies do not have the authority to change or disapprove any administrative decision of the State Medicaid Agency or otherwise substitute their judgment with respect to the application of policies, procedures, rules, and regulations issued by the State Medicaid Agency. This requirement is defined through the State-County Contract and other relevant contracts, where applicable. Contracts specify that each locally-contracted waiver agency must carry out the required policies and procedures, as set forth by the State Medicaid Agency. This relationship is further detailed in the Waiver Program Manual and other DHS-issued Medicaid policy and procedure documents. These documents are authored and issued by the Department. The information contained in the manual and other policy documents is binding to all locally-contracted waiver agencies and cannot be altered.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The DHS provides stringent financial and programmatic oversight of HCBS waiver programs through the State of Wisconsin's Single State Audit process, if specified in the contract with the waiver agency, which is administered through the Department of Administration (DOA). The DOA's State Controller's Office provides overall coordination of the state's single audit activities. The State of Wisconsin has adopted the federal audit requirements in CFR Part 200 Subpart F, "Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards", hereafter known as "Uniform Guidance" for recipients of funding from the State. The State Single Audit Guidelines implement the federal audit requirements for certain state programs and federal programs passed through state agencies. The Single State Audit is performed on an annual basis.

The Single State Audit are completed by designated auditors who must:
-Be licensed by the State of Wisconsin as a certified public accountant, as required by Wis. Stat. 442 and Government Auditing Standards. Mobility and Wisconsin Statute 442 (4) allows for licensees of other states to perform audits if all conditions of referenced paragraph are met.
-Possess the technical qualifications to perform an audit involving government programs, including continuing professional education, as required by auditing standards generally accepted in the United States of America and Government Auditing Standards.
-Undergo an external quality control review (peer review) at least once every three years and make the report on the quality control review available to the auditee and to granting agencies upon request, as required by Government Auditing Standards.

Audits performed under these Guidelines are due to the granting agencies nine months from the end of the fiscal period or 30 days from completion of the audit, whichever is sooner. Extensions of due dates are not allowed. A significant part of the value of the audit process is the opportunity to improve operations through taking corrective action for audit findings. The State Single Audit Guidelines require consideration of fraud in the administration of state funded programs and federal pass-through programs as part of every audit performed in accordance with the Guidelines. In addition, auditors have a responsibility to detect material misstatements of the financial statements, whether caused by error or by fraud.

The auditee shall follow up and take corrective action on audit findings and report these actions in the schedule of prior audit findings and corrective action plan. In addition, Wisconsin's Legislative Audit Bureau conducts single audits of state agencies. As part of the state single audit, the Legislative Audit Bureau tests whether state agencies are complying with the sub recipient audit responsibilities of the Uniform Guidance and the State Single Audit Guidelines.

The DHS Office of Inspector General (OIG) oversees the Department's Single State Audit process for the DHS designated programs, including this waiver program. The Division of Medicaid Services issues waiver-specific State Single Audit criteria, specifications and guidance to the auditors. The auditors review the waiver agency's waiver program records and operations, and issue any findings to the OIG Audit Section. The Department has established a DHS Audit Resolution Team, which is led by OIG and includes DHS representatives from all programs that are subject to the state single audit. This process ensures that DHS program staff (including the waiver program staff) conduct timely and consistent determinations on the appropriate audit finding remediation actions, including sanctions and recoupment of disallowed waiver funds. When audit findings indicate a systematic problem with the waiver agency's procedures, a corrective action plan (CAP), including any necessary repayment, is directed by the State Medicaid Agency. The waiver agency's audit results help determine if systemic issues need to be addressed.

DHS is also responsible for conducting and overseeing other monitoring and quality assurance strategies, including reviewing data system reports, randomly selecting samples of participant records to ensure compliance with the approved performance measures, and analyzing trends and systemic issues. Additionally, DHS assigns staff to provide technical assistance to each locally-contracted waiver agency.

The Department provides regular oversight for each of the functions listed below, which has been contracted to the "Local Non-State Entity." DHS methods includes detailing the waiver program requirements in relevant contracts, regular technical assistance provided by DHS staff, as well as regular monitoring and enforcement through IT system, quality assurance and auditing activities.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that*

applies):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☐
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
A-i-1. Participants or their guardians, as applicable, are notified of their rights at least annually. Numerator= Number of participants or their guardians, as applicable, in the sample who were notified of their rights at least annually. Denominator= Total number of records reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
A-i-2. Children/youth are enrolled according to DHS policy and established timeframes. Numerator= Number of children/youth in the sample whose enrollment is effectuated according to DHS policy and established timeframes. Denominator= Total number of children/youth reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Performance enrollment data

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The performance measures in this section relate to administrative authority will ensure that the locally-contracted waiver agencies implement their program operations as required in their contract and the established policies and procedures. Performance measures within other appendices in this application will also be used to ensure administrative oversight in the implementation of program operations, policies and procedures, as indicated under the Department's established requirements, but are not duplicated in this section. Additional discovery methods related to administrative oversight include issues that arise during the locally-contracted waiver agency's program operations are those that are self-identified or identified through complaints and other discovery methods employed by the Division.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Department directly monitors the locally-contracted waiver agencies to correct any issues discovered through ongoing administrative oversight activities. Locally-contracted waiver agencies are responsible for correcting any issues that are discovered. Issues are tracked from the locally-contracted waiver agency's initial identification to the final resolution. The Department may recommend development of a corrective action plan (CAP). The Department may also require immediate remedial action and impose CAPs to address serious or unresolved issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☒	**Disabled (Physical)**	0	21	
	☒	**Disabled (Other)**	0	21	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☒	**Autism**	0	21	☐
	☒	**Developmental Disability**	0	21	☐
	☒	**Intellectual Disability**	0	21	☐
☒ **Mental Illness**					
	☐	**Mental Illness**			☐
	☒	**Serious Emotional Disturbance**	0	21	

b. Additional Criteria. The state further specifies its target group(s) as follows:

Waiver participants must meet the functional and support needs criteria, as set forth in the Functional Screen, meet Medicaid financial and non-financial requirements, and reside in allowable living situations within the community. Allowable living situations within the community for participants include children who are living with their parents in the family's private residence, whether owned or rented.

Allowable living situations also include participants who are living in the home of a relative or guardian, including foster care providers. For waiver participants who are 18 years or older, an allowable living situation also includes an adult family home (AFH).

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Support and Service Coordinators are expected to maintain a working relationship with youth, the youth's family, adult long-term care programs, and other community supports to ensure a smooth transition out of the program for youth. The Support and Service Coordinator must take reasonable steps to assure continuity of services as the youth reaches adult status.

The Support and Service Coordinator is responsible for supporting the transition planning process with participants and the family throughout their enrollment in the program and documenting plans in the Individual Service Plan (ISP). Discussions about the transition planning process should begin by the time the child is age 14. This includes, among other topics, discussing with youth and the family how parents' legal authority to make decisions for their youth changes when that youth turns 18 years old; providing information about decision-making options to the youth and the family, such as supported decision-making or guardianship, as appropriate; assisting the child or youth to locate safe and appropriate housing; and assisting the youth to pursue vocational and/or educational opportunities, as appropriate. The SSC is required to discuss with the youth and the family the youth's disability determination and Medicaid source if the youth is planning to transition to an adult long-term care program. Limited exceptions to this exist, including when a court has ordered placement for an 18-year old residing in a licensed children's foster home.

No later than when a youth reaches 17 years and 6 months of age, the locally-contracted waiver agency must refer the youth and/or family to the local Aging and Disability Resource Center (ADRC) for options counseling. The SSC is expected to coordinate and communicate with the ADRC about delineating roles and responsibilities to facilitate the final transition process. Young adult participants, 18 through 21 years of age, who are determined functionally and financially eligible for adult long-term care program must be enrolled in those programs without delay.

If a youth is transitioning to an adult long-term care program, locally-contracted waiver agencies must share the relevant documents with the applicable adult long-term care program as part of the transition process, which typically include: 1) a copy of the youth's ISP, 2) current crisis or emergency plans, 3) a copy of the most recent behavior support plan, 4) the approved restrictive measures application, 5) a copy of the youth's Functional Screen and 6) the youth's most recent ISP assessment. Upon transition, locally-contracted waiver agencies are also required to have a discussion with the adult long-term care program of the relevant incident reports for a youth, if applicable.

Participants who are not eligible to transition to an adult long-term care program remain eligible for the waiver through age 21. If a youth does not meet the eligibility criteria for adult waiver services, then transition planning to other community supports and services must be considered.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- (●) **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ( ) **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ( ) **A level higher than 100% of the institutional average.**

    Specify the percentage: [ ]

  - ( ) **Other**

    Specify:

○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

○ **The following dollar amount:**

Specify dollar amount:

The dollar amount *(select one)*

○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

○ **The following percentage that is less than 100% of the institutional average:**

Specify percent:

○ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	17115
Year 2	18192
Year 3	19147
Year 4	19996
Year 5	20750

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

The Department has incorporated several key principles commonly used in developing statewide policies and procedures to establish an effective and equitable system for tracking eligible children waiting to receive waiver services. The most basic principle is that children must be served in the order of their placement on the wait list—the first-come, first-served principle.

The Department is responsible for the equitable distribution of waiver funds to enroll eligible children in the waiver program on a statewide first-come, first-served basis.

1. The locally-contracted waiver agency must document the date the family, applicant or referral source contacted the agency about waiver program eligibility. This referral date is used as the child's placement on the wait list. If multiple children have the same waitlist start date, the waitlist position will be issued based on the individual whose record was created first in the system.
2. The locally-contracted waiver agency must make a preliminary determination of the applicant's Medicaid nonfinancial/financial eligibility, functional eligibility, and the need for waiver services. A referral to the Income Maintenance consortia must occur when applicable.
3. The locally-contracted waiver agency must offer to complete a home visit to complete the child's Functional Screen, along with an initial assessment of the child and family's needs according to DHS established timeframes.
4. Once the child has been determined functionally eligible the locally-contracted waiver agency must place the child on the state-level wait list within the DHS-established timeframe.
5. The locally-contracted waiver agency must provide each applicant placed on the wait list with a notification of her/his wait list position, as well as an estimate of when funding for services may become available every six months.
6. The Department identifies children for enrollment on an ongoing basis. The locally-contracted waiver agency enrolls the child and must complete an initial assessment based on the child and family's needs within the DHS established timeframe.

When enrolling children, the following requirements apply:
1. The child must receive all of the services necessary to meet assessed needs, as identified in the current assessment.
2. Once the Department identifies the child for enrollment, the locally-contracted waiver agency must promptly enroll the child in the waiver program.
3. The Support and Service Coordinator must work with the participant and family to complete the ISP by assessing the family's needs, talking about the family's goals, or outcomes, and the supports and services that are needed for them to reach their goals.
4. The locally-contracted waiver agency must complete the applicant's ISP within 60 days from the date the Department identifies the child for enrollment.

Exceptions to the First-Come, First-Served Medicaid Waiver Wait List Policy: Crisis Needs.

The only allowable exception to the first-come, first-served state-level wait list policy is when the child or parent/guardian meets one of the crisis need criteria. This Department established criteria must be applied in all such circumstances and may not be modified or expanded by the locally-contracted waiver agency. The following reasons are the only permissible times the child may be served out of the first-come, first-served order:

1. Crisis conditions are present in the child's life situation. The need shall be classified as a crisis if an urgent need is identified as a result of any of the following:
 a. Substantiated abuse, neglect, or exploitation of the child in the current living situation; or
 b. Death of the child's primary caregiver or the sudden inability of that caregiver/support person to provide necessary supervision and support, and there is no alternative caregiver available; or
 c. Lack of an appropriate residence or placement for the child due to a loss of housing; or
 d. Child has a documented terminal illness and has a life expectancy of less than six months, based upon the opinion of a medical professional appropriately qualified to make such a determination; or
 e. A sudden change in the child's behavior or the discovery that the child has been behaving in a manner that places the child, or the people with whom he or she shares a residence, or the community at large at risk of harm.
2. A determination by the locally-contracted waiver agency that the health and safety of the child is in jeopardy due to the primary caregiver's physical or mental health status; or
3. A determination by the locally-contracted waiver agency that the child is at imminent risk of a more restrictive placement in an intermediate care facility for individuals with intellectual disabilities, nursing home, or other institutional setting; or

4. A finding by the locally-contracted waiver agency that other emergency or urgent conditions exist that place the child, or youth at risk of harm;
5. The locally-contracted waiver agency finds the child or youth is a vulnerable child who is either eligible for more than one of the three target groups served by the waiver, as determined by the Functional Screen or has a high level of life-sustaining needs with a limited informal support network. In addition, at least one of the following must apply:
-The child is isolated with limited or no adult contact outside the home and is not available to be observed.
-The child is nonverbal and has limited ability to communicate.
-The child is medically complex, requires significant care from a caregiver or parent, and is highly dependent on others to meet basic needs.
-The child is the subject of current or historical child abuse and neglect reports.
-The child has a primary caregiver who is actively abusing substances.
-The child is dependent on caregivers or parents with limited cognitive, emotional, and/or behavioral capacity to provide for these needs.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- ◉ **§1634 State**
- ○ **SSI Criteria State**
- ○ **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- ◉ **No**
- ○ **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ **Low income families with children as provided in §1931 of the Act**
- ☒ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- ☒ **Optional state supplement recipients**
- ☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

- ○ **100% of the Federal poverty level (FPL)**
- ○ **% of FPL, which is lower than 100% of FPL.**

Specify percentage: ☐

- ☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☒ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

• Other caretaker relatives specified in 42 CFR 435.110
• Pregnant women specified in 42 CFR 435.116
• Children specified in 42 CFR 435.118

All other mandatory and optional groups under the Wisconsin State plan are included.

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Medically Needy with Spend Down:

For persons who have a physical disability, the State Medicaid Agency will use the average monthly cost for private patients in nursing facilities as used for assessing a transfer of assets penalty to reduce an individual's income to an amount at or below the medically needy income limit.

For persons with an intellectual disability, the State Medicaid Agency will use the average of the monthly rates charged for inpatient care in a State Center for the Developmentally Disabled to reduce an individual's income to an amount at or below the medically needy income limit.

For persons who have a severe emotional disturbance the State Medicaid Agency will use the average of the monthly rated charged for inpatient care at a psychiatric hospital.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

○ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

○ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

◉ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a**

community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

◉ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
◉ **The special income level for institutionalized persons**

(*select one*):

◉ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The following formula is used to determine the needs allowance:**

Specify:

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable (see instructions)**
○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

◉ **Not Applicable (see instructions)**
○ **AFDC need standard**
○ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's

Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

The state uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ **The following standard included under the state plan**

Select one:

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**

(*select one*):

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

- ○ **A dollar amount which is less than 300%.**

Specify dollar amount:

- ○ **A percentage of the Federal poverty level**

Specify percentage:

- ○ **Other standard included under the state Plan**

Specify:

- ○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

- ◉ **The following formula is used to determine the needs allowance:**

Specify:

The basic needs allowance, indexed annually by the percentage increase in the state's SSI-E payment; plus an allowance for employed individuals equal to the first $65 of earned income and ½ of remaining earned income; plus special exempt income which includes court ordered support amounts (child or spousal support) and court ordered attorney and/or guardian fees; plus a special housing amount that includes housing costs over $350 per month. The total of these four allowances cannot exceed 300% of the SSI federal benefit.

In FFS waivers, Medicaid pays the actual cost of the s.1915 (c) services a member receives.

- ○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

- ◉ **Not Applicable**
- ○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

iii. Allowance for the family (*select one*):

- ○ **Not Applicable (see instructions)**
- ◉ **AFDC need standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
- ○ **The amount is determined using the following formula:**

  Specify:

- ○ **Other**

  Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

The basic needs allowance for each target group (PD, DD and SED), indexed annually by the percentage increase in the state's SSI-E payment; plus an allowance for employed individuals equal to the first $65 of earned income and ½ of remaining earned income; plus special exempt income which includes court ordered support amounts (child or spousal support) and court ordered attorney and/or guardian fees; plus a special housing amount that includes housing costs over $350 per month. The total of these four allowances cannot exceed 300% of the SSI federal benefit.

In FFS waivers, Medicaid pays the actual cost of the s.1915 (c) services a member receives.

○ **Other**

Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

◉ **Allowance is the same**

○ **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the

reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- ○ **The provision of waiver services at least monthly**
- ◉ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

Waiver services may be furnished on a less frequent basis than monthly, as long as monthly contact is maintained with the Support and Service Coordinator with the intent of assuring that the child's health, safety and welfare needs are met through formal or informal supports other than the waiver services.

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Wisconsin's locally-contracted waiver agencies are responsible for performing the child's level of care evaluations and re-evaluations via the web-based automated Functional Screen.

- ○ **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing the Department's Functional Screen, the web-based application/tool that determines a participant's level of care for eligibility determination, must meet the same certification and education/experience standards for initial evaluations and re-evaluations.

The "screener" must have experience regarding the unique needs and functioning of children with significant disabilities. Experienced professionals, typically social workers and registered nurses, must successfully complete the DHS approved web-based training program curricula and have a passing score on the competency examination. Additionally, the individual must be employed by an agency recognized by DHS to access and administer the Functional Screen.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care determination for the Waiver is based on Federal Medicaid institutional admission criteria for relevant institutional settings. A child with an ICF/IID - Developmental Disability (DD) Level of Care has a permanent cognitive disability, substantial functional limitations and a need for active treatment. The level of care criteria is based upon the child having needs similar to people in an intermediate care facility for children with intellectual disabilities (ICF/IID). The intensity and frequency of required interventions to meet the child's functional limitations must be so substantial that without the intervention, the child is at risk for institutionalization within an ICF/IID.

A child with a Psychiatric Hospital/Severe Emotional Disturbance (SED) Level of Care has a long-term, severe mental health condition diagnosed by a licensed psychologist or psychiatrist. In addition, this child demonstrates persistent behaviors that create a danger to self or others, requiring ongoing therapeutic support in order to be able to live at home and in the community. The intensity and frequency of the required ongoing therapeutic support must be so substantial that without the support the child is at risk of inpatient psychiatric hospitalization.

A child with a Hospital or Nursing Home/Physical Disability (PD) Level of Care has a long-term medical or physical condition, which significantly diminishes the child's functional capacity and interferes with the ability to perform age appropriate activities of daily living at home and in the community. This child requires an extraordinary degree of daily assistance from others to meet everyday routines and special medical needs. The special medical needs warrant skilled nursing interventions that require specialized training and monitoring that is significantly beyond that which is routinely provided to children. The intensity and frequency of required skilled nursing interventions must be so substantial that without direct, daily intervention, the child is at risk for institutionalization within a nursing home.

A detailed and thorough description of Wisconsin's level of care requirements is available on the DHS website.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

  Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The certified screener completes the Functional Screen at initial intake and annually thereafter. The Functional Screen incorporates information obtained during interviews with the child. This typically occurs with a parent/caretaker present. If the child has an approved diagnosis, they do not need to complete the entire Functional Screen. An approved diagnosis is one that definitively meets an Institutional Level of Care based on data, prognosis, and diagnostic characteristics.

The components of the Functional Screen are as follows:
-Individual Information
-Contact Information
-Diagnoses
-Mental Health
-Behaviors
-Activities of Daily Living
-Instrumental Activities of Daily Living
-School and Work
-Health-Related Services
-Automated Eligibility Calculation

This information is used by a certified screener to complete the Functional Screen. The screen provides preliminary functional eligibility related to the waiver level of care.

The annual reevaluation is the same process as the initial evaluation.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

  Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Several quality assurance practices assure the timely re-evaluation of the Functional Screen and level of care determination. Support and Service Coordinators are responsible for ensuring that the waiver participant re-evaluations are updated on an annual basis.

DHS conducts regular enrollment database queries and review matching Functional Screen queries. Locally-contracted waiver agencies follow the DHS established re-certification protocol for each participant, which follows the annual completion of the LOC re-evaluation, and confirms that all required re-determination activities have been completed. The Functional Screen is also reviewed as a data source, as it displays the dates of screen calculations for waiver participants. This data is used to identify waiver participants whose functional eligibility has not been determined within the 12-month re-evaluation timeline.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The waiver agency must maintain either a paper file or electronically retrievable files of all evaluations and reevaluations on-site at the agency's designated offices. The agency's file includes documents such as the participant's assessment, the child's Individual Service Plan, the Participant Rights and Responsibilities document, approved service provider(s) screening documentation, service authorization notifications, etc.

Additionally, the Functional Screen maintains an electronic copy of the evaluation and reevaluation. These records are maintained for a minimum of three years, as required.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
B-i-1: Number and percent of new enrollees with initial functional screen completed according to DHS established timelines. Numerator = Number of new enrollees in the sample whose completed initial functional screen LOC determination was determined according to DHS established timelines. Denominator = Total number of new

enrollees.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Functional Screen system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program enrollment data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

Performance Measure:
B-i-2: All applicants must have an eligible level of care prior to enrollment. Numerator= Number of applicants enrolled in the program who have an eligible level of care. Denominator= Total number of applicants enrolled during the calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Functional Screen system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Program enrollment data

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
An applicant's initial functional screen was completed according to the clinical

instructions resulting in an appropriate level of care determination. Numerator=Number of initial applications where the functional screen was completed according to the clinical instructions resulting in an appropriate level of care. Denominator=Total number of initial applications with a completed functional screen.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Functional Screen system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If the results of the Functional Screen is that the child is not functionally eligible, it is the certified screeners' responsibility for confirming the result of the Functional Screen using their professional judgement. If the results are the child is not functionally eligible, the screen should always request an internal review by their agency or entity. If the results are still in question, the screener must contact DHS for assistance.
If the child is found not functionally eligible, the screener should always request an internal review by their agency. Each agency is responsible for quality assurance at a local level. When specific questions arise and eligibility results cannot be verified, waiver agencies must consult with DHS staff. DHS staff review all not functionally eligible results to confirm their accuracy and conduct follow-up activities with locally-contracted waiver agencies, as appropriate.
When an individual problem is identified, DHS directly contacts the certified screener and/or the locally-contracted waiver agency's supervisor to gather more information and determine a solution. If DHS identifies an error with the Functional Screen, the locally-contracted waiver agency must make the modification per DHS instruction.
Should it appear that the locally-contracted waiver agency has more systemic problems related to utilization of the Functional Screen by their certified screeners; a corrective action plan may be required to rectify the situation.
DHS maintains documentation of all actions taken to resolve a specific individual problem. If Functional Screen data combined with enrollment data indicates that redeterminations of eligibility are not completed within waiver timelines, DHS follows up with the waiver agency. Locally-contracted waiver agencies are responsible for correcting any individual issues discovered and informing DHS of their actions. Issues are tracked within the program's enrollment database, from identification to final resolution.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The waiver agency's procedures for informing parents or guardians of the feasible alternatives under the waiver and for allowing individuals to choose either institutional or home and community-based services is discussed with the waiver applicant's parent/guardian at intake and during initial ISP development and at least annually thereafter. The participant's parent/guardian is informed and the choices are explained to the parent/guardian prior to signing the ISP, which includes a verification statement that indicates the parent/guardian have been informed of and understand their choice of community services through the waiver.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Freedom of Choice documentation is maintained by and at the locally-contracted waiver agency for a minimum of three years.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Following the "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against national Origin Discrimination Affecting Limited English Proficient Persons" the Department's Limited English Proficiency (LEP) Administrative Directive requires each Division to ensure the needs of LEP persons are met through both the interpretation and translation of materials.

As required by Wisconsin's Contract Compliance Law under Wis. Stat. § 16.765 and Wis. Admin. Code ch. ADM 50, the Department's contracts with waiver agencies includes requirements for every grantee to agree to equal employment and affirmative action policies and civil rights and translation compliance practices in its programs. All locally-contracted waiver agencies must follow these requirements.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	**Community/Competitive Integrated Employment**
Statutory Service	**Day Services**

Service Type	Service		
Statutory Service	Discovery and Career Planning		
Statutory Service	Respite		
Statutory Service	Support and Service Coordination		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Participant and Family-Direction Broker Services		
Other Service	Adaptive Aids		
Other Service	Adult Family Home		
Other Service	Assistive Technology and Communication Aids		
Other Service	Child Care Services		
Other Service	Children's Foster Care		
Other Service	Community Integration Services		
Other Service	Counseling and Therapeutic Services		
Other Service	Daily Living Skills Training		
Other Service	Empowerment and Self-Determination Supports		
Other Service	Family/Unpaid Caregiver Supports and Services		
Other Service	Grief and Bereavement Counseling		
Other Service	Health and Wellness		
Other Service	Home Modifications		
Other Service	Housing Support Services		
Other Service	Mentoring		
Other Service	Participant and Family-Directed Goods and Services		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Personal Supports		
Other Service	Remote Supports and Equipment		
Other Service	Safety Planning and Prevention		
Other Service	Specialized Medical and Therapeutic Supplies		
Other Service	Translation and Interpretation Services		
Other Service	Transportation		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Community/Competitive Integrated Employment

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

03 Supported Employment	03010 job development

Category 2: **Sub-Category 2:**

03 Supported Employment	03021 ongoing supported employment, individual

Category 3: **Sub-Category 3:**

03 Supported Employment	03022 ongoing supported employment, group

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community/Competitive Integrated Employment consists of intensive, ongoing services that support individuals to achieve competitive employment or business ownership.

Community/Competitive Integrated Employment activities are designed to increase or maintain the individual's skill and independence, and may include a combination of the following activities: career enhancement; job development; job placement; meeting with prospective employers; on-the-job training and support; business ownership; job coaching; job site analysis; skills training; benefits counseling; employer negotiations; co-worker training; vocational assessment; transportation and career advancement services. Also included are other workplace support services not specifically related to job skill training that enable the youth to be successful in integrating into the job setting.

Community/Competitive Integrated Employment offers support to individuals placed in jobs or business ownership in the community and support is provided at the work-site as needed for the individual to learn and perform the job. The provider agency is encouraged to develop natural supports in the workplace to decrease the reliance on paid supports. Individuals must have the opportunity for inclusion in non-disability specific work settings. Community/Competitive Integrated Employment may include competitive jobs in the public or private sector, or business ownership (self-employment).

Community/Competitive Integrated Employment may include support to maintain self-employment, including home-based self-employment. Individual employment supports may also include services and supports that assist the participant in achieving self-employment. Assistance for self-employment may include:
-aid to the participant in identifying potential business opportunities;
-assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business;
-identification of the supports that are necessary in order for the participant to operate the business; and
-ongoing assistance, counseling and guidance once the business has been launched.

Payment for Community/Competitive Integrated Employment services may be based on different methods including, but not limited to, co-worker support models, payments for work milestones, such as length of time on the job, or number of hours the participant works.

The outcome of Community/Competitive Integrated Employment is sustained paid employment and work experiences leading to further career development and individual integrated community-based employment for which a participant is compensated at or above the minimum wage, but not less than the customary wage level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Community/Competitive Integrated Employment services may be provided in a small group by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker or other personnel and these individuals meet the qualifications established below for individual providers of service. Employers may be reimbursed for services provided by co-workers. Participants receiving Community/Competitive Integrated Employment services in a small group may also receive educational, pre-vocational, and/or day services and career planning services. However, different types of non-residential services may not be billed for the same period of time.

The cost of transportation for a participant to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider, or may be reimbursed under transportation, but not both.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service may not duplicate any service that is provided under another waiver service category.

This service does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Agency
Individual	On the job support person

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community/Competitive Integrated Employment

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Personnel who provide individual supported employment services are required to have skills and abilities in the areas of assessment, job development, job placement, job retention, and evaluation, including the following:
-Assessment of individuals who have developmental disabilities.
-Work site analysis.
-Assessment of needs for assistive technology, disability accommodation, and individualized ergonomics.
-Job development.
-Sales and marketing.
-Job coaching.
-Outcome development and program evaluation.

The provider must have the ability and qualifications to provide this service, demonstrated in at least one of the following ways :
-Accreditation by a nationally recognized accreditation agency.
-Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
-Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
-Comparable experience for a qualified entity, including a minimum two years of experience working with the target population providing integrated employment services in the community.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Community/Competitive Integrated Employment

Provider Category:

Individual

Provider Type:

On the job support person

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Personnel who provide individual supported employment services are required to have skills and abilities in the areas of assessment, job development, job placement, job retention, and evaluation, including the following:
-Assessment of individuals who have developmental disabilities.
-Work site analysis.
-Assessment of needs for assistive technology, disability accommodation, and individualized ergonomics.
-Job development.
-Sales and marketing.
-Job coaching.
-Outcome development and program evaluation.

The provider must have the ability and qualifications to provide this service, demonstrated in at least one of the following ways:
-Accreditation by a nationally recognized accreditation agency.
-Existence of a current contract with the DVR for provision of supported employment services.
-Submission of written documentation to demonstrate the agency meets all Division of Vocational Rehabilitation (DVR) technical specifications related to supported employment.
-Comparable experience for a qualified entity, including a minimum two years of experience working with individuals with disabilities, providing integrated employment services in the community.

In addition, the provider is required to comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
04 Day Services	04070 community integration
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Day Services are the provision of services that provide children with regularly scheduled activities for part of the day. Services include coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or multiple environments, including natural settings in the community. Coordination activities may involve the implementation of components of the Individual Service Plan and may involve family, professionals, and others involved with the child as directed by the child's plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Excludes any service that falls under the definition of daily living skills training, personal supports, health and wellness, child care, mentoring or respite care.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Group Child Care Center
Agency	Family Child Care Center
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Individual	Family Child Care Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Services

Provider Category:

Agency

Provider Type:

Group Child Care Center

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 48,
Wis. Admin. Code ch. DCF 251

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting who works directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Services

Provider Category:

Agency

Provider Type:

Family Child Care Center

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 251

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Services

Provider Category:

Individual

Provider Type:

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Child-specific training.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Services

Provider Category:

Individual

Provider Type:

Family Child Care Center

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 251

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

Discovery and Career Planning

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Discovery and Career Planning (DCP) combines elements of traditional prevocational services with career planning. Discovery and Career Planning is based on the belief that all individuals can work when given the opportunity, training, and supports that build on an individual's strengths, abilities and interests.

This service is designed to assist participants to: 1) acquire skills to achieve underlying habilitative goals that are associated with building skills necessary to perform work in community integrated employment; 2) explore possibilities/impact of work; and 3) develop career goals through career exploration and learning about personal interests, skills and abilities.

The outcome of DCP services may include completing or revising a career plan and developing the knowledge and skills needed to get a job in a competitive, integrated employment or be self-employed. DCP services should take place in an integrated setting, where appropriate.

Discovery and Career Planning services include the following:
1. exploring employment goals and interest to identify a career direction;
2. community-based formal or informal situational assessments;
3. task analysis activities;
4. skills training/mentoring, work trials, apprenticeships, internships, and volunteer experiences;
5. training in communication with supervisors, co-workers and customers; generally accepted workplace conduct and attire; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and other skills as identified through the person-centered planning process;
6. broad career exploration and self-discovery resulting in targeted employment opportunities including activities, such as job shadowing, information interviews and other integrated worksite based opportunities;
7. interviewing, video resumes and other job-seeking activities;
8. transitioning the participant into employment supports for individualized competitive integrated employment or self-employment
9. when assisting a participant who is already employed, activities to support the participant in explore other careers or opportunities.
10. career exploration and educational camps
11. career exploration and educational activities, workshops, lessons, and seminars

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service may not duplicate any service that is provided under another waiver service category.

DCP excludes:
1) providing vocational services where participants are supervised for the primary purpose of producing goods or performing services, including services provided in sheltered workshops and contract work at less than minimum wage;
2) payments that are passed through to users of DCP, including payments of wages or stipends for internships or work experience;
3) paying employers incentives to encourage or subsidize the employer's participation in internships or apprenticeships;
4) supporting participants to volunteer at for-profit organizations or businesses or to independently perform services without pay ("volunteering") that benefit the waiver service provider or its staff and which would otherwise require the provider or staff to pay to have that service completed, such as landscaping, painting, or housecleaning.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	**Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.**
Agency	**Educational Camp**
Agency	**Prevocational Provider**
Agency	**Supported Employment Agency**
Agency	**Day Camps**
Individual	**Prevocational Provider**
Individual	**Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Discovery and Career Planning

Provider Category:

Individual

Provider Type:

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Discovery and Career Planning

Provider Category:

Agency

Provider Type:

Educational Camp

Provider Qualifications

License *(specify):*

Wis. Admin. Code § ATCP 78.05

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Discovery and Career Planning

Provider Category:

Agency

Provider Type:

Prevocational Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Discovery and Career Planning

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Personnel who provide individual supported employment services are required to have skills and abilities in the areas of assessment, job development, job placement, job retention, and evaluation, including the following:

- Assessment of individuals who have developmental disabilities.
- Work site analysis.
- Assessment of needs for assistive technology, disability accommodation, and individualized ergonomics.
- Job development.
- Sales and marketing.
- Job coaching.
- Outcome development and program evaluation.

The provider must have the ability and qualifications to provide this service, demonstrated in at least one of the following ways :

- Accreditation by a nationally recognized accreditation agency.
- Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
- Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
- Comparable experience for a qualified entity, including a minimum two years of experience working with the target population providing integrated employment services in the community.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Discovery and Career Planning

Provider Category:

Agency

Provider Type:

Day Camps

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 252

Certificate *(specify):*

Other Standard *(specify):*

-Accredited by a nationally recognized entity
-Comparable training specific to the target groups as for similar services

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Discovery and Career Planning

Provider Category:

Individual

Provider Type:

Prevocational Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Discovery and Career Planning

Provider Category:

Individual

Provider Type:

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite care services maintain and strengthen the child's or youth's natural supports by easing the daily stress and care demands for the family, or other primary caregiver(s), on a short-term basis. These services provide a level of care and supervision appropriate to the child's or youth's needs while the family or other primary caregiver(s) are temporarily relieved from daily caregiving demands. Respite care may take place in a residential setting, institutional setting, the home of the child or youth, the home of a caregiver, or in other community settings.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Adult Family Home
Agency	Family Child Care Center
Agency	Other agency appropriately qualified as approved by the State and as related to the unique service being provided
Agency	Residential Care Center (RCC) for Children and Youth
Agency	Day Camps
Agency	Group Child Care Center
Agency	Respite Agency
Individual	Other person appropriately qualified as approved by the State and as related to the unique service being provided
Agency	Group Homes for Children
Agency	Shelter Care Facilities
Agency	Foster Homes

Provider Category	Provider Type Title
Individual	Family Child Care Center
Agency	Community-Based Residential Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Adult Family Home

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 50,
Wis. Admin. Code ch. DHS 88

Certificate *(specify):*

Wis. Admin. Code ch. DHS 82

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Family Child Care Center

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 250

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Other agency appropriately qualified as approved by the State and as related to the unique service being provided

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Residential Care Center (RCC) for Children and Youth

Provider Qualifications

License *(specify):*

Wis. Stat 48,
Wis. Admin. Code ch. DCF 52

Certificate *(specify):*

Other Standard *(specify):*

RCC respite staff shall have respite care training designed around the unique needs related to the child's mental health needs and the psychiatric/behavioral treatment plan or individual medical care plan of the child.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Day Camps

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 252

Certificate *(specify):*

Other Standard *(specify):*

-Accredited by a nationally recognized entity
-Comparable training specific to the target groups as for similar services

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Group Child Care Center

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 48,
Wis. Admin. Code ch. DCF 251

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or one year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Respite Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Other person appropriately qualified as approved by the State and as related to the unique service being provided

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Group Homes for Children

Provider Qualifications

License *(specify):*

Wis. Stat 48,
Wis. Admin. Code ch. DCF 57

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Shelter Care Facilities

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 59

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Foster Homes

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 48,
Wis. Admin. Code ch. DCF 56

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Family Child Care Center

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 250

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Community-Based Residential Facility

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 50,
Wis. Admin. Code ch. DHS 83

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Support and Service Coordination

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Support and Service Coordination is the provision of services to locate, manage, coordinate, and monitor all covered supports and services, other program services—regardless of their funding source—and informal community supports for the child and family. The Support and Service Coordinator, a qualified individual employed by waiver agency, including county human/social/community departments, the waiver agency's sub-contracted case management entity, or a tribal waiver agency, must assure that waiver services are delivered in accordance with program requirements.

The primary responsibility of the Support and Service Coordinator is promoting the child's health, safety, welfare and inclusion in their home and community, which is accomplished through a broad range of activities, including: 1) General activities 2) Service plan development and execution 3) Programmatic and developmental transitions and 4) Cross-system coordination.

Support and Service Coordinators facilitate and coordinate access to all services and supports, both formal and informal, which are needed by the child and family to meet their identified outcomes. This includes managing, coordinating and monitoring the comprehensive person-centered plan, as well as informal supports, consistent with the child and family's identified outcomes, in a planned, coordinated, and cost-effective manner. The Support and Service Coordinator assures that services are delivered in accordance with waiver program requirements and the child's identified outcomes.

Support and Service Coordinators assess the family's needs so they may adequately support the child in the home or other community setting. The Support and Service Coordinator facilitates establishing and maintaining the child and family's individualized support system. Services provided to children include assuring effective implementation of the child and family's support plan; developing, implementing, and updating the family-centered transition plan, and coordinating across systems, in order to meet the identified outcomes.

The Support and Service Coordinator's role includes facilitating programmatic and developmental transitions. The Support and Service Coordinator is responsible for providing transitional support during various childhood transitions, such as the child transitioning to middle school and assisting the child or youth pursue vocational and/or education opportunities. It also includes supporting transition planning processes for youth transitioning into an adult long-term care program; discussing options if the youth is not transitioning an adult long-term care program; and discussing changes to parents' legal authority to make decisions for their youth when that youth turns 18 years old, among other transition responsibilities.

This service also includes assisting applicants and participants with establishing Medicaid financial, nonfinancial and functional eligibility, and all other aspects of an individual's waiver eligibility. Support and Service Coordination also includes assisting the participant to access Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit (known as HealthCheck in Wisconsin), Medicaid State Plan services, as well as school-based special education services through the Department of Public Instruction, and rehabilitation or college and career ready services through the Department of Workforce Development, Division of Rehabilitation. Support and Services Coordinators also refer the participant and the family and help facilitate access to other mental health, public health, and social services programs, as well as locating resources for natural supports. Support and Service Coordinators are also mandated reporters for child abuse and neglect and must issue referrals to child protection and child welfare services, when warranted.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service excludes the optional targeted case management benefit under the Medicaid State Plan.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	**Other person appropriately qualified as approved by the State and as related to the unique service being provided.**
Individual	**Licensed Social Worker**

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Support and Service Coordination

Provider Category:
Individual
Provider Type:

Other person appropriately qualified as approved by the State and as related to the unique service being provided.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A Support and Service Coordinator (SSC) shall have the skills and knowledge typically acquired through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience with the target group, or through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons of the specific target group for which they are employed, or through a minimum of four years experience as a long-term support SSC, or through an equivalent combination of training and experience that equals four years of long-term support practice in long-term support case management practice, or the completion of a course of study leading to a human services degree and one year of employment working with persons of the specific target group for which they are employed, or an associate's degree in a human services-related field and two years experience working with persons of the specific target group for which they are employed.

SSCs must complete the DHS-required introductory training and pass the competency test and must complete the Mandated Reporter Training prior to billing for SSC services.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Support and Service Coordination

Provider Category:

Individual

Provider Type:

Licensed Social Worker

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 457.08

Certificate *(specify):*

Other Standard *(specify):*

A minimum of one year of employment working with persons of the specific target group for which they are employed.

SSCs must complete the DHS-required introductory training and pass the competency test and must complete the Mandated Reporter Training prior to billing for SSC services.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Financial Management Services assist participants and families with managing waiver services and funding. The Financial Management Services provider (also referred to as the fiscal intermediary or the fiscal agent) performs financial transactions on behalf of the child or youth for the delivery of waiver services. Additionally, the fiscal intermediary serves as an agent for handling employment-related tasks associated with the supports and services in the child's or youth's authorized individual service plan (ISP).

These services function as a safeguard for the child or youth by ensuring that financial and employment activities meet federal, state, and local rules and regulations, and are done in a timely manner.

Financial Management Services assist the participant and/or the family to exercise employer authority by facilitating employment of the participant and family-hired workers. Financial Management Services also include assisting the participant and/or the family to exercise budget authority by managing and directing the disbursement of funds contained in the participant's budget.

Financial Management Service providers may perform a variety of activities, including:
• Verify caregiver's citizenship
• Train caregivers on the requirements for providing financial management services
• Establish accounts for federal and state tax reporting and worker's compensation coverage
• Process timesheets
• Pay caregiver's wages (including tax withholding and worker's compensation)
• Keep account of financial disbursements
• Submit service claims to a third-party administrator claims processing vendor
• Provide income verification

Financial Management Services also may include 1) ensuring sufficient participant-authorized units 2) completing screening activities for caregivers by conducting U.S. Office of the Inspector General List of Excluded Individuals and Entities reviews and caregiver background checks 3) verifying caregiver qualifications and 4) maintaining a list of qualified and available caregivers.

This service also includes paying bills authorized by the participant or their guardian, keeping an account of disbursements and assisting the participant to ensure sufficient funds are available for the participant's needs.

The Financial Management Service provider or fiscal intermediary serves upon the authorization of the locally-contracted waiver agency and is made available to the participant/family to ensure appropriate compensation is issued to providers of services. The Financial Management Services provider is accountable for ensuring compliance with all federal and state laws associated with tax withholding and all other employee benefits.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Excludes payments to court-appointed guardians or court-appointed protective payees if the court has directed them to perform any of these functions. Excludes payment for the cost of room and board.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Intermediary Agency
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided
Individual	Accountant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Agency

Provider Type:

Fiscal Intermediary Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be an agency, unit of an agency or individual that is qualified to provide all of the financial services involved. Providers must have training and experience in accounting or bookkeeping. The Financial Management Services provider must be bonded.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Individual

Provider Type:

Other persons appropriately qualified as approved by the State and as related to the unique service being provided

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must be an agency, unit of an agency or individual that is qualified to provide all of the financial services involved. Providers must have training and experience in accounting or bookkeeping. The Financial Management Services provider must be bonded.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Individual

Provider Type:

Accountant

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. ch. 442

Other Standard *(specify):*

Providers must be an agency, unit of an agency or individual that is qualified to provide all of the financial services involved. Providers must have training and experience in accounting or bookkeeping. The Financial Management Services provider must be bonded.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

Participant and Family-Direction Broker Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Participant and Family-Direction Broker Services are designed to empower participants to define and direct their own services and supports. These services are only for participants who choose the participant-directed service model of service delivery.

A Participant and Family-Direction Broker is an individual who assists participants in securing and directing participant and family-directed supports. The participant chooses whether to receive assistance with participant direction through Participant and Family-Direction Broker Services and the specific activities that the Participant and Family-Direction Broker will provide.

Participant and Family-Direction Broker provide:
1) information and assistance that help the participant in problem-solving and decision making and in developing supportive community relationships and other resources that promote the implementation of the Individual Service Plan.
2) employer-related information and advice for a participant in support of participant and family-direction to make informed decisions related to day-to-day management of staff providing services within the available budget.
3) information, coaching, and mentoring about participant and family-direction, including roles and responsibilities.

The exact direct assistance provided by Participant and Family-Direction Brokers to assist the participant in meeting participant-direction responsibilities depends on the needs of the participant and includes assistance, if needed, with recruiting, hiring, training, managing, evaluating, and changing employees, scheduling and outlining the duties of employees, understanding provider qualifications, record keeping and other requirements.

Participant and Family-Direction Broker Services may not duplicate, replace, or supplant Support and Service Coordination. Participant employer authority and budget authority responsibilities may not be delegated to this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin’s income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Participant and Family-Direction Broker Agency
Individual	Individual Participant and Family-Direction Broker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Participant and Family-Direction Broker Services

Provider Category:

Agency

Provider Type:

Participant and Family-Direction Broker Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual may be considered a qualified participant and family-direction broker only when they demonstrate adequate knowledge of the unique needs/preferences of the participant and the participant's specific target group, and they have knowledge of the local service delivery system and local resources available to the participant. The participant can decide the amount and type of training they require of the Participant and Family-Direction Broker. Knowledge of the unique needs/preferences of the participant and the service system.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Participant and Family-Direction Broker Services

Provider Category:

Individual

Provider Type:

Individual Participant and Family-Direction Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual may be considered a qualified participant and family-direction broker only when they demonstrate adequate knowledge of the unique needs/preferences of the participant and the participant's specific target group, and they have knowledge of the local service delivery system and local resources available to the participant. The participant can decide the amount and type of training they require of the Participant and Family-Direction Broker. Knowledge of the unique needs/preferences of the participant and the service system.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Adaptive Aids

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

14 Equipment, Technology, and Modifications	14031 equipment and technology

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adaptive aids include items, controls, or appliances that enable the child or youth to increase their ability to perform activities of daily living, and successfully access, navigate, and participate in their home and community.

These include the purchase of vehicle modifications (such as van lifts, hand controls for youth learning to drive, equipment modifications, etc.) that allow the vehicle to be used by the participant to access the community, or those costs associated with the maintenance or repair of these items. The cost of installation, maintenance, and repair of allowable adaptive aids are included in the adaptive aids service. The cost of testing and/or evaluation to determine the appropriateness of an adaptive aid is also included.

Examples of Adaptive Aids may include:
-Hygiene/meal preparation aids
-Environmental control units
-Accessible computer keyboard
-Adaptive security systems
-Adaptive door handles and locks
-Adaptive bike or tricycle
-Adaptive accessories
-Computer and necessary software
-Control switches
-Control switches, pneumatic devices, including sip and puff controls
-Electronic control panels
-Over the bed tables
-Portable ramps
-Standing board/frames
-Scald preventing showerhead
-Specialized clothing
-Talking alarm clocks
-Van/vehicle lift/transfer unit (manual, hydraulic or electronic)
-Vehicle hand controls

This service may also include the initial purchase of a service animal, training, and routine veterinary costs for a service animal. Wisconsin Statute § 106.52 (1) (fm) states: "Service animal" means a guide dog, signal dog, or other animal that is individually trained or is being trained to do work or perform tasks for the benefit of a person with a disability, including the work or task of guiding a person with impaired vision, alerting a person with impaired hearing to intruders or sound, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items.

As per the Americans with Disabilities Act, service animals are dogs (and in some cases, miniature horses) trained to perform major life tasks to assist people with physical disabilities. For a person to legally qualify to have a service dog, the child must have a disability that substantially limits the child’s ability to perform at least one major life task without assistance.

To qualify as a service dog, the dog must be individually trained to perform that major life task. All breeds and sizes of dogs can be trained as service animals. The federal American Disabilities Act (ADA) does NOT require certification or registration of service animals.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Excludes food, grooming, and non-routine veterinary care for service animals based on DHS guidelines.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Durable Medical Equipment Provider
Agency	Other providers appropriately qualified
Agency	Pharmacy

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Individual

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers appropriately qualified to distribute Durable Medical Equipment.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Agency

Provider Type:

Other providers appropriately qualified

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of systems or devices such as adaptive aids shall ensure that all items meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of systems or services must ensure that all items meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

Service Title:

Adult Family Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02013 group living, other
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 4:	**Sub-Category 4:**
02 Round-the-Clock Services	02031 in-home residential habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult Family Home (AFH) is a residence where one to four persons live and in which care, treatment or service above the level of room and board is provided as a primary function of the facility. The residence is the primary domicile of the Adult Family Home operator(s). Only the costs directly associated with participant care, support and supervision in the adult family home may be billed under this service. No costs associated with room and board of the residents may be billed to the waiver.

Adult Family Home also includes “community care home” until statutory authority is established for community care homes. “Community care home” is a residence where one to four adult residents live and also where the resident(s) receives care, treatment, support or service above the level of room and board. In the community care home the operator owns, rents, or leases the residence and employs staff who provide care and service. The community care home is not the primary domicile of the provider.

One- and two-bed adult family homes must be certified pursuant to the standards established by the Department of Health Services, which includes requirements regarding the age of individuals permitted to reside at the home.

Three- or four-person Adult Family Homes must be licensed by the Department of Health Services, Division of Quality Assurance or another approved licensing agency. DHS 88, Licensed Adult Family Homes contains the regulations and standards governing this service, including requirements regarding the age of individuals permitted to reside at the home.

Specific target group requirements:

1. There must be documentation of the specific exceptional needs of the person and the individual psychiatric/behavioral care plan or individual medical care plan that the adult family home provider will implement.
2. There must be documentation of the specific training the adult family home provider received related to the individual’s needs and the psychiatric/behavioral treatment plan or individual medical care plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For AFH services, transportation services may be included under this service or separately billed under the service Transportation so long as there is no duplicate billing for any unit of service.

Excludes environmental modifications to the home, adaptive equipment or communication aids under this service. Any needed environmental modification, adaptive equipment or communication aid may be covered by the waiver but must be claimed under the services “Home Modifications,” “Communication Aids," or “Adaptive Aids” respectively.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin’s income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Family Home
Individual	Adult Family Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Family Home

Provider Category:

Agency

Provider Type:

Adult Family Home

Provider Qualifications

License *(specify):*

Wis. Admin. Code Chs. DHS 88

Certificate *(specify):*

Wis. Admin. Code Chs. DHS 82

Other Standard *(specify):*

The Department of Health Services, Division of Quality Assurance or another approved licensing agency must license adult family homes for three or four persons. Wisconsin Administrative Code DHS 88, contains the regulations and standards governing this waiver service.
All one to two bed adult family homes shall be certified pursuant to standards established by the Department. Wisconsin Administrative Code DHS 82, contains the regulations and standards governing this waiver service. Adult Family Home standards are also described in the publication: Medicaid Waiver Standards for Adult Family Homes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Adult Family Home

Provider Category:

Individual

Provider Type:

Adult Family Home

Provider Qualifications

License *(specify):*

Wis. Admin. Code Chs. DHS 88

Certificate *(specify):*

Wis. Admin. Code Chs. DHS 82

Other Standard *(specify):*

The Department of Health Services, Division of Quality Assurance or another approved licensing agency must license adult family homes for three or four persons. Wisconsin Administrative Code DHS 88, contains the regulations and standards governing this waiver service.
All one to two bed adult family homes shall be certified pursuant to standards established by the Department. Wisconsin Administrative Code DHS 82, contains the regulations and standards governing this waiver service. Adult Family Home standards are also described in the publication: Medicaid Waiver Standards for Adult Family Homes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology and Communication Aids

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
17 Other Services	17020 interpreter
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assistive Technology and Communication Aids are items, pieces of equipment, product systems, or services that increase, maintain, or improve functional capabilities of children at home, work, and in the community. Assistive technology service means a service that directly assists the child/youth in the selection, acquisition, or use of an assistive technology device and/or communication aid.

This service includes:
a) the evaluation of the assistive technology needs of the child, including a functional evaluation of the impact of providing appropriate assistive technology and services to the child in the customary environment of the child;
b) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for children;
c) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;
d) coordination and use of necessary therapies, interventions, or services that incorporate the use of assistive technology device;
e) training or technical assistance for the child/youth, or where appropriate, the family members, guardians, advocates or authorized representatives of the child; and
f) training or technical assistance for professionals or other individuals, who provide services to, employ or are otherwise substantially involved in the major life functions of children.

Assistive technology includes communication aids that are devices or services needed to assist children with hearing, speech, communication or vision impairments. These items or services assist the individual to effectively communicate with service providers, family, friends and the general public; decrease reliance on paid staff; increase personal safety; enhance independence; and improve social and emotional well-being.

Communication aids include any device that addresses these objectives such as augmentative and alternative communication systems, hearing or speech amplification devices, aids and assistive devices, interpreters, and cognitive retraining aids and the repair and/or servicing of such systems. Communication aids also include electronic technology, such as tablets or mobile devices, and related software that assist with communication, when the use provides assistance to a person who needs such assistance due to the child’s disabilities. Applications for mobile devices or other technology also are covered under this service, when the use provides assistance related to the child’s disabilities. Internet access services that enable the functionality of other allowable assistive technology and communication aid devices is permitted under this service. This list is intended to be illustrative and is not exhaustive.

Interpreter services are provided to people with hearing impairments and who require sign language translation to effectively communicate with people in the community, employees or others. Interpreters provide sign language services for participants with hearing impairments.

Electronic devices must meet UL or FCC standards.
Individual interpreters must be on the state or national interpreter registry.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Waiver funds may only be used for interpreter services when it is not the responsibility of the provider or another party to provide this service.

Excludes interpreter services that are otherwise available, including for communication with the waiver agency, its contractors or other health care professionals, which are required to provide interpreter services under the State of Wisconsin's civil right compliance requirements, as part of their rate.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers of Communication Aids
Individual	Individual Sign Language Interpreters

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology and Communication Aids

Provider Category:

Agency

Provider Type:

Providers of Communication Aids

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Communication aids vendors must be Medicaid certified providers.
Providers of systems or devices such as adaptive aids must ensure that all items meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology and Communication Aids

Provider Category:

Individual

Provider Type:

Individual Sign Language Interpreters

Provider Qualifications

License *(specify):*

Wis. Stat. § 440.032(3)

Certificate *(specify):*

Other Standard *(specify):*

Individual Sign Language interpreters must be on the state or national interpreter registry

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Child Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
04 Day Services	04070 community integration
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Child Care Services include the provision of supplementary child care staffing necessary to meet the child's exceptional care needs above and beyond the cost of basic child care that all families with young children may incur.

Child care services may include supplementary supports and supervision services to address exceptional emotional or behavioral needs, or physical or personal care needs for eligible participants.

This covered child care waiver service may include supplementary supports and supervision services to address exceptional physical, emotional, behavioral or personal care needs of the child. Child care waiver services may include, but are not limited to, services offered by the Department of Children and Families (DCF) licensed or certified family day care, group day care, day camps. In addition, child care services may be delivered by providers chosen by the parent/guardian that meet the DHS child care waiver training and work experience qualification requirements.

Waiver funding may be used to cover costs for child care services when the child has aged out of their traditional child care settings (typically up to age 12), but due to the child's disability continues to require care or supervision when the parent/guardian is working or training. Examples include school and community-based settings that children of that age typically participate (e.g., after school programs, 4-H clubs, family residence etc.). The entire cost of child care for participants age 12 years and over may be covered under the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Excludes any service that falls under the definition of daily living skills training, personal supports, mentoring, or respite care.

This service excludes the basic cost of day care unrelated to the child's disability that may be needed by parents or regular caregivers to allow them to work, or participate in educational or vocational training programs. The "basic cost of day care" means the rate charged by and paid to a child care center for children who do not have special needs. The basic cost of child care does not include the provision of supplementary staffing this cost may be covered by this service.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Group Child Care Center
Agency	Day Camps
Individual	Family Child Care Center
Agency	Family Child Care Center
Individual	Certified Child Care Provider
Individual	Parent/Guardian Selected Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Child Care Services

Provider Category:

Agency

Provider Type:

Group Child Care Center

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 48,
Wis. Admin. Code ch. DCF 251

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or one year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Child Care Services

Provider Category:

Agency

Provider Type:

Day Camps

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 252

Certificate *(specify):*

Other Standard *(specify):*

-Accredited by a nationally recognized entity
-Comparable training specific to the target groups as for similar services

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Child Care Services

Provider Category:

Individual

Provider Type:

Family Child Care Center

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 250

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting who work directly with children must have a combination of one year of training in child development or one year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Child Care Services

Provider Category:

Agency

Provider Type:

Family Child Care Center

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 250

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting who work directly with children must have a combination of one year of training in child development or one year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Child Care Services

Provider Category:

Individual

Provider Type:

Certified Child Care Provider

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 202

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Child Care Services

Provider Category:

Individual

Provider Type:

Parent/Guardian Selected Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers that are selected by the parent/guardian that are not licensed or certified by DCF must complete appropriate training, as approved by DHS, related to the child's unique needs to effectively address each child being served and to ensure their health, safety and welfare. If the child's unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's approved behavioral treatment plan. In addition, the provider must have 1 year of experience in working in a program that serves children.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Children's Foster Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A Foster Home is a family-oriented residence operated by a person licensed as a Foster Home under s.48.62 of the Wisconsin Statutes and DCF 56 of the Wisconsin Administrative Code.

This service includes supplementary intensive supports and supervision services beyond the maintenance payment made to foster parents and to address the child's or youth's exceptional emotional or behavioral needs, or physical or personal care needs, in a family environment.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service excludes the cost of room and board provided by the foster home provider. Waiver funding cannot supplant IV-E funding.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Level 5 Exceptional Foster Home
Individual	Individual Family Foster Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Children's Foster Care

Provider Category:

Agency

Provider Type:

Level 5 Exceptional Foster Home

Provider Qualifications

License *(specify):*

Wis. Stat. § 48.62,
Wis. Admin. Code ch. DCF 56

Certificate *(specify):*

Other Standard *(specify):*

All foster home providers must have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure the child's health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs, then the foster home provider must have training specific to the child's needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Children's Foster Care

Provider Category:

Individual

Provider Type:

Individual Family Foster Provider

Provider Qualifications

License *(specify):*

Wis. Stat. § 48.62,
Wis. Admin. Code ch. DCF 56

Certificate *(specify):*

Other Standard *(specify):*

All foster care providers must have specialized training related to the child’s unique needs in order to effectively address the needs of each child served in a particular home and to ensure the child's health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs, then the foster care provider must have training specific to the child’s needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Integration Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
04 Day Services	04070 community integration
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Integration Services is built upon current wrap-around service delivery models and includes services and supports that are identified by the child/parent and the multidisciplinary team as necessary to support the child and family within a community setting based on their strengths and needs.

Community Integration Services programs benefits families with children who have multiple and complex mental health and/or behavioral concerns, and are involved in multiple services and service systems, by providing intensive care coordination, in addition to Support and Service Coordination and by a provider who is not the Support and Service Coordinator.

Community Integration Services extend beyond the traditional financial and geographic boundaries to develop a creative and flexible continuum of care. Community Integration Services works well for participants who would benefit from a single point of contact for multiple waiver services and service systems and a consistent approach across services and systems.

The child or youth, their parent, and the multidisciplinary team identify services and supports, based on the child and family's strengths and needs, that are necessary for the child or youth and family to move seamlessly through all community environments, and prevent out-of-home placement. The Community Integration Services team coordinator is required to facilitate coordination of the multidisciplinary team and the child's or youth's integration into their community.

Typical waiver services that the Community Integration Services team coordinator may provide and/or coordinate include: daily living skills, mentoring, parent education and training, community integration activities and behavior interventions, safety planning and prevention, development and nurturing of natural supports, transportation and respite services. Community Integration Services is for the coordination of these supports. The supports being coordinated should be billed under their respective service codes. The outcome of this program is to assist, empower and build upon the strengths of the child and family or order that the child can be fully integrated into the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

1. The minimum service requirements are that providers shall attend quarterly team reviews or sooner (or more frequent if requested) if requested by the SSC that would include the parent or guardian and the child (if deemed appropriate) relevant service provider agency staff/supervisor (when applicable), the overseeing SSC and that person's supervisor.
2. Community Integration providers shall complete a written report every six months or sooner if the child's condition changes or warrants and updated progress towards and identified outcome that details the participant's past and current level of functioning, as well as the intended outcome and obstacles that stand in the way of those outcomes. This report shall be provided to the SSC.
3. Excludes experimental or adverse treatments as defined by the Medicaid State Plan
4. Excludes residential services as part of the community integration program see relevant residential service definitions foster care or adult family care or institutional respite.
5. If providers are transporting the child, the waiver agency must have written documentation on file that the provider has a current valid driver's license, current liability insurance coverage and the vehicle is mechanically sound as defined under the Transportation services standards. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under transportation service, but not both. All providers shall ensure that all standards described in the Transportation service are met.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Provider
Agency	Licensed Social Worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:

Individual

Provider Type:

Individual Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must have a minimum of two years experience working with the target population. However, the waiver agency may employ qualified providers who are less experienced if the waiver agency ensures the provider receives comprehensive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the individual service plan.

In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the waiver manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:

Agency

Provider Type:

Licensed Social Worker

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 457.08

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Counseling and Therapeutic Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11120 cognitive rehabilitative therapy
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11130 other therapies
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Counseling and Therapeutic Services include the provision of professional evaluation and consultation services to children and youth with identified needs for physical, personal, social, cognitive, developmental, emotional, or substance abuse services. The goal of counseling and therapeutic services is to maintain or improve participant health, welfare, and functioning of the child or youth in the community. The service may be provided in a natural setting or in a service provider's office. Includes therapies provided by state licensed or certified medical professionals which are not available under the Medicaid State Plan. Providers of counseling and therapeutic services shall deliver services limited to their areas of formal education and training, as directed by their professional code of ethics.

Any counseling or therapeutic service funded by the waiver must address an individual's assessed need and be directly related to a therapeutic or palliative goal.

Services may include but aren't limited to:
-Animal-Assisted Therapy: In animal-assisted therapy, animals are utilized in goal directed treatment sessions, as a modality, to facilitate optimal physical, cognitive, social and emotional outcomes of a waiver participant such as increasing self-esteem and motivation, and reducing stress. Examples include hippotherapy and equine-assisted therapy.
-Aquatic Therapy uses the resistance of water to rehabilitate an individual with a chronic illness, poor or lack of muscle tone or a physical injury/disability.
-Expressive Therapy is the provision of creative art, music or play therapy which gives children the ability to creatively and kinesthetically express their medical situation.
-Movement Therapy is the use of music therapy and/or dance therapy as a therapeutic tool for the habilitation, rehabilitation, and maintenance of behavioral, developmental, physical, social, communication, pain management, cognition and gross motor skills.

Services may also include assistance with interpersonal relationships, day/summer camp, and group activities. Counseling and therapeutic services must meet a clearly defined outcome, be proven effective for the child's condition or outcome and be cost-effective.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Counseling and therapeutic supports and services may not be experimental or aversive in nature nor may they otherwise jeopardize the health and safety of the participant.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Individual	Art Therapist
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided
Individual	Music Therapist
Agency	Other providers appropriately qualified.
Agency	Educational Camp
Individual	Massage or Bodywork Therapist
Agency	Day Camps
Individual	Hippotherapist
Individual	Equine-Assisted Therapist
Individual	Therapeutic Recreation Specialist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Counseling and Therapeutic Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Wis. Stat. § 50.49,
42 CFR 484,
Wis. Admin. Code chs. DHS 131 and DHS 12 including Appendix A

Certificate *(specify):*

Other Standard *(specify):*

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification, must be authorized by a medical professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Individual

Provider Type:

Art Therapist

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 440

Certificate *(specify):*

Other Standard *(specify):*

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Individual

Provider Type:

Other persons appropriately qualified as approved by the State and as related to the unique service being provided

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Individual

Provider Type:

Music Therapist

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 440

Certificate *(specify):*

Other Standard *(specify):*

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Agency

Provider Type:

Other providers appropriately qualified.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Agency

Provider Type:

Educational Camp

Provider Qualifications

License *(specify):*

Wis. Admin. Code § ATCP 78.05

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Individual

Provider Type:

Massage or Bodywork Therapist

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 460

Certificate *(specify):*

National Certification Board for Therapeutic Massage and Bodywork (NCBTMB)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Agency

Provider Type:

Day Camps

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DCF 252

Certificate *(specify):*

Other Standard *(specify):*

-Accredited by a nationally recognized entity
-Comparable training specific to the target groups as for similar services

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Individual

Provider Type:

Hippotherapist

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 440

Certificate *(specify):*

Other Standard *(specify):*

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Individual

Provider Type:

Equine-Assisted Therapist

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 440

Certificate *(specify):*

Other Standard *(specify):*

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:

Individual

Provider Type:

Therapeutic Recreation Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

National Counsel of Therapeutic Recreation Certification (NCTRC)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Daily Living Skills Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Daily living skills training services provide education and skill development or training to support the child's or youth's ability to independently perform routine daily activities and effectively use community resources.

Services are instructional, focused on skill development, and are not intended to provide substitute task performance. This service includes funding for educational or training services that directly benefit the child.

Daily living skills training may include education and skill development, such as:
-Personal hygiene
-Food preparation
-Home upkeep and maintenance
-Money management
-Accessing and using community resources
-Community mobility
-Computer and technology use
-Driving evaluation, lessons, and other related fees
-Transportation usage

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided
Agency	Providers of Daily Living Skills Training

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Daily Living Skills Training

Provider Category:

Individual

Provider Type:

Other persons appropriately qualified as approved by the State and as related to the unique service being provided

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of daily living skills training must have a minimum of two years' experience working with the target population.
However, providers who are less experienced that have received comprehensive participant-specific training to enable them to competently work with the participant and meet the objectives outlined in the individual service plan can meet the daily living skills training qualifications.
Providers shall ensure Daily Living Skills Training staff are knowledgeable in the adaptation and use of specialized equipment and in the modification of participant environments and that these staff complete regular training/continuing education coursework to maintain/update their level of expertise.
In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the waiver manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Daily Living Skills Training

Provider Category:

Agency

Provider Type:

Providers of Daily Living Skills Training

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of daily living skills training must have a minimum of two years' experience working with the target population. However, the waiver agency may employ qualified providers who are less experienced if the waiver agency ensures the provider receives comprehensive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the individual service plan.
In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the waiver manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Empowerment and Self-Determination Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Empowerment and Self-Determination Supports help the child or youth and the family acquire skills to exercise control and responsibility over their other supportive services. Exercising control and responsibility over supportive services helps the child and the child's family build an interdependent care network within their community and promotes self-determination. Empowerment and Self-Determination Supports provide training programs, workshops, conferences, and other events that help the participant and the family develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. Empowerment and Self-Determination Supports may be provided to the child and/or the child's parent(s), unpaid caregiver(s), and/or legal representative(s).

Covered expenses may include enrollment fees, books and other educational materials and transportation related to participation in training courses, conferences and other similar events that address the objectives of this service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service excludes payment for hotel and meal expenses while participants or their legal representatives attend allowable training/education events.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.
Agency	Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Empowerment and Self-Determination Supports

Provider Category:
Individual
Provider Type:

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Empowerment and Self-Determination Supports

Provider Category:

Agency

Provider Type:

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Each provider must have demonstrated skills related to the specific area of training and the applicability of that information to children with disabilities and their families.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family/Unpaid Caregiver Supports and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Family/Unpaid Caregiver Supports and Services provides supports and services that enhance an unpaid caregiver's ability to help the child/youth live their best possible life. Family/Unpaid Caregiver Supports and Services provides education, training, and support to an unpaid caregiver of a participant that increases confidence, stamina and empowerment to support and care for the participant. For purposes of this service, unpaid caregiver is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to the waiver participant.

This service may help an unpaid caregiver to 1) understand the disability of the participant 2) achieve greater competence and confidence in providing support 3) develop and access community and other resources and supports 4) develop or enhance key parenting strategies and 5) increase methods for coping and learn techniques to manage challenges and to promote achieving an inclusive, interdependent, and self-empowered life.

This service is intended to maintain or increase balance and harmony in the home, bolster effective communication, support independence and inclusion, and foster growth for both the participant and family.

This service includes, but is not limited to:
-Training, instruction, or support provided in a participant's home, community, or other appropriate locations
-Conferences
-Resource materials
-Online training
-Family-to-family navigation
-Registration and training fees associated with formal instruction.

This service may also provide supports to unpaid caregivers in the areas of:
-Behavior and Communication
-Community Inclusion and Wellness
-Emotional Support and Stress Management
-Family Dynamics and Parenting

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

- This service does not cover training to be a paid caregiver.
- This service does not cover training focused on the waiver participant's training needs.
- This service excludes payment for lodging and meal expenses incurred while attending a training event or conference.
- This service does not cover teaching self-advocacy, which is covered under Empowerment and Self-Determination Supports.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/Unpaid Caregiver Supports and Services

Provider Category:

Agency

Provider Type:

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Each provider must have demonstrated skills related to the specific area of training and the applicability of that information to children with disabilities and their families.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family/Unpaid Caregiver Supports and Services

Provider Category:

Individual

Provider Type:

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Grief and Bereavement Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

This service includes counseling of the participant and/or family in dealing with and adjusting to the possible death of the child and the aftercare of the family due to the death of the child. Grief and Bereavement Counseling may be provided to family members to guide and help them cope with the participant's illness and/or death. This service supports families if the child has a life-threatening illness or if the child dies unexpectedly. Participants may also receive this service if they have a life-threatening illness.

Grief and bereavement activities provide opportunities for dialogue, expressing emotions, asking questions about death, and grieving in a safe environment. The focus of counseling includes, but not limited to, identifying, communication and coping with the multiple emotions surrounding a family with a child who has a life-limiting diagnosis with the outcome of death, and in dealing with the loss of the child. Enabling the participant and family members to express and cope with emotions improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Grief and Bereavement Counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Grief and Bereavement Counseling services are billable one-time for a flat rate for usage after the child's death. The service may be billed once the family has shown interest in receiving the service and prior to the child's death.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospice
Agency	Home Health Agency
Individual	Licensed Psychologist
Agency	Any agencies appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Individual	Licensed Social Worker
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Individual	Licensed Professional Counselor
Individual	Spiritual Counselor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grief and Bereavement Counseling

Provider Category:
Agency

Provider Type:

Hospice

Provider Qualifications

License *(specify):*

Wis. Stat. § 50.90,
Wis. Admin. Code ch. 131

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grief and Bereavement Counseling

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

42 C.F.R. § 484,
Wis. Stat. § 50.49,
Wis. Admin. Code ch. DHS 131

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grief and Bereavement Counseling

Provider Category:

Individual

Provider Type:

Licensed Psychologist

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. Psy 2

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grief and Bereavement Counseling

Provider Category:

Agency

Provider Type:

Any agencies appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grief and Bereavement Counseling

Provider Category:

Individual

Provider Type:

Licensed Social Worker

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 457.08

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grief and Bereavement Counseling

Provider Category:

Individual

Provider Type:

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grief and Bereavement Counseling

Provider Category:

Individual

Provider Type:

Licensed Professional Counselor

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 457.12

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Grief and Bereavement Counseling

Provider Category:

Individual

Provider Type:

Spiritual Counselor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

American Association of Pastoral Counselors (AAPC)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Health and Wellness

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 3:	**Sub-Category 3:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 4:	**Sub-Category 4:**
17 Other Services	17990 other

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The primary purpose of Health and Wellness services is to support the child's inclusion with the family and peers in health and wellness activities within their community. Health and Wellness services focus on healthy habits thereby preventing or delaying higher cost institutional care.

a) Healthy Lifestyles – Participants can take classes, lessons, events, or other educational opportunities, such as health and wellness web and mobile applications, to address issues regarding living with a disability and having a healthy lifestyle, including nutrition, physical activity, and sensory regulation. This increases the capacity of the participant to self-advocate, navigate community resources and improve overall health and socialization skills. These skills keep participants in the community and out of an institution.

b) Non-traditional/alternative medicine and wellness, such as yoga, meditation, mindfulness, sound healing, Traditional African Based Holistic Services, Ayurveda, Chinese or Oriental medicine, Reiki, Tai Chi, Native American healers (Treatments may include prayer, dance, ceremony and song, plant medicines and foods, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel and/or other sacred objects), and spiritual counseling.
c) Sexuality Education and Parenting Training for Participants– intended to provide a proactive educational program about the values and critical thinking skills needed to form and maintain meaningful relationships, healthy sexuality, and sexual expression and train and support participants who are also parents.
-Sexuality learning objectives include positive self-image, communication skills, reproductive anatomy, conception and fetal development, safe sex, and health awareness.
-Positive outcomes for the individual student include safety from negative consequences of being sexual, assertiveness about setting boundaries and reporting violations, expressing physical affection in a manner that is appropriate, and making informed choices about the relationships in the child's or youth's life. Independent living skills are enhanced and improved work outcomes result from a better understanding of interpersonal boundaries, and improved communication, critical thinking, and self-reliance skills.
-Sexuality Education and Parenting Training for Participants may also include training adapted for participants who are parents that may consist of in-home visits, an assessment of parenting needs and goals, as well as education and support in 1:1 or group settings.
-Sexuality Education and Parenting Training for Participants is focused on sexuality education can be taught in a group classroom setting with the support of direct support professionals, family members, and natural supports as well as the guidance of mentors where appropriate.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Socialization and Sexuality Provider
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Individual	Certified Personal Trainer
Agency	Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Agency	Independent Living Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Individual

Provider Type:

Socialization and Sexuality Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Individual

Provider Type:

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Individual

Provider Type:

Certified Personal Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Cardiopulmonary resuscitation
(CPR) and automated external defibrillation (AED);
National certification from an accredited agency

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Agency

Provider Type:

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Agency

Provider Type:

Independent Living Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Independent Living Centers as outlined in the State Plan for Independent Living (SPIL) approved by the U.S. Department of Health and Human Services' Administration on Community Living (ACL).

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home modifications maximize the child's or youth's independent functioning in their home through services to assess the need for, arrange for, and provide modifications and/or improvements to the home.

Home modifications are generally permanent fixtures and/or changes to a physical structure. This service may be used to ensure safe, accessible means of entry and exit to the home, and otherwise provide safe access to rooms, facilities, or equipment within the home or adjacent buildings that are part of the residence.

Home modifications include the cost of the permit to authorize the changes, the materials, and services needed to complete the installation of specific equipment, the modification of the physical structure or the reconfiguration of essential systems within the home.

Home modifications may include adaptations, including, but not limited to:
-Ramps (fixed), ramp extensions and platforms
-Porch/stair lifts
-Doors/doorways, door handles/door opening devices
-Adaptive door bells, locks/security items or devices
-Plumbing, electrical modifications related to adaptations
-Medically necessary heating, cooling or ventilation systems
-Shower, sink, tub and toilet modifications
-Faucets/water controls
-Accessible cabinetry, counter tops or work surfaces
-Grab bars (see exception below), handrails, accessible closets
-Smoke/fire alarms and fire safety adaptations
-Adaptive lighting/light switches
-Flooring and/or floor covering to address health and safety
-Wall protection

Modifications not specifically described above may be approved if the item or service meets the definition and the standards for allowable home modifications.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.
Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Living Center
Agency	Building Supply Company
Individual	Electrician
Individual	Heating & Air Conditioning
Agency	Contractor
Individual	Plumber
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided.
Individual	Engineer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Independent Living Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Building Supply Company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Electrician

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. ch. 443

Other Standard *(specify):*

The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Heating & Air Conditioning

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § 305.71

Other Standard *(specify):*

The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Plumber

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. ch. 443

Other Standard *(specify):*

The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Other persons appropriately qualified as approved by the State and as related to the unique service being provided.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Engineer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. ch. 443

Other Standard *(specify):*

The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.
All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Housing Support Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
16 Community Transition Services	16010 community transition services
Category 3:	**Sub-Category 3:**
17 Other Services	17990 other

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Housing Support Services are supports to help participants and families navigate housing opportunities; address or overcome barriers to housing; get essential items and services needed to establish a community living arrangement; and sustain tenancy.

Housing Support Services include consultations to obtain and retain independent housing. During the consultation, the service provider assesses the participant's and family's housing needs and develops an individualized housing support plan and includes:
1. Conducting a tenant screening and housing assessment including collecting information on potential housing barriers and identification of potential housing retention challenges;
2. Developing an individualized housing support plan that includes:
(a) Short- and long-term goals;
(b) Strategies to address identified barriers including prevention and early intervention services when housing is jeopardized; and
(c) Natural supports, resources, community providers, and services to support goals and strategies.

This service involves providing comprehensive guidance on housing opportunities available to meet the needs and preferences of the participant and family. This service includes guidance on how a participant may gain access to available public and private resources to assist the person to obtain or retain safe, decent, accessible, and affordable housing and avoid institutionalization.

Housing Support Services include searching for housing, housing application processes, requesting reasonable accommodations in accordance with the Fair Housing Act, and reviewing the lease, homeownership documents, or other related documents, including property rules, prior to signing.

Housing Support Services include planning, guidance and assistance in accessing resources related to homeownership, financing, accessibility and architectural services and consultation, as well as health and safety evaluations of physical property. The provider may deliver consultation by meeting with the participant and family and collecting individual-specific information. This information is used to provide guidance and assistance which is appropriate to the individual situation.

Housing Support Services also include essential items and services needed to establish a community living arrangement for children or youth who are relocating from an institution, foster home or who are moving out of the family home to a less restrictive or independent setting. This includes person-specific services, supports or goods that will be put in place in preparation for the child/youth relocation to a safe, accessible and affordable community living arrangement.

Housing Support Services may include the purchase of necessary furniture, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings and kitchen appliances not otherwise included in a rental arrangement if applicable.

Housing Support Services may include the payment of a security deposit, utility connection costs and telephone installation charges. This service includes payment for moving the child/youth personal belongings to the new community living arrangement and general cleaning and household organization services needed to prepare the selected community living arrangement for occupancy.

Housing Support Services assist the participant and family with maintaining living in their rented or leased home and includes:
1. Education and training on the role, rights and responsibilities of the tenant and landlord; how to be a good tenant; and lease compliance;
2. Coaching to develop and maintain key relationships with landlord/property manager and neighbors;
3. Assistance with housing recertification process;
4. Early identification and intervention for behaviors that jeopardize tenancy;
5. Assistance with resolving disputes with landlords and/or neighbors;
6. Advocacy and linkage with community resources to prevent eviction; and
7. Coordinating with the individual to review, update and modify the housing support plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.).

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Housing Counseling Agency
Agency	Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.
Agency	Moving companies, public utilities, real estate agencies, vendors of home furnishings
Individual	Individual movers / individual landlords

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Agency

Provider Type:

Housing Counseling Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A qualified provider must be an agency or unit of an agency that provides Housing Counseling as a regular part of its mission.
Counseling must be provided by staff with specialized training and experience in any of the following housing issues; home ownership, both pre and post purchase, home financing and refinancing, home maintenance, repair and improvements including abating environmental hazards, rental counseling, not including any cash assistance, accessibility and architectural services and consultation, weatherization evaluation and assistance in accessing these services, lead-based paint abatement evaluation, low-income energy assistance evaluation, access to transitional or permanent housing, accessibility inventory design, health and safety evaluations of physical property, debt/credit counseling, and homelessness and eviction prevention counseling.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Agency

Provider Type:

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Individual

Provider Type:

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Agency

Provider Type:

Moving companies, public utilities, real estate agencies, vendors of home furnishings

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have established a stable financial history, with no outstanding debts or amounts due to the Wisconsin Department of Health Services or other government agencies, including unpaid forfeitures and fines.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Support Services

Provider Category:

Individual

Provider Type:

Individual movers / individual landlords

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have established a stable financial history, with no outstanding debts or amounts due to the Wisconsin Department of Health Services or other government agencies, including unpaid forfeitures and fines.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Mentoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation
Category 2:	**Sub-Category 2:**
04 Day Services	04070 community integration

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Mentoring services improve the child's or youth's ability to interact in their community in socially advantageous ways.

The mentor provides the child or youth with experiences in peer interaction, social and/or recreational activities, and employability skill-building opportunities. The mentor implements learning opportunities by guiding and shadowing the child or youth in the community while practicing and modeling interaction skills. Interventions are spontaneous and in real-life situations, rather than in a segregated or classroom-type environment.

This service may fund expenses related to participation in community activities that address the objectives and identified outcomes in the child's or youth's individual service plan. Costs for meals and admission fees for the mentor and child or youth may be included.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any agency appropriately qualified as approved by the State and as related to the unique service
Individual	Mentors

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Mentoring

Provider Category:

Agency

Provider Type:

Any agency appropriately qualified as approved by the State and as related to the unique service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of mentoring services must be 18 years or older. The waiver agency must ensure that the provider receives child specific training provided by the agency, SSC and parent/guardian, and there must be documentation of this training in the child's record.
Individual mentors must receive child specific training provided by the Support and Service Coordinator, parent, guardian, and/or other relevant professional who is knowledgeable of the participant's daily needs. Providers shall be involved in frequent and ongoing communication with the Support and Service Coordinator, and family, regarding child specific updates, information, and concerns.
In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the waiver manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Mentoring

Provider Category:

Individual

Provider Type:

Mentors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of mentoring services must be 18 years or older. The waiver agency must ensure that the provider receives child specific training provided by the agency, SSC and parent/guardian, and there must be documentation of this training in the child's record.
Individual mentors must receive child specific training provided by the Support and Service Coordinator, parent, guardian, and/or other relevant professional who is knowledgeable of the participant's daily needs. Providers shall be involved in frequent and ongoing communication with the Support and Service Coordinator, and family, regarding child specific updates, information, and concerns.
In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the waiver manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Participant and Family-Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

These are services, supports, supplies or goods not otherwise provided through this waiver or the Medicaid State Plan. These items must address an identified need and outcome in the participant's individual service plan and meet the following requirements.

The item or service would: 1) decrease the need for other Medicaid services; 2) promote inclusion in the community; 3) promote the independence of the participant; 4) fulfill a medical, social, or functional need [based on unique cultural approaches]; or 5) increase the participant's safety in the home environment.

In addition goods and services purchased must be a cost-effective means of addressing an identified need and outcome in the service plan and solely benefit the participant.

Outcomes: 1) maintain the participant's ability to remain in the community; 2) enhance the participant's community inclusion and family involvement; 3) develop or maintain the participant's personal, social, physical, or work-related skills; and 4) increase the participant's independence.

The service, equipment, or supply must not be captured under an exclusion of another service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Education and Training Agency
Agency	Supportive Home Care Agency
Individual	Personal Care Worker
Agency	Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant and Family-Directed Goods and Services

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

42 C.F.R. § 484,
Wis. Stat. § 50.49,
Wis. Admin. Code ch. DHS 131

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant and Family-Directed Goods and Services

Provider Category:

Agency

Provider Type:

Education and Training Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant and Family-Directed Goods and Services

Provider Category:

Agency

Provider Type:

Supportive Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agency providing services receive training on information specific to disabilities, abilities, needs, functional deficits, and strengths of the population to be served. This training should be person-specific for the child or youth to be served and generally focused.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant and Family-Directed Goods and Services

Provider Category:

Individual

Provider Type:

Personal Care Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 105.17(3)(a)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant and Family-Directed Goods and Services

Provider Category:

Agency

Provider Type:

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Participant and Family-Directed Goods and Services

Provider Category:

Individual

Provider Type:

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The personal emergency response system (PERS) service secures an immediate response and access to assistance in the event of a physical, emotional, or environmental emergency.

A PERS uses a community-based telephonic, global positioning system, or other electronic communications device to provide a direct electronic communications link between the child or youth and emergency responders.

This service may include devices and services necessary for the operation of PERS when otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as appropriate. Electronic devices must meet Underwriters Laboratories® (UL) Standards. Telephonic devices must meet Federal Communications Commission (FCC) regulations.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.
Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Telephone service including cellular
Individual	Community Based Electronic Communications Unit
Agency	Community Based Electronic Communications Unit

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Telephone service including cellular

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Underwriter’s Laboratory and/or Federal Communication Commission or equivalent standard.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Individual

Provider Type:

Community Based Electronic Communications Unit

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Underwriter’s Laboratory and/or Federal Communication Commission or equivalent standard.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System (PERS)

Provider Category:

Agency

Provider Type:

Community Based Electronic Communications Unit

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Underwriter’s Laboratory and/or Federal Communication Commission or equivalent standard.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08020 home health aide
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08040 companion
Category 3:	**Sub-Category 3:**
08 Home-Based Services	08050 homemaker
Category 4:	**Sub-Category 4:**
08 Home-Based Services	08060 chore

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal Supports are individualized supports, delivered in a personalized manner, to support a participant in their home and community in which the participant wishes to be involved, based on their personal resources. Personal Supports is the provision of services to directly assist the participant with daily living activities and personal needs and to assure adequate functioning and safety in their home and community.

a. Personal Supports covers direct assistance with instrumental activities of daily living (IADLs), as well as observation or cueing of the participant to safely and appropriately complete activities of daily living (ADLs) and IADLs.

Personal Supports is related to assistance with functional skills and may help a child who has difficulties with these types of skills accomplish tasks including but not limited to: life safety, medication and health management, communication skills, mobility, appropriate social behaviors, and problem-solving.

Some specific ADL services include but are not limited to: personal hygiene needs, preferences, and techniques for assisting with activities of daily living, including, where relevant, bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.

Some specific IADL services available includes but is not limited to: assistance with bill paying and other aspects of money management; ordering food from a menu; assistance with communication; observation to assure appropriate self-administration of medications; arranging and using transportation; checking out library books; and paying for tickets to events.

b. Personal Supports covers supervision necessary for safety at home and in the community.
Supervision which ensures the level of supervision necessary to keep the waiver participant safe in the home and community. It also may include supervision as the waiver participant engages in other activities. Levels of supervision may include line-of-sight, one-on-one, room-to-room, periodic cuing and check-ins, and within sight distance. Supervision which may include a provider safeguarding the child or youth or utilizing technology for the same purpose. Behavioral needs includes, but is not limited to, the waiver participant’s physical and verbal aggressiveness, sexual inappropriateness, victimization, property destruction, self-harm, suicidal, and stealing. It may include working with the waiver participant to better understand and comprehend cause and effect and the correlation between behaviors and consequences. It may also take the form of repetitive directions, staying on task, levels of receptive language capabilities, and retention of information.

c. Personal supports covers services that consist of the performance of basic household tasks within the participant's primary residence (i.e., cleaning, laundry, or household care) including maintenance which are related to the participant's disability and provided by a qualified homemaker. This assistance must be due to the participant's disability that results in additional household tasks and increases the parent/caregiver's ability to provide care needed by the participant.

d. Pest control to aid in maintaining an environment free of pests to enhance safety, sanitation, and cleanliness of the participant's home or residence. Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/or annoys humans and is causing or is expected to cause more harm than is reasonable to accept.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Other agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Agency	Home Health Agency
Agency	Supportive Home Care Agency
Agency	Commercial pesticide application business
Individual	Certified individual commercial pesticide applicator
Individual	Licensed individual commercial pesticide applicator
Individual	Licensed Practical Nurse
Individual	Registered Nurse
Individual	Other Person appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Individual	Personal Care Worker
Individual	Nurse Aide

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Other agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Other agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

42 C.F.R. § 484,
Wis. Stat. § 50.49,
Wis. Admin. Code ch. DHS 131

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Supportive Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agency providing services receive training on information specific to disabilities, abilities, needs, functional deficits, and strengths of the population to be served. This training should be person-specific for the child or youth to be served and generally focused.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Agency

Provider Type:

Commercial pesticide application business

Provider Qualifications

License *(specify):*

Wis. Admin. Code § ATCP 29.20

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Certified individual commercial pesticide applicator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § ATCP 29.26

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Licensed individual commercial pesticide applicator

Provider Qualifications

License *(specify):*

Wis. Admin. Code § ATCP 29.25

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify):*

Wis. Stat. § 441.10

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Registered Nurse

Provider Qualifications

License *(specify):*

Wis. Stat. § 441.06

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Other Person appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Other Person appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Personal Care Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 105.17(3)(a)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Supports

Provider Category:

Individual

Provider Type:

Nurse Aide

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. ch. 50,
Wis. Admin. Code ch. DHS 129

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Remote Supports and Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The purchase of the equipment and related services, including Internet, is limited to items and services that facilitate accessing waiver services being delivered remotely and increase, maintain, or improve the child's functional capabilities at home, work, and in the community.

The purchase of equipment and related services used strictly for recreational purposes is prohibited.

Payment of recurring costs for the same or similar equipment is not allowable through this service unless it is determined that the item or device has exhausted its useful life or has been rendered unsafe or unusable due to damage or defect. Items not working properly that need repair must be repaired at an authorized service provider.

Electronic devices must meet UL or FCC standards.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.
Agency	Telecommunications equipment or maintenance provider
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.
Individual	Telecommunications equipment or maintenance provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Supports and Equipment

Provider Category:

Agency

Provider Type:

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Supports and Equipment

Provider Category:

Agency

Provider Type:

Telecommunications equipment or maintenance provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of systems or services must ensure that all items meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Supports and Equipment

Provider Category:

Individual

Provider Type:

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Supports and Equipment

Provider Category:

Individual

Provider Type:

Telecommunications equipment or maintenance provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of systems or services must ensure that all items meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Safety Planning and Prevention

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 3:	**Sub-Category 3:**
17 Other Services	17990 other
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Safety Planning and Prevention provides planning and prevention support to keep children safe in their homes and communities. This service includes safety planning and emergency preparedness and involves 1) working with the child and unpaid and paid caregivers to help them learn and prepare for safety and emergency events 2) working with community resources and other waiver service providers to build relationships and plans for the child and family in the event of a safety or emergency event at home or in the community.

Safety planning and emergency preparedness is appropriate for a variety of situations, including but not limited to: dangerous behaviors, natural disasters, community events, and in-home safety.

Safety Planning and Prevention involves education, training, preparation, engagement, implementation and/or coordination with relevant professionals, including but not limited to: law enforcement, fire departments, waiver service providers, and other community services.

This service is holistic, trauma-informed, and culturally/linguistically sensitive and utilizes skillful engagement, meaningful partnerships with families and their support networks, and development of plans to ensure child safety and well-being.

Through Safety Planning and Prevention, the service provider identifies strengths, desires, support needs, expectations, non-verbal and verbal communication preferences and abilities, and goals of child/youth and family. As appropriate, the Safety Planning and Prevention provide identifies external, physical, and other factors that contribute to behavior and affect safety and well-being.

Developing the plan
Safety Planning and Prevention assists participants who without such supports are experiencing, or are likely to experience, challenges at home or in the community as a result of their disability, trauma, behavioral, social, or emotional issues. Safety Planning and Prevention includes developing individualized plans in order to enhance the family and other waiver provider’s ability to keep the child safe and included in their home and community.

For emergency situations where the child/youth exhibits dangerous behaviors that affect the health and safety of the participant and/or their paid and unpaid caregivers, the plan should include action steps to implement strategies that address identified risk factors and dangerous behaviors and maintain optimal health, including positive behavior support, prevention strategies, blocking and redirection approaches, environmental consults and modifications, de-escalation techniques, and other non-coercive strategies.

If planning for a natural disaster, in-home or community safety, or other relevant scenarios, the plan may include strategies and action steps for prevention/mitigation, preparation, response, and recovery. The plan should be developed with input from the child, the family, paid and unpaid caregivers, and other relevant professionals, as appropriate.

Building and Maintaining Partnerships
The service provider may develop and manage relationships with relevant professionals and create safety and/or emergency information documents and plans and distributes among parties, as appropriate. The plans should be reviewed periodically, updated appropriately, and practiced.

Implementing the Plan
In the case of dangerous behavior, Safety Planning and Prevention assists the participant’s paid and unpaid caregivers with developing expertise so that they can help the participant meaningfully and appropriately engage and be involved with others and in the community. This includes instruction and support for unpaid caregivers and/or paid support staff who are implementing support interventions. This service includes training and technical assistance to carry out the plan and monitoring of the waiver participant and the paid and unpaid caregivers in the implementation of the plan. This service includes the provision of training for waiver service providers that are or will be serving participants with complex needs (beyond routine care).

This service also includes consultations with service providers and potential providers to identify providers that can meet the unique needs of the child/youth and identify additional supports necessary. For example, when a child/youth with complex needs is relocating from a state institution, this service may be used to train unpaid caregivers and other waiver service providers on the plans necessary for community integration. Instruction and consultations can be 1-on-1 or in a group to help paid and unpaid caregivers better meet the health and safety needs

of the waiver participant.

In the case of planning for natural disasters, community events, and/or in-home safety, Safety Planning and Prevention assists the participant, unpaid caregivers, and other relevant individuals to understand, practice, and execute the plan. It also may include items and supplies necessary for safety and emergency preparedness for the child.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Cardiopulmonary Resuscitation (CPR) Instructor
Agency	Other providers appropriately qualified
Individual	Licensed Psychologist
Individual	Licensed Applied Behavior Analyst
Individual	Licensed Professional Counselor
Individual	Licensed Social Worker
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Safety Planning and Prevention

Provider Category:

Agency

Provider Type:

Cardiopulmonary Resuscitation (CPR) Instructor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers must use a curriculum based on American Heart Association guidelines.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Safety Planning and Prevention

Provider Category:

Agency

Provider Type:

Other providers appropriately qualified

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of Safety Planning and Prevention services may maintain current state licensure or certification in their field of practice.
Providers of Safety Planning and Prevention services provide services limited to their areas of formal education and training, as directed by their professional code of ethics.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Safety Planning and Prevention

Provider Category:

Individual

Provider Type:

Licensed Psychologist

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. Psy 2

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Safety Planning and Prevention

Provider Category:

Individual

Provider Type:

Licensed Applied Behavior Analyst

Provider Qualifications

License *(specify):*

Wis. Stat. § 440.312

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Safety Planning and Prevention

Provider Category:

Individual

Provider Type:

Licensed Professional Counselor

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 457.12

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Safety Planning and Prevention

Provider Category:

Individual

Provider Type:

Licensed Social Worker

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 457.08

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Safety Planning and Prevention

Provider Category:

Individual

Provider Type:

Other persons appropriately qualified as approved by the State and as related to the unique service being provided

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of Safety Planning and Prevention services may maintain current state licensure or certification in their field of practice.
Providers of Safety Planning and Prevention services provide services limited to their areas of formal education and training, as directed by their professional code of ethics.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical and Therapeutic Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized medical and therapeutic supplies include items necessary to maintain the child's health, manage a medical or physical condition, improve functioning or enhance independence. The cost of items, or devices provided, may be in excess of the quantity of medical equipment or supplies covered under the Medicaid State Plan, when coverage of the additional items or devices is denied. Items or devices provided must demonstrate direct medical or remedial benefit to the participant.

Allowable items may include the following:
• Items and aids designed to augment a professional therapy or treatment plan.
• Items and aids to support environmental regulation assessed as necessary for the child's or youth's condition.

The cost of professional set-up, installation, and routine maintenance (excluding medication set-up) of allowable specialized medical or therapeutic supplies are included in this waiver service.

All items and supplies must meet applicable standards of manufacture, design, installation, safety, and treatment efficacy, such as those established by Underwriter's Laboratory® and the Federal Communications Commission.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.
Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Pharmacy
Agency	Medical Supply Company
Individual	Other providers appropriately qualified as approved by the State as related to unique service being delivered to the child
Individual	Authorized Dealers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical and Therapeutic Supplies

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of systems or devices must ensure that all items meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical and Therapeutic Supplies

Provider Category:

Agency

Provider Type:

Medical Supply Company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code ch. DHS 105

Other Standard *(specify):*

Underwriters Laboratory and/or Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical and Therapeutic Supplies

Provider Category:

Individual

Provider Type:

Other providers appropriately qualified as approved by the State as related to unique service being delivered to the child

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Underwriter's Laboratory and/or Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical and Therapeutic Supplies

Provider Category:

Individual

Provider Type:

Authorized Dealers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Underwriters Laboratory and/or Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Translation and Interpretation Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17020 interpreter
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

This service includes translation and interpretation services necessary to facilitate and assist individuals who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English (Limited English Proficient or LEP skills). The purpose of this service is to assist participants in effectively communicating with family, friends, co-workers, members of their community, and the general public. This service is intended to increase community inclusion and should not be used in situations where a certified interpreter or translator is required or where it is the responsibility of the service provider to ensure language access.

This service does not supplant the responsibility of service providers to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency (LEP). [68 Fed. Reg. 153 at 47322] Providers that must provide language assistance services in order to comply with Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual interpreters
Agency	Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Translation and Interpretation Services

Provider Category:

Individual

Provider Type:

Individual interpreters

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual interpreters must be proficient in the translation of the applicable language and the standards for privacy and confidentiality of participant-related communication.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Translation and Interpretation Services

Provider Category:

Agency

Provider Type:

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individual interpreters must be proficient in the translation of the applicable language and the standards for privacy and confidentiality of participant-related communication.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Transportation maintains or improves the child's mobility in the community and increases their inclusion, independence, and participation in the community.

This service funds the child's or youth's nonmedical, nonemergency transportation needs related to engaging with the community—with the people, places, and resources that are meaningful for their self-determination—and to meet their goals and daily needs. If the child or youth needs transportation to access authorized waiver services, it may be reimbursed through this service. Additionally, the fare or other transportation charges for an attendant, if needed, to accompany the child or youth when accessing the community is included.

Transportation services may include the pre-purchase or provision of such items as bus tickets, train passes, taxi vouchers, ride-share, or other fare or may include a direct payment to providers covering the cost of transportation.

Transportation may also be approved as mileage according to the Federal IRS rules related to mileage reimbursement and DHS established limits. Mileage is calculated based on the starting and ending points and is approved by the number of miles needed. Parents may provide this service if they meet the provider qualifications.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

-Transportation cannot be used to pay for transportation that is the obligation of the school district.
-The transportation service does not cover the participant driving himself/herself to a location.
-The mileage reimbursement rate may not be supplemented to cover vehicle operating, maintenance or repair costs.
-Vehicle adaptations and modifications are excluded (they would be funded as adaptive aids).
-Excludes transportation services to and from medical providers.
-Costs for the participant or the family to maintain a vehicle are excluded.

Only services or items covered under this service that support the child/youth in relocating from an ineligible living arrangement to an eligible community living arrangement may be purchased more than 90 days (or longer with prior DHS approval) prior to the date the participant meets all eligibility requirements for the waiver. Any services provided prior to the date the participant meets all eligibility requirements may be covered as an aggregate total on the date that all eligibility requirements are met.

This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the waiver from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Private Drivers
Agency	Public Carriers e.g. taxi cabs, mass transit
Agency	Specialized Transportation

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual
Provider Type:

Private Drivers
Provider Qualifications

License *(specify):*

Operators License from the Department of Transportation

Certificate *(specify):*

Other Standard *(specify):*

Vehicles in good repair with all operating and safety systems functioning.

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is responsible for verifying provider qualifications and making appropriate screening decisions upon initial agreement, and terminating service authorizations if the provider is no longer qualified. Once a CWA has verified that the provider has self-registered on the Wisconsin Medicaid Waiver Provider Registry and submitted the signed Medicaid Waiver Provider Agreement to the Department, the CWA is responsible to verify that the provider meets the qualifications for each applicable waiver service, as defined in the HCBS Waivers Manual. The CWA verifies the appropriate licensure/certification/registration status through a credential search of the DHS or other state departmental systems (e.g., DHS Wisconsin Nurse Aide Registry and Wisconsin Personal Care Worker Registry, Wisconsin Department of Professional Services, etc.). County waiver agencies terminate their agreements and authorizations for waiver providers based on updated status information, including updated substantiated findings of abuse or neglect, licensure status changes, criminal history information, termination of business or other factors.

Frequency of Verification:

Each responsible agency must ensure provider qualifications initially and at a minimum of every four years thereafter.

As part of the CLTS Waivers annual record review audit, the Department provides oversight of the CWAs functions by verifying the CWA completed all steps necessary to ensure only screened and qualified providers are authorized to deliver waiver services. The DHS reviews the participants ISP and ensures the CWA met all requirements for each listed provider by verifying the CWA:

Ensured the provider is listed on the Wisconsin Provider Registry and signed the Medicaid Waiver Provider Agreement

Conducted a credential search for the provider

Determined the credential (licensure/certification/registration) is appropriate for each authorized waiver service

Verified the provider is appropriately trained and experienced for the authorized waiver service, as defined in the HCBS Waivers Manual

Conducted a caregiver background check and reviewed the results to ensure the provider has no barring crimes, licensure suspensions/revocations, or substantiated findings of abuse or neglect

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Public Carriers e.g. taxi cabs, mass transit

Provider Qualifications

License *(specify):*

Operator's License issued by the Department of Transportation

Certificate *(specify):*

Other Standard *(specify):*

Operator is insured.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Specialized Transportation

Provider Qualifications

License *(specify):*

Operator's License issued by the Department of Transportation

Certificate *(specify):*

Other Standard *(specify):*

Operator is insured, and vehicle is insured, is in good repair with all operating and safety systems functioning.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only registered, screened, and qualified providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to register as a waiver provider and every four years, thereafter, at a minimum.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The requirement for the completion of Wisconsin's caregiver background checks applies to all paid and unpaid service providers who are listed on the Individual Service Plan (ISP), meet the definition of a caregiver, and are authorized to deliver services to a waiver participant. Under Wisconsin's Caregiver Law, s. 50.065, and s. 48.685, caregivers are defined as those persons who have regular, direct contact with participants. "Regular" means contact that is scheduled, planned, expected or otherwise periodic. "Direct" means face-to-face physical proximity to a participant that affords the opportunity to commit abuse or neglect or to misappropriate participant property.

Examples of service providers who meet the definition of a caregiver include but are not limited to: counseling and therapeutic services providers, foster care providers, personal supports providers, and respite providers. Generally, a provider who delivers outside chores and does not have direct access to the waiver participant, such as a snow removal provider, does not meet the definition of a caregiver.

Locally-contracted waiver agencies and their sub-contracted agencies must ensure that a caregiver background check is completed for all persons working as caregivers. The required checks must be completed upon the authorization of a caregiver and repeated every four years, at a minimum.

For caregivers who are employed by agencies contracted by the locally-contracted waiver agency, locally-contracted waiver agencies can meet the requirement for completing caregiver background checks through their contract with the agency and do not need to maintain documentation of the caregivers' background checks.

Locally-contracted waiver agencies are responsible for completing background checks for sole proprietor/individual providers who are caregivers.

When a request is made for a Wisconsin caregiver background check, it triggers an automated inter-departmental search via the DHS Integrated Background Information System (IBIS) of criminal, professional and paraprofessional registries and databases and produces the following:

1. Results from a search of Wisconsin's Department of Justice criminal history records
2. Results from a search of Wisconsin's Caregiver Misconduct Registry, maintained by the Wisconsin Department of Health Services regarding substantiated findings of abuse, neglect and misappropriation of property by non-credentialed caregivers
3. Results from findings of abuse, neglect or misappropriation in another state (if known)
4. Results from search of the status of professional credentials, licenses or certifications maintained by the Department of Safety and Professional Services
5. Denials of revocations of operating licenses for adult programs regulated by the DHS Division of Quality Assurance
6. Denials or revocation of operating licenses for child programs (e.g., day care centers, foster care providers, etc.) regulated by the Department of Children and Families.

A search of the U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG) Exclusions List (LEIE) is also a required screening activity. DHS is the responsible entity for conducting the OIG LEIE screening.

In addition, the State of Wisconsin oversees a Single State Audit process for locally-contracted waiver agencies, as applicable. The waiver program includes requirements for the auditors to assure compliance with the caregiver background checks, as part of the program's audit requirements. The locally-contracted waiver agencies must maintain documentation to ensure that prior to authorizing providers to deliver services to waiver participants, the agency has verified there are no barring offenses (e.g., substantiated finding of abuse or neglect or criminal history record indicating felony for the applicable waiver participant).

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

(a) The Department of Health Services (DHS) requires locally-contracted waiver agencies to ensure a caregiver background check is completed for all paid and unpaid service providers who are listed on the Individual Service Plan (ISP), meet the definition of a caregiver, and are authorized to deliver services to a waiver participant. The DHS maintains a caregiver misconduct registry which is available to the public. The Wisconsin Caregiver Misconduct Registry is a record of the names of nurse aides, personal care workers, and other non-credentialed caregivers with substantiated findings of caregiver misconduct (abuse or neglect of a client, or misappropriation of a client's property). This information must be reviewed regularly to determine appropriate hiring and employment decisions.

A search of the U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG) Exclusions List (LEIE) is also a required screening activity. DHS is the responsible entity for conducting the OIG LEIE screening.

(b) The requirement for the completion of caregiver background checks, which includes an automated search of both Wisconsin's criminal history record information, the Wisconsin Caregiver Misconduct Registry and several other children and adult provider licensure databases, must be conducted for all paid and unpaid service providers who are authorized to deliver services listed on the waiver participant's ISP and meet the definition of a caregiver. Under Wisconsin's Caregiver Law, s. 50.065 and s 48.685, caregivers are defined as those persons who have regular, direct contact with waiver participants. "Regular" means contact that is scheduled, planned, expected or otherwise periodic. "Direct" means face-to-face physical proximity to a participant that affords the opportunity to commit abuse or neglect or to misappropriate participant property. Examples of service providers who meet the definition of a caregiver include but are not limited to personal supports providers, respite providers, child care providers, and foster care providers.

Currently, locally-contracted waiver agencies and their subcontracted entities must ensure that all persons working as caregivers have had a completed caregiver background check. The process is triggered when a request is submitted to the Wisconsin Department of Justice for a caregiver background check. The DHS Integrated Background Information System (IBIS) conducts an automated interdepartmental search of criminal, professional and paraprofessional licensing registry databases and produces the following:

1. Results from a search of Wisconsin's Department of Justice criminal history records
2. Results from a search of DHS Wisconsin Caregiver Misconduct Registry regarding substantiated findings of abuse, neglect and misappropriation of property by non-credentialed caregivers
3. Results from findings of abuse, neglect or misappropriation in another state (if known)
4. Results from search of the status of professional credentials, licenses or certifications maintained by the Department of Safety and Professional Services
5. Denials of revocations of operating licenses for adult programs
6. Denials or revocation of operating licenses for child programs (e.g., day care centers, foster care providers, etc.)

The locally-contracted waiver agency must ensure the required checks are completed upon hire or contract, and that checks are repeated every four years, at a minimum. Providers are also required to report any change in their criminal history record (arrest or conviction) to their employer or contractor.

The waiver program, under the Single State Audit process, requires an audit review as detailed in the contract with the waiver agency, where applicable, to ensure compliance with the provider caregiver background check requirement. The locally-contracted waiver agencies must maintain documentation of all required caregiver background checks and the provisions of contracts related to this requirement. Auditors view the results of the mandatory screening for each paid and unpaid service provider who meets the definition of a caregiver.

In addition, the waiver program implements a comprehensive quality review process through a contracted quality review organization, to ensure the locally-contracted waiver agencies are in compliance with the provider background check requirements.

Information regarding Wisconsin's caregiver background check requirements, including links to the federal HHS Office of Inspector General Exclusion Database, is available on the DHS website.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

◉ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

○ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above

the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  Appendix C-3 details when relatives/legal guardians may furnish waiver services. Services are rendered by relatives/legal guardians when:
  -The service addresses an assessed need and identified outcome and is documented on the participant's ISP.
  -The participant and family's preference is for the individual to provide the service.
  -The individual meets the provider qualifications and standards for the service

  Support and Service Coordinators are responsible for monitoring and documenting that the services purchased from the relative/legal guardian are actually delivered in accordance with the participant's ISP. Locally-contracted waiver agencies mitigate associated risks when concerns are raised about potential payment for unworked hours. DHS and its compliance contractor monitor waiver agencies' oversight of all service providers, including relatives/legal guardians.

  A participant may use a parent who is appropriately qualified to provide Transportation services only.

- ○ **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

DHS administers an online provider registration and qualification process through which any willing and qualified Medicaid provider has the opportunity to enroll, with the exception of providers of Support and Service Coordination services as outlined in the concurrent § 1915(b)(4) waiver application. DHS also administers a single, statewide public directory of providers for the waiver program.

The Provider Registry and Directory allows all willing providers to complete the online registration process at any time and our listed on the statewide directory of providers for the program. Any provider that registers and meets the waiver provider qualifications for the services they indicate they want to provide is enrolled by DHS and listed on the statewide directory of providers.

Enrollment information and forms are continuously available online. A paper form and manual process is available upon request for providers who do not have Internet access or encounter connectivity issues.

Upon entering the registration site, providers receive the following information:
-How to navigate the online registration process
-Requirements for willing providers to sign and submit an executed Medicaid Provider Agreement and accept the DHS-established service rates
-Provider qualifications required for each service type
-Directions of steps required to become a qualified provider
-Information about the online Provider Directory, available to the general public

Providers are instructed to complete the user-friendly registration process, which gathers all data necessary to comply with federal claims processing and encounter reporting requirements, including:
-Provider’s business name
-Provider type (agency, sole proprietor)
-Tax ID Number (TIN), Social Security number (SSN) or federal Employer Identification Number (EIN), as filed with the Internal Revenue Service (IRS)
-Service(s) the provider wishes to deliver
-National Provider Index (NPI), if delivering a medical service
-Licensure or certification
-Agency’s physical service address
-Geographic area the provider wishes to serve
-Provider’s email and website addresses

Then, DHS reviews and confirms the data entered by registering provider. After DHS confirms the provider’s data, the Department lists the provider on the Provider Registry and Directory.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance,

complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C-i-1: Providers initially meet DHS required licensure and/or certification standards and are listed on the Provider Registry. Numerator = Number of providers in the sample who are listed on the Provider Registry and obtained appropriate licensure and/or certification. Denominator = Number of licensed and/or certified providers reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter claim records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Registry

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
C-i-2: Providers continuously meet required licensure and/or certification standards and are listed on the Provider Registry. Numerator = Number of providers in the sample who are listed on the Provider Registry and continuously maintained licensure and/or certification. Denominator = Number of licensed and/or certified providers reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter claim records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Registry

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C-ii-1: Number and percent of non-licensed/non-certified providers who are listed on the Provider Registry and adhere to waiver requirements. Numerator = Number of non-licensed/non-certified providers in the sample who are listed on the Provider Registry and adhere to waiver requirements. Denominator = Total number of non-licensed/non-certified providers reviewed in the sample.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Encounter claim records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Registry

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
C-iii-1: Providers of waiver services meet State and waiver training requirements, as applicable. Numerator = Number of waiver providers in the sample who meet State and waiver training requirements, as applicable. Denominator = Total number of waiver providers with State and waiver training requirements reviewed in the participant sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DHS monitors and follows up with locally-contracted waiver agencies that have been identified as having compliance issues related to willing and qualified providers. Locally-contracted waiver agencies that fail to comply with the qualified provider requirements receive technical assistance and guidance from DHS when individual problems are discovered. DHS works directly with the locally-contracted waiver agency and other entities as appropriate to ensure that the specific issue is resolved. Locally-contracted waiver agencies are responsible for correcting any individual issues discovered and informing their assigned DHS staff of their actions.

If it appears that there is a systems issue of concern, or if performance and compliance does not improve as a result of technical assistance and training, DHS may recommend that a Corrective Action Plan (CAP) be developed with measurable outcomes, including timelines. This CAP is monitored by DHS until compliance is achieved. Any formal corrective action plan is developed in coordination with DHS, and the Department tracks all actions related to the CAP. The Department may also require immediate remedial action and impose CAPs to address these issues. DHS collects and tracks information to ensure appropriate remediation has occurred.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the

future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Wisconsin Statewide Transition Plan was developed by the Department of Health Services in accordance with the Medicaid Home and Community-Based Setting Requirements of the Medicaid Home and Community-Based Services Final Regulation at CMS 2249-F/2296-F.

Per the final rule, the participant's private residence, including the parental home for a child, is presumed to be compliant. Additionally, DHS determined that the following settings would typically meet the requirements of 42 C.F.R. § 441.301(c)(4):

-Places of integrated, competitive employment.
-Community sites predominantly used by the general public for typical community activities, unless specifically prohibited by 42 C.F.R. § 441.301(c)(5), including but not limited to: retail establishments; schools; recreational and entertainment facilities; libraries; places of religious worship; public and private transportation settings such as buses, trains, and private vehicles; restaurants; community centers; professional offices; non-disability related service establishments; streets; and other public accommodations.

The following settings in this waiver also meet the requirements of the rule:

-Family's private residence, whether owned or rented.
-Child care facilities predominantly used by the general public for child care.
-Child care provider's private residence, whether owned or rented, used for child care.

The following settings will also be reviewed for compliance on an ongoing basis:

-Foster homes for children
-Level 5 exceptional treatment foster homes
-Children's day service settings

DHS has determined that the settings listed above are typically integrated in the greater community, or in the case of residences in rural settings, are the person's choice and consistent with the character of such communities; do not segregate or isolate participants, except with respect to private residences in rural areas where such is the chosen preference of the person, or his or her guardian; provide opportunities for regular interaction in daily activities with non-HCBS waiver participants; facilitate participant-centered choice in services, daily activities, and assumption of typical, age-appropriate social roles; and support rights to dignity, respect, autonomy, and freedom from coercion.

As part of the ongoing person-centered planning process used by all waiver agencies in Wisconsin, all settings in which waiver services are delivered, including those described above, will be assessed by the waiver agency or other entity delegated by DHS, to ensure that the setting is not designed in such a way that it isolates the individual from the greater community.

To assure continuing compliance with setting requirements, DHS has done the following:

-Licensed and certified settings are subject to periodic compliance site-visits by the state licensing authority, or by the entity that certified the provider.
-Identification and completion of site-specific remediation by providers.
-Sites found to have continued deficiencies are required to implement corrective actions and can lose their license or certification when non-compliance continues or is egregious.

Waiver Agencies operating Wisconsin's HCBS waiver programs are charged with the continuous evaluation of settings as they fulfill their care management responsibilities. New providers and settings will be subject to an assessment of compliance with the Statewide Transition Plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Service Plan (ISP)

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

DHS has submitted a 1915(b)(4) application, as a companion to the 1915(c) renewal application, to renew approval for qualified individuals employed by locally-contracted waiver agencies (or their sub-contracted case management agencies) to be the sole provider to deliver Support and Service Coordination services.

The only services that locally-contracted waiver agencies will be permitted to deliver to waiver participants and seek waiver claim payment, in addition to Support and Service Coordination, includes the following:
-Allowable services provided through foster care.
-Purchased products and supplies from third-party entities and vendors for which the locally-contracted waiver agency receives no benefit from the vendor.
-Prepayment for waiver allowable services from subcontractors where the locally-contracted waiver agency makes the payment to the vendor.

For all other waiver services, the SSC must provide full disclosure and assurance to the participant and the parent/guardian to support their right to free choice of providers, as well as information about the full range of covered waiver services. In addition, the locally-contracted waiver agency must administratively separate the function and individual responsible for developing the ISP from the direct service functions for allowable services provided through foster care or products and supplies purchased from third-party entities and vendors.

A conflict of interest is present whenever a person or any other entity involved in operating any part of the waiver has an interest in or the potential to benefit from a particular decision, outcome or expenditure. A single individual, agency or entity occupying several roles often signals that conflict of interest may be present.

DHS requires locally-contracted waiver agencies to operate the waiver program in a manner that is free of conflict of interest, to the greatest extent possible. Where conflicts cannot be eliminated, they must be identified and their impact must be minimized by the intervention of the locally-contracted waiver agency. Conflict of interest situations that must be addressed include both those that are present and those that may be perceived. Each locally-contracted waiver agency must have a written policy or plan to address conflict of interest. If resolving or mitigating the conflict is not feasible, the locally-contracted waiver agency must take action to minimize the effect(s) of the conflict. These efforts are subject to DHS review.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Individual Service Plan (ISP) is developed through a person-centered and family-centered ISP assessment process that is focused on identifying the child's needs and learning about the desired child and family outcomes. Families are critical partners in the development of the desired outcomes for the child and the necessary supports and services required to achieve these outcomes in home and community settings.

The Support and Service Coordinator gathers information for the ISP by involving the people who know the child well, such as parents, other family members, friends, and other caregivers to gain a clear understanding of the child's strengths and needs. The child and family determine who is involved in the ISP development process and can invite and include anyone they believe will be helpful in the ISP development process.

The Support and Service Coordinator provides information to the participant and family regarding the application process, waiver participation, freedom of choice, rights and responsibilities, and allowable supports and services under the waiver program, as well as other formal and informal community supports.

In cases of participant and family-direction, while participants, family members, and guardians are included in the service plan development process, the Support and Service Coordinator still serves as the case manager is responsible for completing the ISP.

Families are also able to access information regarding the waiver program requirements and covered services on the DHS website.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Individual Service Plan (ISP) is developed by the Support and Service Coordinator (SSC) in partnership with the child's parent(s) or guardian, and the child, as appropriate to the child's age and ability. The purpose of the ISP assessment is to gather current, comprehensive information about the child/youth to determine which services, supports, and environmental modifications will benefit the child, build on the child's strengths, and maximize the child's independence and community participation.

To develop the ISP with the participant and the family, the Support and Service Coordinator (SSC) uses a step-by-step team approach to facilitate dialogue between SSCs and families using a family-centered, collaborative decision-making framework to develop comprehensive outcome-based support plans. This approach recognizes and maximizes the child and family's capacities, resiliency, and unique abilities, and promotes self-determination and inclusion in all facets of family and community life.

The SSC who completes the ISP assessment must have the skills needed to facilitate the child and family's identification of individual outcomes. This includes a focus on the whole child, not solely on functional deficits. An understanding of the child and family is essential to helping to translate a stated wish or goal or personal priority into an attainable individual outcome. The SSC assists the child and family to identify and include those with an important role in their life or knowledge of their situation to participate in the process.

The content of the ISP assessment includes identifying the child and family's needs as well as desired individual outcomes. The individual outcomes identified are child-specific, based on the child and family's lifestyle, goals, ambitions, values, personal preferences and priorities. It includes, but is not limited to, preferences in the following areas: service delivery method, living arrangement, medical care, and community participation. The process also gathers information on abilities, needs, desired outcomes, current supports, and the range of choices and services that may be beneficial. The ISP assessment is the basis for the service plan development. This ensures that the ISP is tailored to meet the child and family's identified outcomes and the needs of the child. The services and supports provide an alternative to institutional care.

The following topical areas are explored and documented as a result of the ISP assessment:
-Background and social history
-Physical and medical health history
-Individual outcomes important to the child and family
-Ability to perform physical activities of daily living
-Ability to perform instrumental activities of daily living
-Emotional and cognitive function
-Behaviors that positively or negatively affect lifestyle or relationships
-Social participation, friendships, existing formal and informal social supports
-Cultural, ethnic and spiritual traditions and beliefs
-Community participation and involvement
-Personal preferences for how and where to live, including daily activities
-Potential benefits and risks associated with identified behaviors
-Future plans, including the child's or youth's ability to direct their own supports
-Preferences regarding physical environment
-Available resources and how they're managed
-Need for long-term community support services as an alternative to institutional care
-Rights of the child or youth and the family, and their ability to understand and assert them
-Formal and informal supports available to the child and family
-A review of the child and family's interest and ability to self-direct supports.

The ISP results from the ISP assessment, utilizing the most cost-effective waiver and non-waiver funded resources available to bridge the gap between the needs identified in the ISP assessment and the desired individual outcomes. The services and the service providers listed on the ISP reflect the family and, to the extent possible, child's desired outcomes and preferences identified through the course of an informed decision-making process. The ISP integrates the services listed with the individual outcomes.

The ISP contains individual demographic information and summarizes the individualized supports and services designed to address the child and family's individual outcomes. The plan establishes services provided, the identified provider, service costs, frequency, and funding sources. ISP content must include:

• A statement of the child's or youth's and family's desired outcomes and priorities. Outcomes summarize the child's or youth's and family's goals and the results they would like to see. These form the basis for determining the supports and services to include in the ISP to help the child or youth and family meet their goals.
• A description of the waiver's supports and services to be used, including frequency, intensity, annual cost, provider information, care levels for applicable services, and any unique restrictions or specifications.
• Supports and services in place for the child or youth provided through other programs and/or systems, and unpaid and informal supports.
• If applicable, any reason(s) a family's preferences for supports and services were not able to be accommodated.

A complete service plan consists of the Individual Service Plan and the Individual Service Plan Outcomes. The ISP must be completed within 60 days from the date the Department identifies the child for enrollment.

The locally-contracted waiver agency obtains the signatures of all individuals, including the essential providers responsible for the ISP's implementation. The locally-contracted waiver agency will distribute a copy of ISP to the parent(s)/guardian, the participant (if applicable), and the essential provider responsible for the ISP's implementation, according to applicable program policies.

The ISP represents an agreement between the waiver agency, the family, and the child as to how the program will meet the identified needs of the participant, and in so doing, help the child reach their desired outcomes. The ISP is an evolving instrument that can be adapted to meet changes in the child and family needs and preferences at any time. The ISP may also be adapted to address changing conditions among formal or informal supports, including waiver service providers. The ISP must be updated to reflect whenever changes occur in services provided or when there is a change in the provider of service.

At a minimum, the SSC must review and update an ISP every six months during a face-to-face visit with the child or youth and the family; however, the ISP must be reviewed as needed. This review is documented in the participant record maintained by the locally-contracted waiver agency. The case note indicates that the plan review was conducted and current services and support needs were discussed and evaluated by the parent(s)/guardian, participant (based on the age of the child), and the SSC. The updated ISP will describe any changes that will be made (e.g., increases or decreases in service hours, change of service provider(s), addition or removal of services or supports). Changes are also made upon the identification of new or increased service needs that must be addressed or made as the review identifies new preferences or desired outcomes.

For participants who have a guardian, activated power of attorney, authorized representative, or other legal representative, the six-month face-to-face meeting with the participant remains mandatory however, the guardian/legal representative must sign the updated ISP. The contact with the guardian/legal representative should be face-to-face as well.

When there is a change to the service plan, a completed copy of the ISP must be placed in the participant record. A copy of the updated ISP should be provided to the parent/guardian, the participant, if 14 years or older, essential providers—as identified by program policy—and the legal representative, if applicable.

During the process of completing the service plan, the SSC will explain the federal requirement to share information, and work with families to help ensure that they understand that the child or youth's outcomes will be shared with essential service providers included on the child's plan. For non-essential providers, the locally-contracted waiver agency will attach a copy of the provider's signed service contract, agreement, or authorization to the ISP.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Both the level of care determination and the ISP assessment process identify possible risks and concerns related to available community support and services. Any issues identified through these processes are addressed within the development of the ISP. The Support and Service Coordinator must identify any potential risk that exists for the child and/or family. The Support and Service Coordinator, in coordination with the child, family, guardian, child welfare, court system, school, medical professionals, service providers, and others, as appropriate, develops a response plan to minimize, reduce or eliminate the potential of harm to the child's health, safety, and welfare whenever risks are identified.

The Support and Service Coordinator must also determine whether any service may poses a risk to the child's health, safety, and welfare, if it is not provided as scheduled. Services which pose a risk to the child if not delivered in a timely manner, according to the agreed upon schedule, must be identified in the ISP and include back-up plans to assure the child's continued health and safety. The ISP back-up plan may include an on-call or crisis response system as available by either the provider or the locally-contracted waiver agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

All children and youth and the families participating in the waiver must be given a choice of qualified service providers as required by 42 CFR §431.51. Locally-contracted waiver agencies are responsible to inform the child or youth and the family of their right to choose willing and qualified providers. This takes place at each review of the child's or youth's individual service plan (ISP), including but not limited to initial plan development, six-month plan review, and review during annual recertification. The information given to the child or youth and the family must include:
-The full range of services available through the waiver.
-A description of all qualified providers available for the services the child or youth is authorized to receive.
-Information about options and processes for the child or youth to dispute whether other entities or providers could deliver the services authorized for them.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The ISP must be completed within 60 days from the date the Department identifies the child for enrollment.

The locally-contracted waiver agencies must ensure that all ISP revisions and covered services are prior authorized and issued to both waiver providers and the TPA vendor, on a timely basis, to ensure scheduled service delivery to the participant and prompt payment to the provider.

The Provider Agreement and Acknowledgement of Terms of Participation includes instructions to locally-contracted waiver agencies articulating the Department's authority to review any ISP, upon request.

A representative sample of the waiver program applications is reviewed by the Department's contracted quality review organization on an annual basis as part of the onsite record review protocol. A statistically significant representative sample of records is established as part of the record review protocol.

The record review protocol also includes a review of the family-centered assessment, the health, safety and welfare of the child, including potential risk, and the services and supports included in the service plan to meet the assessed needs and identified outcomes of the child and family.

The Department offers technical assistance, as necessary, to locally-contracted waiver agencies to assess whether or not a plan is reasonably appropriate to meet the child and family's identified needs and outcomes.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ◉ **Every six months or more frequently when necessary**
- ○ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☒ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Support and Service Coordinators coordinate and facilitate access to all services and supports, both formal and informal, which are needed by the child and family to meet their identified outcomes. This includes managing, coordinating, and monitoring the ISP, as well as informal supports, consistent with the child and family's identified outcomes, in a planned, coordinated, and cost-effective manner. The SSC assures that services are delivered in accordance with waiver program requirements, and the child's identified outcomes. A primary responsibility of the Support and Service Coordinator is promoting the child's health, safety, welfare and inclusion in their home and community.

Section D-1-e Risk Assessment and Mitigation further describes Wisconsin's remediation of incidents and events.

Every child or youth and the family require varying levels of engagement with the SSC. At a minimum, the SSC is required to make the following contacts:
-Monthly collateral contact
-Direct contact with the family every three months
-Face-to-face contact at least every six months (with the child or youth)
-Annually, at least one of the face-to-face contacts is required to take place at the child and family's place of residence.

The determination of the type and frequency of contacts with the child or youth, their caregivers, and their providers is based on the following variables as applicable:
-The child's or youth's health
-The capacity of the child or youth and the family to direct the child's individual service plan
-The strength of in-home supports and the child's or youth's informal support network.
-The stability of provider staffing (frequency and reliability of staffing, turnover, and availability of emergency backup staff)
-The stability of the child's or youth's individual service plan (for example, history of and/or anticipated frequency of change or adjustment to the plan)
-The frequency and types of critical incidents
-The amount and types of involvement with other systems

Based on the factors detailed above, the SSC works with the parent/guardian, participant and chosen providers to develop and monitor a "back-up plan" if necessary. This plan is coordinated and monitored and adjusted as necessary to meet the child and family's needs. The SSC is responsible to inform the Department in a timely manner when an incident occurs and intervention is required.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

DHS has submitted a 1915(b)(4) application, as a companion to the 1915(c) renewal application, to renew approval for qualified individuals employed by locally-contracted waiver agencies (or their sub-contracted case management agencies) to be the sole provider to deliver Support and Service Coordination services.

The only services that locally-contracted waiver agencies will be permitted to deliver to participants and seek waiver claim payment, in addition to Support and Service Coordination, includes the following:
- Allowable services provided through foster care.
- Purchased products and supplies from third-party entities and vendors for which the locally-contracted waiver agency receives no benefit from the vendor.
- Prepayment for waiver allowable services from subcontractors where the locally-contracted waiver agency makes the payment to the vendor.

For all other waiver services, the SSC must provide full disclosure and assurance to the participant and the parent/guardian to support their right to free choice of providers, as well as information about the full range of covered waiver services. In addition, the locally-contracted waiver agency must administratively separate the function and individual responsible for developing the ISP from the direct service functions for allowable services provided through foster care or products and supplies purchased from third-party entities and vendors.

A conflict of interest is present whenever a person or any other entity involved in operating any part of the waiver has an interest in or the potential to benefit from a particular decision, outcome or expenditure. A single individual, agency or entity occupying several roles often signals that conflict of interest may be present.

DHS requires locally-contracted waiver agencies to operate the waiver program in a manner that is free of conflict of interest, to the greatest extent possible. Where conflicts cannot be eliminated, they must be identified and their impact must be minimized by the intervention of the locally-contracted waiver agency. Conflict of interest situations that must be addressed include both those that are present and those that may be perceived. Each locally-contracted waiver agency must have a written policy or plan to address conflict of interest. If resolving or mitigating the conflict is not feasible, the locally-contracted waiver agency must take action to minimize the effect(s) of the conflict. These efforts are subject to DHS review.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D-i-1: Most recent ISP addresses participant's assessed needs, health & safety risks, personal goals, & outcomes through the provision of waiver & non-waiver services.
Numerator= # of most recent ISPs reviewed that addressed assessed needs, health & safety risks, personal goals, & outcomes through waiver and/or non-waiver services.
Denominator= Total # of most recent ISPs reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D-iii-1: ISPs are updated / revised by the SSC at least annually or as warranted by

changes in the waiver participant's needs. Numerator = Number of records reviewed in the sample that indicate the ISP was updated by the SSC at least annually or as warranted by changes in the waiver participant's needs. Denominator = Total number of records reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D-iv-1: Services were delivered consistent with the ISP. Numerator = Number of records in the sample where evidence indicates the waiver services were delivered consistent with the ISP. Denominator = Total number of records reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter claim records

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
D-v-1: Participants, parents and/or guardians were afforded choice between and among waiver services and providers. Numerator = Number of records reviewed that includes clear documentation that the SSC offered choice of waiver services and providers. Denominator = Total number of records reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
D-v-2: Parent/guardian input was used to develop the ISP based on the child and family's needs and goals. Numerator = Number of surveys in the sample that reflect parent/guardian input was used to develop the ISP. Denominator = Total number of surveys reviewed in the sample.

Data Source (Select one):
Participant/family observation/opinion
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DHS directly monitors locally-contracted waiver agencies when the need to correct any issues is discovered through the review of service plans. Locally-contracted waiver agencies are responsible for correcting any individual issues discovered and informing DHS.

Issues are tracked from identification to final resolution. DHS may recommend development of a corrective action plan in some cases where there appears to be a systems issue. The Department may also require immediate remedial action and impose corrective action plans to address these issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget

or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The participant and family-direction option gives participants and families the freedom to make choices and plan how services best fit into their lives, authority to control the resources allocated to them to acquire needed supports, a more flexible system, the opportunity to choose their own supports and the responsibility to make choices and take responsibility for those choices. For participants and families who wish to direct their services, this flexible system may help them live more productive and participatory lives within their homes and communities.

Participant and family-direction opportunities support participant and family preferences and honor their desire to direct their own services; how and when supports and services are provided; and who will assist them in developing and monitoring a support and spending plan that accurately reflects their identified outcomes.

Services provided under the waiver are specifically tailored to the interests, preferences, needs, and identified outcomes of the child/youth and the family and respectful of the personal values and lifestyle of the participant and the family.

A participant and the family may elect employer authority or budget authority and can direct a single service or all of their services for which participant and family-direction is an option.

The Participant and Family-Directed Service Model affords participants or their designated representative the opportunity, among others, to:
1) Identify goals during the ISP assessment process with a Support and Service Coordinator
2) Identify service providers that meet their needs and identified outcomes
3) Specify how services are provided
4) Set wages in accordance with waiver program service rates and schedule workers
5) Orient, manage, and discharge workers
6) Utilize Participant and Family-Direction Broker Services to assist with employer responsibilities
7) Work with a Fiscal Management Services provider to assist with budget and payment responsibilities.

See Appendix E-1-g for information on participant direction opportunities available for each waiver service. The provider of each service must meet the DHS established provider qualifications for the specific service. Participants and families can specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3.

The Support and Service Coordinator will share information regarding the components of participant/family directed services to the child and the representative at the time of assessment planning and at least annually thereafter. Support and Service Coordinators must discuss the benefits, responsibilities and potential liabilities of utilizing this option with the participant and family.

The following entities can provide support services to participants in the Participant and Family-Directed Service Model: Support and Service Coordinators, Participant and Family-Direction Broker Services, and Financial Management Services. The SSC will provide supports that enable the participant and family to identify and address how to meet the child and family's outcomes while ensuring the protection of the child's health and safety. SSCs responsibilities include but are not limited to:
1) Providing information to the participant to support informed decisions about what service design and delivery will work best for the participant and their support network in accordance with their identified outcomes;
2) Sharing information with the participant and family about the rights, risks, and responsibilities of the Participant and Family-Directed Service Model.
3) Explaining roles and responsibilities of the Participant and Family-Direction Broker Services, and the FMS pertaining to the types of available supports within the Participant and Family-Directed Service Model;
4) Providing information related to participant and family-directed service options, Support Brokers, and the FMS services and providers/vendor options for the participant to choose;
5) Facilitating the timely development and revision of the ISP and budget designed to meet the participant's needs, preferences, goals, and outcomes in the most integrated setting and cost-effective manner;
6) Monitoring the provision of services and conducting related follow-up activities.

Locally-contracted waiver agencies will assure the following:
-Participants, families, other natural supports, and providers have access to information that describes the Participant and Family-Directed Service Model;
-Children, families and other natural supports are involved in developing the ISP and involved in the ongoing oversight of the plan;

-Service plans developed with participant and family direction are based on the individual goals and preferences that allow the child to live in the community, establish meaningful community associations, and make valued contributions to the community;
-A flexible array of services and supports that meet the participant's identified outcomes and provides choice as to nature, level and location of services;
-Participating children and families, guardians and other natural supports are supported to know their rights; learn about the aspects of participant and family direction to permit greater control of decision-making and to develop skills to be more effective in identifying and implementing personal goals;
-Consultation, problem-solving, and technical assistance to assist children and families in accessing and developing the desired support(s); and
-Assist in securing administrative and financial management assistance to implement the supports(s).

Participant and Family-Direction Broker Services are offered as an optional service to participants and families who elect to direct their own services. Participant and Family-Direction Broker Services help the participant and the family in meeting their participant and family-direction responsibilities.

Financial Management Services are designed to act as a fiscal intermediary to assist the participant and the family in managing their waiver service funding. FMS providers assist with employer and budget related functions as per federal, State, and local laws, regulations, and policies necessary for successful participant and family-direction.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

  Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Participant and family directed services and supports involve a number of components related to the child and family's ability fulfil their employer and budget authority responsibilities.

Waiver participants and their parents/guardians who choose to participate in family direction must demonstrate the following:
- The skills to direct service providers to assure quality service delivery;
- The ability to maintain quality records to document delivered services;
- The ability to manage within a specified budget;
- The ability to direct providers to meet the individual needs of the child; and
- The ability to work within a team and direct their team in an effective manner.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The locally-contracted waiver agency's Support and Service Coordinator will share information regarding the components of participant/family directed services to the child and the representative upon initial ISP development and at least annually thereafter. During the ISP development and review, the Support and Service Coordinator will review all possible service options and service delivery methods available under the waiver. Support and Service Coordinators must discuss the benefits, responsibilities and potential liabilities of utilizing this option with the participant and family.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Participant and Family-Direction Broker Services	☒	☒
Child Care Services	☒	☒
Remote Supports and Equipment	☒	☒
Safety Planning and Prevention	☒	☒
Specialized Medical and Therapeutic Supplies	☒	☒
Empowerment and Self-Determination Supports	☒	☒
Translation and Interpretation Services	☒	☒
Home Modifications	☒	☒
Financial Management Services	☒	☒
Community Integration Services	☒	☒
Respite	☒	☒
Grief and Bereavement Counseling	☒	☒
Family/Unpaid Caregiver Supports and Services	☒	☒
Assistive Technology and Communication Aids	☒	☒
Health and Wellness	☒	☒
Daily Living Skills Training	☒	☒
Community/Competitive Integrated Employment	☒	☒
Day Services	☒	☒
Adaptive Aids	☒	☒
Mentoring	☒	☒
Discovery and Career Planning	☒	☒
Housing Support Services	☒	☒
Transportation	☒	☒
Personal Emergency Response System (PERS)	☒	☒
Participant and Family-Directed Goods and Services	☒	☒
Counseling and Therapeutic Services	☒	☒
Personal Supports	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services providers (also referred to as the fiscal intermediary or the fiscal agent) performs financial transactions on behalf of the child or youth for the delivery of waiver services. FMS are provided as a waiver service by non-governmental individual or agency vendors that are qualified. The locally-contracted waiver agency offers the participant and/or their parent or guardian a choice among available FMS providers that meet the qualifications for this provider type.

Providers are initially qualified by the Department of Health Services and fully qualified by the locally-contracted waiver agency. FMS providers must submit a waiver program provider agreement and acknowledge of terms of participation.

The Financial Management Services provider is subject to an audit to ensure all transactions have been properly executed. This service excludes payments to court appointed guardians or court appointed representative payees if the court has directed them to perform these functions.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS administrative costs are considered costs related to the delivery of services chosen by the child's family, and are paid in accordance with the statewide rate schedule. The FMS submit their waiver service claims to the contracted TPA vendor for payment.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☐ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☐ **Other**

  Specify:

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

  Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

  Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

a) In addition to the discovery methods DHS employs for ALL waiver services, which are outlined throughout this application, the Support and Service Coordinator works closely with the child's family to monitor performance of the FMS provider. The Support and Service Coordinator monitors the integrity of the financial transactions. This is done by reviewing submitted time sheets and confirming directly with the child's family to ensure services were delivered as expected. In addition, the Third Party Administrator (TPA) claims vendor reviews, processes, and adjudicates provider claims. The TPA vendor brings any claim anomalies or trends to the Department's attention for further investigation.

b) The Support and Service Coordinator and DHS use discovery methods described in this application for all waiver services.

c) The Support and Service Coordinator monitors the integrity of the financial transactions on a monthly basis. DHS employs discovery and remediation activities as described in this application for all waiver services.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Participant and Family-Direction Broker Services	☐
Child Care Services	☐
Remote Supports and Equipment	☐
Safety Planning and Prevention	☐
Specialized Medical and Therapeutic Supplies	☐
Children's Foster Care	☐
Empowerment and Self-Determination Supports	☐
Translation and Interpretation Services	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Modifications	☐
Financial Management Services	☐
Community Integration Services	☐
Respite	☐
Grief and Bereavement Counseling	☐
Family/Unpaid Caregiver Supports and Services	☐
Assistive Technology and Communication Aids	☐
Health and Wellness	☐
Daily Living Skills Training	☐
Community/Competitive Integrated Employment	☐
Day Services	☐
Adaptive Aids	☐
Mentoring	☐
Discovery and Career Planning	☐
Housing Support Services	☐
Transportation	☐
Adult Family Home	☐
Personal Emergency Response System (PERS)	☐
Support and Service Coordination	☒
Participant and Family-Directed Goods and Services	☐
Counseling and Therapeutic Services	☐
Personal Supports	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

- (●) **No. Arrangements have not been made for independent advocacy.**
- ( ) **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Voluntary termination of participant direction can occur anytime a participant or parent/guardian determines they no longer wish to participate in this service delivery model.

The Support and Service Coordinator is responsible to transition all service delivery activities to the locally-contracted waiver agency so that the participant can engage in a traditional service delivery model. Services are not discontinued or disrupted during this transition period, thus ensuring service continuity and participant health, safety and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of participant/family direction can occur after remediation strategies fail under the following circumstances:
- The child's health and safety, or another person's safety is threatened;
- Individual expenditures are inconsistent with the budget and the plan;
- Conflicting interests of another person are taking precedence over the desires and interests of the child; or
- Funds have been used for illegal purposes.

In the event that funds have been used for illegal purposes the Support and Service Coordinator must contact their County Corporation Counsel to begin an investigation at the local level and submit an Incident Report to DHS. If the local investigation confirms a finding of fraud, the county contacts the DHS Office of Inspector General (OIG) who engages Wisconsin's Department of Justice in prosecution and recoupment activities regarding Medicaid fraud. Any provider found guilty of Medicaid fraud is placed on the caregiver misconduct registry and is reported to the U.S. Department of Health and Human Services OIG Exclusions List, and is barred from the ability to deliver Medicaid-funded services.

If a locally-contracted waiver agency restricts or terminates the child and family's ability to direct their services, then the child and family receive information regarding the specific steps necessary for the restrictions or termination to be withdrawn. If the level of participant and family-direction is restricted, then the locally-contracted waiver agency also informs the child and family about their right to file a grievance or request a Fair Hearing if he or she disagrees with the limitation. The locally-contracted waiver agency is required to have written policies and procedures in place as to how it would assist children and families in attaining or regaining participant and family-directed authority.

The Support and Service Coordinator is responsible to transition all service delivery activities to the locally-contracted waiver agency so the participant can engage in a traditional service delivery model. Services are not discontinued or disrupted during this transition period, thus ensuring service continuity and participant health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1765
Year 2		1876
Year 3		1975
Year 4		2062
Year 5		2140

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports

are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Private financial management agencies and fiscal intermediaries, local government agencies and any other appropriately qualified to provide financial management services.

☐ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Caregivers employed by a participant through a fiscal agent system or under a self-directed services plan must have caregiver background checks completed. Locally-contracted waiver agencies are not responsible for completing background checks for these caregivers and can contract with financial management service providers to meet this requirement.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☐ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☐ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☐ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Support and Service Coordinator works with the family to assess the child's disability-related support needs and to identify the services necessary to meet the identified outcomes in order to develop the child's ISP.

The amount of the individual budget is determined by costing out the services and supports in the ISP, after an ISP that meets the participant's identified outcomes has been developed. In the ISP, each service or support is identified in amount, scope, and duration. The participant and family-directed budget should be developed for a reasonable period of time that allows the participant to exercise flexibility (usually one year). A dollar value is assigned to the plan using the traditional service delivery system payment rates. This creates the total participant and family-directed budget for which the participant can exercise employer and budget authorities. This information is discussed verbally and written on the child's ISP, which the parent authorizes.

Once services are being delivered, the Department's Third Party Administrator (TPA) claims vendor issues weekly provider claims reports to assist the waiver agencies to monitor their budgets. This information helps the SSC identify and respond to increasing service utilization and costs, so that they can work with the family to both help bring expenditures under control and ensure that the changing needs of the child are adequately addressed. The SSC has the authority to adjust the budget based upon the child's unique or changing needs and identified outcomes.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The SSC completes the Individual Service Plan which outlines the specific budget for each service as well as for the entire plan once the budget is established. The child and family are partners in this process and are supported to take the lead on establishing needed supports and service providers. The details of service providers and other information are documented on the ISP. The child, when appropriate and possible, the parents or guardian, and the SSC sign the ISP. This process serves as a formal contract between the child and family, and waiver agency.

Modifications to the participant and family-directed budget must be preceded by a change in the service plan. When the child's family identifies a change in need or services, the SSC adjusts the service plan to reflect the change in services. This is the case for participants using participant and family-directed supports as well as those using traditional supports.
Adjustments to a waiver participant's service plan must be based upon an identified outcome(s). All changes or modifications to the child's services and/or budget must be reflected on the ISP and the Outcomes document.

During the annual onsite record review process, any participant requests or other information in the child's file is reviewed to ensure that changes in the child's needs are reflected by updates and changes to the child's ISP.

If a participant's request for budget adjustment is denied or outcome of the budget is reduced, the participant has the opportunity to request a Fair Hearing as outlined in Appendix F-1. Parents, or other legal representatives, receive notification of their rights and responsibilities, which explains the fair hearing process, at application, upon service plan development and at least annually thereafter. Parents, or other legal representatives, also receive this document whenever eligibility or services are changed, reduced or denied. The SSC has the additional obligation of explaining these rights and responsibilities and assuring that parents, or legal representative, as well as the child when appropriate, understand the information contained in the notification.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The SSC works closely with the child and family to monitor ongoing costs to ensure these are within the individual budget and that they will not be depleted prematurely. The Department's contracted TPA claims vendor issues a weekly provider claims reports to assist locally-contracted waiver agencies to monitor their budget allocations.

Specified staff at locally-contracted waiver agencies have access their agency's adjudicated encounter claims data, which is stored in the DHS data warehouse. In addition, the SSC uses the provider claim reports and encounter claim reports to monitor whether services are delivered as authorized to meet the child's needs.

In addition, the TPA claims vendor flags potential over expenditure or budget underutilization to the attention of the Department; e.g., insurance coordination of benefits, authorization problems, provider claim modifiers, etc.

Providers must submit their claims to the TPA according to DHS timelines. When claims are submitted first to another funding source (e.g., private health insurance), providers must submit their claims for waiver reimbursement according to DHS timelines after the coordination of benefits.

The SSC identifies and responds to increasing service utilization and costs, and can both help ensure expenditures are cost-effective and that the changing needs of the child are adequately addressed. The SSC also maintains regular direct contact with the child's family to monitor the quality of services provided and verify that the level of services continues to meet the child's needs.

The SSC is responsible to provide the necessary authorizations of services to the FMS agency to ensure the child has funding available to reimburse the child's directed services. The TPA claims reports assist the SSC in tracking the expended funds and services that have been delivered. The waiver agency is responsible for ensuring that the participant's funds are spent appropriately.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the

request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Specific rights protect waiver applicants, participants, and the family or other legal representatives. Along with these rights, the applicant, participant, the participant's family or other legal representatives, have responsibilities as a condition of participation in the Medicaid HCBS waiver.

The Model Participant Rights and Responsibilities Notification document details these rights and responsibilities. Parents, or other legal representatives, receive this document at application, upon service plan development and at least annually thereafter. A notification of rights explains the options that are available to applicants and participants to request an appeal of an action or decision related to their enrollment in or services authorized for them through the waiver, file a complaint, and/or file a local grievance; how any of these actions can be completed; and how the locally-contracted waiver agency will help them to complete these actions.

Parents, or other legal representatives, also receive this document whenever eligibility or services are changed, reduced, or denied. The Support and Service Coordinator (SSC) has the additional obligation of explaining these rights and responsibilities and assuring that parents, or legal representative, as well as the child when appropriate, understand the information contained in the notification. The child and family, or legal representative, at initial application and annually each year thereafter, sign the document. The child and family, or legal representative, receive a copy. The original signed document is placed in the participant's file with the waiver agency.

The Functional Screen has system logic to determine functional eligibility for the waiver, based on the data entered by trained and certified screeners. If the child is determined not functionally eligible for the waiver upon initial screen or recertification, the waiver agency notifies the family in writing of their right to request a Fair Hearing. If the child and family's services are terminated, reduced or changed, the SSC also notifies the family verbally and in writing of their right to request a Fair Hearing. This notice details the denial or discontinuation of eligibility and provides specific information about the hearing request process, as well as relevant timelines and the effective date of the action taken. Locally-contracted waiver agencies are required to provide specific details of grievance procedures in the notification of rights. When an adverse action is taken, the notification of rights and notice of action information must be provided to the family. The information on the right to appeal includes the name and address of the Department of Administration, Division of Hearings and Appeals. The notice also informs the child and family of the right to contact Disability Rights Wisconsin for assistance and advocacy.

A locally-contracted waiver agency may not take any adverse action to a waiver participant's eligibility or authorized services, without issuing the participant a ten-day notice of the action, as well as the appeal information previously noted. Participants must be given notice of adverse action for any action that may adversely affect their enrollment in or the supports and services authorized for them through the waiver.

A notice of action must be provided with the Model Participant Rights and Responsibilities Notification and state all of the following: 1) the proposed action 2) the reasons why the action is proposed 3) the specific regulation supporting the action 4) the effective date of the action and 5) the child's or youth's and their parents' and/or legal guardians' rights, including procedures for state appeals and fair hearings by the Wisconsin Department of Administration's Division of Hearings and Appeals and local grievances.

If the child has previously been determined eligible and is receiving services, then eligibility and services must continue pending an appeal, as long as the child and family, or legal representative, appeals the decision before the date of the adverse action stated in the notice letter. If a family no longer wishes to continue services pending an appeal, the family must indicate they want to discontinue services. The waiver agency retains original documentation of the adverse action and notification of the right to a Fair Hearing, with a copy sent to the Department of Health Services.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ◉ **No. This Appendix does not apply**
- ○ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Incidents that must be reported to DHS include:
-Death
-Broadly defined allegations of physical, psychological, emotional, verbal and sexual abuse, neglect, and exploitation (ANE), including substantiated cases of ANE
-Errors in medical or medication management that result in a significant adverse reaction that requires hospitalization
-Hospitalization due to involuntary or voluntary psychiatric emergency
-Unauthorized use of isolation, seclusion, restraint, or restrictive intervention by a service provider
-Any instance of law enforcement contact or investigations of an event or allegation regarding the child or youth as either the perpetrator or victim.

If an incident poses an active, ongoing, and continued significant risk to the child's or youth's health, safety, and welfare, the incident is deemed critical.

The locally-contracted waiver agency's incident management protocol must define who is required to report incidents and the procedure for reporting. The child or youth's family and/or legal guardian(s), caregivers, and providers are all required to report threats to the child or youth's safety or well-being to the locally-contracted waiver agency. In turn, the locally-contracted waiver agency is required to report each incident to DHS utilizing the Department's web-based incidents reporting system and conduct the immediate follow-up activities. In addition to notifying DHS of an incident, the locally-contracted waiver agency must also notify the child or youth's parent(s) and/or legal guardian(s) if they are not already aware of the incident.

Any concerned individual can report suspected abuse or neglect directly to the local Child Protective Services (CPS) agency or law enforcement agency, if appropriate. Employees and professionals who have contact with children or youth, including Support and Service Coordinators, are mandated reporters and are required by law to report any suspected abuse or neglect or threatened abuse or neglect to the child or youth seen in the course of their professional duties.

Locally-contracted waiver agencies must notify DHS within 1 business day for any critical incident and 3 business days for all other reportable incidents of the date that the waiver agency was notified of the incident.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

DHS has developed material that has been issued to locally-contracted waiver agencies to disseminate to participants, families, caregivers, and others regarding the protections from abuse, neglect, and exploitation and how to notify the appropriate authorities.

Additionally, topics the locally-contracted waiver agency must discuss and ensure that the family understands include:
- How to minimize preventable risk.
- Procedures and requirements in place to identify and remediate any risk to the child or youth's well-being when it arises.
- How the family, providers, and waiver agency must collaborate to achieve each of these objectives.

Locally-contracted waiver agencies must provide information about the policies and procedures in place to address health and safety at the child or youth's initial application to the program and at least annually thereafter.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Once they are notified, the locally-contracted waiver agency's Support and Service Coordinator (SSC) is required to collect information regarding the incident and ensure the participant's immediate health and safety. SSCs are required to report each incident to DHS utilizing the Department's web-based incidents reporting system and conduct the immediate follow-up activities. The locally-contracted waiver agency uses the incident report to summarize the details of the incident, the outcome(s), remediation actions, and preventive strategies. DHS collects the incident reports and conducts oversight activities of locally-contracted waiver agencies, as appropriate and determined by the Department.

SSCs must address and resolve incidents and implement strategies or systems to decrease the likelihood of a recurrence of an incident. Locally-contracted waiver agency staff, or an entity authorized by the locally-contracted waiver agency, must gather information to assess the health, safety, and welfare of the waiver participant who is the subject of an incident. The locally-contracted waiver agency must take action to ensure any remedial action needed is implemented. If there is evidence of immediate risk to the health, safety, or welfare of a waiver participant, the waiver agency must take all reasonable steps to protect the participant.

Locally-contracted waiver agency staff submits the completed incident report form to DHS within 30 calendar days of the incident (or earlier, if warranted). If locally-contracted waiver agency staff are unable to gain access to certain findings or records within the 30-day calendar period due to concurrent investigations or other extenuating circumstances beyond their control, the locally-contracted waiver agency must send in all available information, indicating the report is incomplete and the anticipated date for the completed report, if that can be predicted.

DHS collects the incident reports and ensures the locally-contracted waiver agency properly remediates the incident and prevents similar incidents from occurring for each instance of: 1) death 2) unauthorized use of isolation, seclusion, restraint, or restrictive intervention by a service provider 3) substantiated cases of ANE and 4) critical incidents. Unexplained death of a child or youth is investigated by the locally-contracted waiver agency in conjunction with their local Child Protective Services unit and the Department of Children and Families.

DHS further ensures the health, safety, and welfare of waiver participants by analyzing data from other types of incidents to determine when it would be beneficial for DHS to provide technical assistance and conduct other oversight activities. DHS analyzes trends in incident reports and determines if an incident would benefit from further follow-up by the State in the following areas: 1) broadly defined allegations of ANE 2) errors in medical or medication management that result in a significant adverse reaction that requires hospitalization 3) hospitalization due to involuntary or voluntary psychiatric emergency 4) any instance of law enforcement contact or investigation of an event or allegation regarding the child or youth as either the perpetrator or victim.

DHS may:
- Conduct a targeted review for a first-hand assessment of the situation;
- Schedule such a review for a later time;
- Refer the allegation for further investigation to the Department of Children and Families, if the accused caregiver is an unlicensed caregiver, or to the Department of Safety and Professional Services if the caregiver is a licensed professional;
-Issue a formal plan of correction;
- Offer technical assistance, as appropriate.

Locally-contracted waiver agencies are responsible for "closing" all incident reports. "Closing" means submitting a report and any necessary updates so that all pertinent information about the event and response is included in the report. Locally-contracted waiver agency staff must complete all other required reporting procedures, such as child abuse reporting and the timelines of other required reports. Those requirements remain in force and are not replaced or superseded by this process.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

DHS is responsible for overseeing the reporting of and response to incidents that affect waiver participants. DHS conducts this oversight by individually reviewing specified incident reports and analyzing incident reporting trends.

Individual reviews are intended to determine whether:
- The child or youth's health, safety and welfare are now adequately protected;
- The response to the situation and event was reasonable and appropriate;
- The waiver agency's procedures and system for responding to such incidents were adequate;
- The child or youth's Individual Service Plan is adequate;
- Relevant steps were taken to prevent similar incidents from occurring;
- All service providers or staff involved in the incident appear to be adequately trained or that additional training needed is provided pursuant to the report; and
- There is coordination across systems responsible for the care and protection of the participant.

Analyzing incident reporting data are intended to determine:
- County, regional, or state-wide trends
- Participant-related trends
- Provider-related trends
- Other relevant trends

Analyzing incident reporting data allow for the development of training or technical assistance interventions to decrease the likelihood of recurrence and appropriate supports for the participant, family, waiver agency, and/or provider. DHS issues an appropriate response, as necessary, which may include technical assistance, site visits, a formal plan of correction, or a licensing referral. Additionally, oversight is conducted through selecting a sample of incidents for additional review of compliance, as outlined in this appendix.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DHS does not allow for the use of personal restraints, drugs used as restraints, or seclusion in a locked or unlocked room. DHS does allow for the use of mechanical restraints, including protective equipment, in very limited situations. For a community placement, the use of mechanical restraint shall be specifically approved by the Department on a case-by-case basis.

The Department uses multiple approaches to assure safeguards are in place to prevent the use of unnecessary and/or unauthorized use of restraints. Waiver agencies and DHS monitor incident reporting for patterns and trends specific to a child or provider and more general trends that may suggest additional training needs. Support and Service Coordinators (SSCs) meet with families regularly to identify the child's changing needs, changes in behaviors, and methods being used to address the significant or challenging behaviors of the child. The SSC provides families with the supports to address the needs of the child, assure that the least restrictive measures are being utilized, and connect them to other community resources and Medicaid services. The SSC should update the Individual Service Plan, as needed, to support the child and family.

The locally-contracted waiver agency is responsible to ensure that mechanical restraints are used only in emergencies where the child/youth is exhibiting dangerous behavior. The SSC may contact DHS to discuss the situation and review alternative approaches to emergency situations to avoid the use of restrictive measures.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

DHS is the entity responsible for overseeing the use of restraints and ensuring that safeguards concerning their use are followed. DHS reviews each application for the use of a mechanical restraint, as well as the behavior support plan or medical support plan, in conjunction with DHS policy and guidelines to verify that all elements of the application and support plan are met before approval.

DHS conducts a review of all applications requesting the use of mechanical restraint. A representative from the Department of Children and Families jointly reviews each application if the child is in an out-of-home placement. A written letter of approval or denial is issued. All approved mechanical restraint applications must demonstrate that there is adequate staff training, less restrictive measures have been exhausted, and the Department will be notified if the approved approaches are not effective. All approvals are time-limited and include parameters requiring elimination for the need for the mechanical restraint.

The locally-contracted wavier agency monitors the use of the approved mechanical restraint, assures the plan is being implemented appropriately, monitors effectiveness, and assures training requirements are being maintained. Incident reports are required if the use of a restrictive measure result in injury and if any unauthorized restrictive measure is used, including restraints, restrictive interventions, and seclusion.

DHS collects the incident reports and ensures the locally-contracted waiver agency properly remediates the incident and prevents similar incidents from occurring for each instance of an unapproved use of isolation, seclusion, restraint, or restrictive intervention by a service provider. DHS may:

- Conduct a targeted review for a first-hand assessment of the situation;
- Schedule such a review for a later time;
- Refer the allegation for further investigation to the Department of Children and Families, if the accused caregiver is an unlicensed caregiver, or to the Department of Safety and Professional Services if the caregiver is a licensed professional;
- Issue a formal plan of correction;
- Offer technical assistance, as appropriate.

DHS further ensures the health, safety, and welfare of waiver participants by analyzing incident reporting data to determine when it would be beneficial for DHS to provide technical assistance and conduct other oversight activities. Incident reports are also reviewed for potential unauthorized use of restrictive measures.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

DHS, locally-contracted waiver agencies, and DHS' contracted quality review organization share responsibility for detecting the unauthorized use of restrictive interventions. The Department uses multiple approaches to prevent the use of unnecessary and/or unauthorized use of restrictive interventions.

Locally-contracted waiver agencies conduct regular monitoring of participant safety, health, and welfare. SSCs meet with families regularly to identify the child's changing needs, changes in behaviors, and methods being used to address significant or challenging behaviors of the child. The SSC provides families with the supports to address the needs of the child, assure that the least restrictive measures are being utilized, and connect them to other community resources and Medicaid services. The SSC should update the Individual Service Plan, as needed, to support the child and family.

DHS and the contracted quality review organization may conduct performance reviews of provider quality periodically. DHS uses incident reports and the contracted quality review organization's record reviews as methods for detecting unauthorized, overuse, or inappropriate use of restrictive measures, and to ensure that all applicable state requirements are followed.

DHS also oversees the incident management system where reports are collected on the unauthorized use of restrictive measures and if the use of a restrictive measure results in an injury, including restraints, restrictive interventions, and seclusion. DHS collects the incident reports and ensures the locally-contracted waiver agency properly remediates the incident and prevents similar incidents from occurring for each instance of an unapproved use of isolation, seclusion, restraint, or restrictive intervention by a service provider.

DHS may:
- Conduct a targeted review for a first-hand assessment of the situation;
- Schedule such a review for a later time;
- Refer the allegation for further investigation to the Department of Children and Families, if the accused caregiver is an unlicensed caregiver, or to the Department of Safety and Professional Services if the caregiver is a licensed professional;
- Issue a formal plan of correction;
- Offer technical assistance, as appropriate.

DHS further ensures the health, safety, and welfare of waiver participants by analyzing incident reporting data to determine when it would be beneficial for DHS to provide technical assistance and conduct other oversight activities.

Waiver agencies and DHS monitor incident reporting for patterns and trends specific to a child or provider and more general trends that may suggest additional training needs.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

DHS, locally-contracted waiver agencies, and DHS' contracted quality review organization share responsibility for detecting the unauthorized use of seclusion. The Department uses multiple approaches to prevent the use of unnecessary and/or unauthorized use of seclusion.

Locally-contracted waiver agencies conduct regular monitoring of participant safety, health, and welfare. SSCs meet with families regularly to identify the child's changing needs, changes in behaviors, and methods being used to address significant or challenging behaviors of the child. The SSC provides families with the supports to address the needs of the child, assure that the least restrictive measures are being utilized, and connect them to other community resources and Medicaid services. The SSC should update the Individual Service Plan, as needed, to support the child and family.

DHS and the contracted quality review organization may conduct performance reviews of provider quality periodically. DHS uses incident reports and the contracted quality review organization's record reviews as methods for detecting unauthorized, overuse, or inappropriate use of restrictive measures, and to ensure that all applicable state requirements are followed.

DHS also oversees the incident management system where reports are collected on the unauthorized use of restrictive measures and if the use of a restrictive measure results in an injury, including restraints, restrictive interventions, and seclusion. DHS collects the incident reports and ensures the locally-contracted waiver agency properly remediates the incident and prevents similar incidents from occurring for each instance of an unapproved use of isolation, seclusion, restraint, or restrictive intervention by a service provider.

DHS may:
- Conduct a targeted review for a first-hand assessment of the situation;
- Schedule such a review for a later time;
- Refer the allegation for further investigation to the Department of Children and Families, if the accused caregiver is an unlicensed caregiver, or to the Department of Safety and Professional Services if the caregiver is a licensed professional;
- Issue a formal plan of correction;
- Offer technical assistance, as appropriate.

DHS further ensures the health, safety, and welfare of waiver participants by analyzing incident reporting data to determine when it would be beneficial for DHS to provide technical assistance and conduct other oversight activities.

Waiver agencies and DHS monitor incident reporting for patterns and trends specific to a child or provider and more general trends that may suggest additional training needs.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Support and Service Coordinator, under the supervision of the locally-contracted waiver agency's supervisor, is responsible for assessing each child's strengths and needs and identifying the services and supports that are needed. The SSC is responsible for assuring that the supports and services on the Individual Service Plan will address these needs and assure health, safety and welfare. This includes an assessment of the child's health and healthcare needs, including medication administration. If the child or youth is in an out-of-home setting permitted under the waiver, a comprehensive plan to address these needs is developed.

The administration of medication is defined under Adult Family Home and Children's Foster Care regulations found respectively in Wisconsin Administrative Codes DHS chs. 82 and 88, and DCF ch. 56.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The majority of children enrolled in the waiver program reside with their parents who are responsible for the management of their children's medication management and are not under the jurisdiction of the Department or the locally-contracted waiver agency.

The waiver program permits two types of residential settings other than the child and family's home. These settings are Adult Family Home and Children's Foster Care. Adult Family Home settings are licensed facilities under Wisconsin Administrative Code DHS chs. 82 and 88, and Children's Foster Care is defined under Wisconsin Administrative Code DCF ch. 56. Medication Administration is regulated under these codes for individuals within these settings.

In circumstances where children reside in one of these regulated settings, the locally-contracted waiver agency is responsible for assessing each child's health care needs, including medication administration. If the child is in an out-of-home regulated setting, a comprehensive plan to address these needs is developed including a medication administration plan. The administration of medication is regulated under Adult Family Home and Foster Settings license or certification regulations. The administration of medication is defined under Adult Family Home and Children's Foster Care regulations found respectively in Wisconsin Administrative Code DHS chs. 82 and 88, and DCF ch. 56.

Both codes define safety standards for administration, storage and disposal of all medications within the setting. Both standards define the required training and documentation associated with medication, including medication refusal. A licensee or service provider must have a written order from a physician and a properly labeled prescription, including the dosage, prior to dispensing medication. If the medication prescribed is given on an as-needed basis, then a clear definition of the circumstances under which the medication is to be administered must be provided as well. Staff administering medications must receive training related to medication administration specific to the child or youth. The type of services provided and the capability of the staff that will be providing the service will determine the amount of that specific training. The training must be sufficient to assure the health and safety of the child or young adult. Medication errors, such as a missed dose or wrong medication, must be documented, and if the error resulted in hospitalization, it must be reported as an incident.

The DHS Division of Quality Assurance, Wisconsin's designated State Survey Agency, and the Department of Children and Families, report any findings related to health and safety that are discovered in out-of-home settings that include a waiver participant.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A service provider must have a written order from a physician and a properly labeled prescription, including the dosage, prior to dispensing medication. If the medication prescribed is given on an as-needed basis, then a clear definition of the circumstances under which the medication is to be administered must be provided as well. Staff administering medications must receive training related to medication administration specific to the child or youth. The type of services provided and the capability of the staff that will be providing the service will determine the amount of that specific training. The training must be sufficient to assure the health and safety of the child or youth. Medication errors, such as a missed dose or wrong medication, must be documented, and if the error resulted in hospitalization, it must be reported as an incident.

In addition, licensed service settings are regulated by their licensure standards as defined in each service category as described under Appendix C.

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

Medication errors, such as a missed dose or wrong medication, must be documented, and if this results in hospitalization it must be reported as an incident. Agencies providing these services are reviewed by the locally-contracted waiver agency on an annual basis and more frequently if non-compliance has been identified in any area. The identification of potentially harmful practices is reviewed during this process. The State agencies provide ongoing oversight of these practices and intervene if a pattern of error is discovered.

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

A representative sample of the waiver program applications are reviewed by the DHS-contracted quality assurance organization, in consort with the Department. This includes a review of all medications taken by the child. The child or youth's assessment must address the management of medications for the individual child, including the administration of medications by providers other than the child's family. The DHS Division of Quality Assurance and the Department of Children and Families report any findings related to health and safety that are found in out-of-home settings that include a waiver participant. Medication errors, such as a missed dose or wrong medication, must be documented, and if the error resulted in hospitalization, it must be reported as an incident.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G-i-1: The participant's parents or guardians were provided information on how to report abuse, neglect, exploitation, and other incidents. Numerator = Number of participants' parents or guardians in the sample who were provided information on how to report abuse, neglect, exploitation, and other incidents. Denominator = Total number of records reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
G-i-2: Numerator=Number of participant records with evidence of abuse, neglect, exploitation & unexplained death that were reviewed & addressed by the SSC in a manner that ensures the health & safety. Denominator=Total number of participant records with evidence of abuse, neglect, exploitation and/or unexplained deaths reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Children's Incident Tracking and Reporting system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other**	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G-i-3: Incident reports are completed and submitted to DHS for each identified incident, based on DHS incident reporting requirements that occurred during the review period. N=# of records with identified incidents that had a completed incident report that was submitted to DHS, according to DHS incident reporting requirements. D=Total # of records with identified incidents reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Children's Incident Tracking and Reporting system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G-ii-1: The waiver agency effectively resolved incidents and documented the outcome(s) of incidents. Numerator = Number of incident reports in the sample where the waiver agency effectively resolved an incident and documented the outcome(s) of an incident. Denominator = Total number of incident reports reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Children's Incident Tracking and Reporting system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		+ / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G-ii-2: Incident reports are submitted to DHS within required timeframe, based on DHS-established incident reporting requirements. Numerator = Number of incidents reports in the sample that were submitted to DHS within the required timeframe. Denominator = Total number of incidents reports reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Children's Incident Tracking and Reporting system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G-iii-1:All approved restraint applications are reviewed by DHS according to DHS-established timelines & meet DHS policies and protocols. Numerator=# of restraint review applications that were submitted to DHS within the DHS-established timelines & according to DHS policies & protocols. Denominator=Total # of restraint review applications submitted that meet the requirements & are approved by DHS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Restrictive Measures Application Log

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G-iii-2: Unauthorized uses of restrictive measures have a remediation plan developed as a result of an incident per DHS policy. Numerator = Number of unauthorized restrictive measures incident reports with a remediation plan per DHS policy. Denominator = Total number of incident reports submitted due to an unauthorized restrictive measures intervention per DHS policy.

Data Source (Select one):
Other
If 'Other' is selected, specify:

Children's Incident Tracking and Reporting system

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☒ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Restrictive Measures Application Log

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100%**

		Review
☒ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
G-iv-1: Parents or guardians are educated on the importance of an annual well visit with their primary care provider. Numerator = Number of records reviewed in the sample that document parents or guardians were educated on the importance of an annual well visit with their primary care provider. Denominator = Total number of records reviewed in the sample.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☒ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
G-iv-2: Child can see health professionals when needed. Numerator = Number of surveys in the sample that reflect that the child can see health professionals when needed. Denominator = Total number of surveys reviewed in the sample.

Data Source (Select one):
Participant/family observation/opinion
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The locally-contracted waiver agency is responsible for addressing individual issues related to the health, safety, and welfare of each waiver participant. The Support and Service Coordinator works with the appropriate agencies and officials, such as child protective services and law enforcement, to ensure appropriate and timely remediation occurs and provide follow-up as needed.

Incidents are tracked in the Department's web-based incidents reporting system. The system allows DHS to track the timeliness of the response, remediation, and closure of an incident report. Dates include when the incident was discovered, when it was reported by the waiver agency to DHS, and when the incident was closed.

As described in the associated Performance Measures, incident details and the waiver agency's response to the incident are tracked during the record review process. DHS is responsible for overseeing the reporting of and response to incidents that affect waiver participants.

DHS ensures the locally-contracted waiver agency properly remediates incidents and prevents similar incidents from occurring for specific incidents, as specified in Appendix G-1. DHS staff review incident reporting data to monitor for any trends that might indicate a systems-level issue. If a systemic issue is identified, then appropriate corrective action plan improvements are required.

The Department directly monitors the locally-contracted waiver agencies to correct any issues discovered through ongoing administrative oversight activities. Locally-contracted waiver agencies are responsible for correcting any issues that are discovered. Issues are tracked from the locally-contracted waiver agency's initial identification to the final resolution. The Department may also recommend development of a corrective action plan (CAP) The Department may also require immediate remedial action and impose CAPs to address serious or unresolved issues.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Discovery and remediation information comes from the continuous measurement of progress on a collection of Department of Health Services (DHS) and locally-contracted waiver agencies performance indicators, referred to as the record review process.

These DHS-developed indicators along with other quality measurements (e.g. Scorecard, system data, and family experience surveys) demonstrate if the locally-contracted waiver agency is meeting the waiver assurances (described throughout the waiver) and how successful they are in meeting other program performance and quality requirements.

The indicators are divided into four categories: enrollment, ISP updates and recertification, health and welfare/safety, and qualified providers. The record review is completed annually.

DHS then analyzes the findings and determines remediation strategies and activities. DHS pays particular attention to those performance indicators that support the waiver assurances. As a result of the discovery and remediation information, DHS identifies if the poor performance is a result of the practices established by the locally-contracted waiver agencies or if it is a systemic issue that needs to be addressed by DHS through programmatic policy change or waiver amendment.

When the finding is directly related to the performance of the locally-contracted waiver agency, DHS works to develop strategies to enhance performance. When findings are related to a programmatic or systemic issue, DHS works internally to develop strategies to increase compliance and performance.

Trend reports are generated from various discovery mechanisms that are reviewed and used to prioritize system-level improvement projects. DHS meets with external stakeholders to identify issues and discuss options for improvement strategies. Improvements needed that impact participant health and safety are prioritized, followed closely by those that would improve participant outcomes and address program integrity. To determine if the improvement activity or strategy was successful, DHS continues to monitor the record review data and other reporting mechanisms.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

DHS is responsible for assessing the impact of the system design changes. DHS documents system changes in a format that can be shared with internal and external stakeholders.

DHS' format consists of:
-Description of the needed system change;
-Desired outcome of the system change;
-Steps to complete the system change; and
-Method to measure the effectiveness of the system change;

As needed, DHS develops performance indicators related to each system change and incorporates them into the record review process. Once the system design has been implemented, DHS continues to monitor the effectiveness of this change through various reporting mechanisms.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy is evaluated by the DHS on an annual basis. DHS reviews performance on waiver measures and revisits high-level goals linked to DHS' vision, mission, and values of children's long-term care programs. DHS evaluates progress on meeting performance goals, decides a course of action to meet unmet goals, and monitors high-level effects of system-wide changes. Additional the performance goals are reviewed and updated, if needed, on an annual basis.

Annual quality reviews and ongoing quality activities are periodically reviewed and updated as they relate to the overall Quality Improvement Strategy.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The Department's Division of Medicaid Services (DMS) and the Office of Inspector General's (OIG) each have responsibilities in monitoring key aspects of financial accountability. These functions are described below.

DHS currently contracts with a third-party administrator (TPA) to process authorized waiver service claims. DHS provides fiscal oversight of the service utilization data. Service utilization data details are submitted to the Department through the encounter data reporting system. The TPA is the exclusive submitter of data to this system related to the waiver program. The encounter data system collects data submitted electronically. The data is reconciled and certified by TPA staff before data is transmitted to DHS. Before accepting and uploading the data to the DHS Data Warehouse, DHS reviews and certifies the encounter data.

The Department's TPA claims process operates as follows:
-Locally-contracted waiver agencies prepare the participant Individualized Service Plans (ISPs) and authorize services for children based on their needs and outcomes, which includes authorization and claims for Support and Service Coordination.
- Locally-contracted waiver agencies submit service authorizations to the TPA vendor for acceptance into the system.
-The provider receives the accepted service authorization, delivers the authorized service and submits claims to private health insurance, as appropriate, before submitting a claim to the TPA.
-The TPA ensures coordination of benefits (COB) with the health insurance benefit. To assist in this process, Wisconsin's Medicaid fiscal agent/MMIS vendor sends the TPA a monthly third-party liability (TPL) health insurance file, obtained from the Office of the Commissioner of Insurance. After adjudicating any COB, the TPA processes claims with the corresponding authorizations.
-The TPA invoices DHS daily and the Department reviews and approves or denies the daily invoice. If approved, the provider receives payment. The TPA processes provider checks or electronic funds transfers and mails them to the rendering providers or deposits them in the providers' supplied account. If denied, the TPA reviews and resubmits the corrected invoice to the Department.

The TPA validates authorizations and pays claims according to the statewide published rate schedule. DHS monitors claims data to understand how the rate schedule is impacting service utilization and access. This includes analysis of how care levels and outlier rates are being applied. DHS monitoring also informs ongoing rate schedule maintenance and helps determine if rates need to be adjusted to address participant access or budget issues.
Both the Department and locally-contracted waiver agencies conduct fiscal monitoring and an annual fiscal reconciliation.

Locally-contracted waiver agencies are responsible for ensuring claims paid align with participant ISPs, authorized services, and eligible settings. Any variances must be clarified between the source documents referenced above with the TPA. If a claim was paid incorrectly, waiver agencies submit an overpayment request through the TPA. The waiver agencies claims data review is an ongoing protocol embedded in the reconciliation process.

On a quarterly basis, DMS identifies claims that were paid for dates of service overlapping with a participant's institutional stay. DMS compiles the claims and sends each affected waiver agency a report and notes that the waiver expenses will be disallowed during the reconciliation process, unless the claim was erroneous and is corrected before the annual reconciliation process.

The TPA reconciles the state centralized bank account and shares a monthly bank reconciliation schedule with DHS. Finally, DMS conducts a final reconciliation process, which is used to ensure that waiver participants were eligible when they received services and that the appropriate funding source is applied to the appropriate services. The DMS reconciliation process occurs annually, after the end of the calendar year. Waiver agencies verify that reconciliation totals tie out to their reporting.

Locally-contracted waiver agencies monitor claims processing against their authorization systems. Issues with individual claims submissions to the TPA must be corrected through a reversal process or through the annual fiscal reconciliation process described above. The reversal process involves the waiver agency submitting documentation to reverse the claim and then processing the revised claim, if appropriate. Locally-contracted waiver agencies may also submit a revision when the service was appropriate for the participant, but there was a coding error. The TPA has established edits to detect prescribed coding logic, which could result in instances of reversing the claim payment that would require a provider refund. The TPA system validates authorizations and claims payments in alignment with the policies and procedures governing the state-established rate schedule.

The Department has established three quality review processes to confirm billed services were actually rendered to participants.

1. Each month the child's Support and Service Coordinator (SSC) must make collateral contacts to ensure the participant's needs are being fully met, including satisfactory delivery of all authorized services.
2. As part of the annual record review process, the DHS-contracted quality review organization receives a list of all TPA paid service claims for each selected participants. The contracted quality review organization reviews and compares the service claims to the participant's Individual Service Plan (ISP) to ensure the participant's needs have been met.
3. DHS issues annual surveys to all waiver participants' parents and guardians which includes several questions regarding satisfactory service delivery to meet the child's needs.

DMS administers the TPA contract. The TPA submits contract invoices for administrative services to DMS, based on a per member per month expense calculated from program enrollment data.
Administrative services refer to the service the TPA vendor performs on behalf of the Department (i.e., the TPA's cost for processing claims), and do not include participant waiver service costs. The invoices are verified for accuracy and submitted to DMS for payment processing. The verification process includes ensuring the number of participants with claims is not greater than the number of enrolled participants, that the total claim amount does not exceed the anticipated claim amount, and that no unauthorized provider is paid.

DHS requires locally-contracted waiver agencies to have a contracted, independent CPA firm perform the state single audits, as detailed in their contract with the State. The CPA firm conducts an audit of waiver agency operations, following the procedures provided in the State Single Audit Guidelines, which are written and approved each year by DMS and the DHS Office of Inspector General (OIG). These guidelines include requirements ensuring participants were eligible at time of service, that only qualified providers deliver authorized services, and that certain services are targeted for review, including high cost home and van modifications. The OIG's Audit Section also ensures that providers subject to the purchase of service contract requirements under § 46.036, Wis. Stats have an audit completed by an independent auditor, unless waived.

Under Wisconsin's statutory purchase of service (POS) contracting and audit regulations detailed at Wis. Stat. § 46.036(4)(c), both agency and sole proprietor providers receiving DHS-funded services, are subject to an independent financial audit.

DHS contracts with a third party administrator (TPA), which requires the support and maintenance of internal quality assurance (QA) processes to detect and correct problems in all functional areas, and support and maintain internal quality improvement (QI) processes to detect and prevent quality issues from occurring. DHS staff are assigned to oversee the quality assurance processes and review evidence from these endeavors. DMS is responsible for program operations and approving payment to the TPA for administrative services. DMS is also responsible for assuring that the per member per month (PMPM) administrative charge to the Department from the TPA is appropriate.

DMS also has day-to-day accountability and integrity roles. DMS runs quarterly checks of encounter data, including ensuring waiver agencies and providers are properly billing only participants who are eligible for the waiver at the time that services were billed, and authorizing the daily invoice from the TPA. DMS also conducts year-end waiver agency contract reconciliation, which checks to ensure that service claims were appropriate, disallowing them if they were not, and ensuring the correct funding source was used for participants.

Additionally, DMS ensures the accuracy and integrity of the data submitted by the TPA, including checking for appropriate coding for encounter reporting.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I-i-1: Paid waiver service claims are consistent with the approved service authorization. Numerator = Number of paid service claims in the sample that are consistent with the approved service authorization. Denominator = Total number of paid service claims reviewed in the sample.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Encounter claim records

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☒ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *+ / - 5%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Service prior authorization data

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☒ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *+ / - 5%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
I-ii-1: Claims are paid in accordance with the state rate methodology. Numerator = Number of claims reviewed in the sample that were paid in accordance with the state rate methodology. Denominator = Total number of paid claims reviewed in the sample.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Encounter claim records

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***

☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☒ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *+ / - 5%*
☐ ***Other*** *Specify:*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.*

DMS uses several methods to monitor operational functions delegated to the locally-contracted waiver agencies to ensure service plans are being met, ensure equitable access to services for participants, and evaluate purchase of goods and services. These include the third party administrator (TPA), manual review, the annual Single State Audit process, record reviews conducted by the contracted quality review organization, and regionally assigned staff.

The TPA is responsible for ensuring waiver services claims are preauthorized, billed, adjudicated and paid appropriately. On a quarterly basis, DMS identifies waiver service claims that were paid for dates of service overlapping with a participant's institutional stay. DMS compiles the claims and sends each affected locally-contracted waiver agency a report and notes that the waiver expenses will be disallowed during the reconciliation process, unless the claim was erroneous and is corrected before the annual reconciliation process or sufficient documentation can be provided to validate that the service provided does not overlap with an institutional stay.

DMS is responsible for the annual fiscal reconciliation of waiver agencies. The DHS OIG oversees the audit process and tracks financial findings in the audits. DMS pursues and ensures remediation of audit findings. The locally-contracted waiver agencies must reimburse the State and Federal government for errors found during the financial audit. On a monthly basis, DMS sends claims information to the expenditure tracking system for locally-contracted waiver agencies to facilitate their review of the data. In addition, DMS monitors claims errors quarterly and annually and continues to follow up on errors using MMIS data until they are resolved. All adjustments are available through business intelligence reports. On a daily basis, the TPA vendor and fiscal agent, obtains from the enrollment system a listing of participants enrolled in the waiver program, which includes the participant's enrollment start date (and end date when applicable), their target group, and the responsible locally-contracted waiver agency. The TPA will reject service authorizations and claims for any person not included on the enrollment list.

The TPA rejects claims for any service that is not prior authorized by the locally-contracted waiver agency. The Department uses the record review and the annual Single State Audit processes as means of discovery to ensure delivered services were included on the Individualized Service Plan, where applicable. Where the statewide rate-methodology dictates adherence to specific features of the methodology, DMS provides technical assistance, review and final approval.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The rate schedule is published on the DHS website. 1. Rates for waiver services similar to state plan services are identical to the Medicaid state plan rate, including: transportation services; counseling & therapeutic services-Occupational, Physical & Speech Language Therapy.
2. All other rate methods: rate methods share similar values, calculations & expense categories with some variations. Rates factor both the individual care need & professional experience required & have common calculations and factors. Individual service planning is where participant information informs care & support needs. Rates are applied once care needs and individual outcomes are identified. Rates are published in the DHS fee schedule & used with the DHS code and unit crosswalk and service definitions. Waiver agencies review requirements to determine appropriate rates, codes & units as part of the person-centered planning process, & in the ISP. The rate & service information in the ISP is the basis for authorizing waiver services delivered by operational agencies and providers paid via TPA claims payment. For most rates, direct staffing wage costs are the main driver. A base wage uses matching job categories similar to waiver service job descriptions & standard occupational classification codes from the Bureau of Labor Statistics. Average wages adjust to differentiate between level of service professional needed & whether the provider is a self-employed individual or an agency that employs direct caregivers. Agencies incur the higher overhead & fringe costs of being an employer. DHS accounted for higher overhead and fringe costs for agency (employer) versus individual providers by analyzing a variety of data sources. During the initial stages of the initiative the DHS subcontracted analyst, the University of Wisconsin Center for Health Systems Research & Analysis developed some preliminary models of overhead and fringe, which were later tested with input from provider surveys, DHS obtained ongoing county & provider feedback during rate development. For service rates with a provider type component (individual or agency), these costs were added to base BLS job category wage rates. Provider related overhead and fringe expenses built into rates include direct service wages, supervision (when applicable), employee-related cost factors (required tax and benefit obligations), & client and program overhead factors (expense related to indirect support and service delivery). When an individual requires an exception to the state rate in order to meet their unique needs, locally-contracted waiver agencies may submit an outlier request to increase a service rate based on either the individual's need or service availability. Outlier requests are available for all services subject to the rate schedule. Requests are reviewed & approved or denied by the state. Eight new services are being added to the statewide maximum fee schedule, including Discovery & Career Planning; Grief & Bereavement Counseling; Health & Wellness; Participant & Family-Directed Broker Services; Participant & Family-Directed Goods & Services; Remote Supports & Equipment; Safety Planning & Prevention; & Translation & Interpretation Services. Portions of Participant & Family-Directed Goods & Services and Remote Supports & Equipment may be reimbursed outside of the statewide maximum fee schedule in accordance with market rates. Methodology by Service Category. Adult Family Home-rate is the average amount paid by Family Care PIHPs, per most recent available encounter data. Child Care Services–rate is based on child care market data that DHS obtained from the Wisconsin Department of Children and Families (DCF). DCF conducts a market rate survey to determine the prices of regulated child care in the private market. Child care rates are set according to the maximum average market rates. To maximize community integration & access, the waiver's rate for this service is intended to approximate the average child care market rates throughout the state in inclusive childcare settings. Every time DCF conducts a new market rate survey, DHS will obtain & analyze the results, as well as assess the waiver's child care service utilization. DHS will determine through these analyses whether child care rates should be adjusted. Community Integration Services-the program's rate method includes two tiers based on the provider education level. The rate values were calculated using historical rate data. DHS obtained 2018 rate information from providers to determine an average rate. After publishing the average rate in the rate schedule, DHS received additional feedback from counties & providers that the rate was too low and should be tiered to reflect the education level of the provider. DHS developed Tier 1 rates for providers with a bachelor's level degree & Tier 2 rates for providers with a master's level degree. The skill level required to meet the participant's needs & outcomes is determined through the ISP process. Counseling & Therapeutic Services-for occupational therapy, physical therapy, & speech language therapy, the rates are set identical to State Plan fee for service rates. This service category also includes alternative therapies that pay 85% of provider market rates for each alternative therapy (music, dance, art, etc), up to $170/session. Daily Living Skills Training-rates based on individual & agency providers, but not differentiated by care level. Rates use the BLS job classification category that aligns with required staff skill level. The professional category needed is higher than the rates for Respite and Personal Supports. Day services-rate calculation mirrors child care service rates due to service similarities, are based on child care market data collected by DCF, & is set according to the maximum average market rates. It pays a single full rate for all age groups. Financial Management Services-the rate methodology creates a standardized list of services with two tiers: basic & enhanced. The enhanced tier of FMS is comparable to that provided to adult participants under the IRIS waiver program. Thus, the enhanced FMS rate is set equal to the IRIS rate. County & provider input & feedback have been instrumental in the development of the enhanced rate. During the rate development period, a work group of counties & providers helped develop & confirm the types of activities that should be provided at the basic & enhanced tiers. After DHS released the draft rates in July 2018, county & provider feedback helped DHS determine that the initial enhanced rate was too low to sustain the required

activities. The feedback led DHS to further review the IRIS service rate & determine it appropriately aligned with the waiver's enhanced FMS activities. Mentoring-the rates are informed by the BLS job classification category that aligns with non-professionals with lived experience providing the service. The schedule sets both individual & agency provider rates assuming a low-to-medium care level. Respite rates are based off of weighted average BLS wage survey data for related job categories. These base rates were then adjusted for both care level & provider type components & require a care level classification. Support & Service Coordination-the existing methodology is maintained for determining SSC rates for locally-contracted waiver agency providers. Rates are set for each county using a weighted average hourly rate. The rate includes allowable administration costs supported as outlined in the DHS Allowable Cost Policy Manual, & can be specifically attributed to the provision of support and service coordination. Community/Competitive Integrated Employment-the rates are informed by the BLS job classification category & selected to align with the rates paid by the Wisconsin Department of Vocational Rehabilitation for job development staff. The rate methodology incentivizes individual employment with higher hourly rates. There is also a rate option that increases pay for providers with the number of weekly hours the participant works. Personal Supports-the rates mirror respite rates methodology described above. Transportation-mileage rates mirror the federal mileage reimbursement rate & will reflect annual federal updates. The trip rates align with per member per month costs to transport children through the Medicaid State Plan. Methodology Key Components-DHS developed a unique methodology for several services that include at least one of the following components: child's care level classification and provider type. Care Level Classifications-Respite & Personal Supports services have three care level classifications: low, medium, & high. The progressively higher rate for each care level is informed by BLS job classification categories for caregiver levels to align with increased need for employee skill, training, experience. SSCs determine care levels with the family & apply their expertise to assess the child and family's level (or intensity) of support need with respect to these two service categories. SSCs consider information from formal sources & input from the participant. Several factors are considered, including: Information from the functional screen & assessment processes; Child & family's situation or circumstances; Intensity, type of support, or degree of professional experience required; Extent of training/experience a provider must have to safely/effectively work with the individual. See Care Level Guidelines document for further details. Outlier Rate Request-Waiver agencies may request an exception to the waiver's rate schedule when either or both of the following criteria are present: The complexity or intensity of the individual's care needs (acuity) exceeds what is common among waiver participants; No caregiver is located within a reasonable distance of the participant, or no caregiver within a reasonable distance will accept the rate. Waiver agencies submit outlier requests to DHS for review & final approval. DHS has not established outlier rate maximums, but rather has published a draft Outlier Rate Guidelines document on the DHS website to help waiver agencies determine whether an outlier rate is warranted. Up to 5% of participants are anticipated to meet the outlier criteria. Individual Care Needs-consider whether the participant:Exhibits significant behaviors that require frequent intervention or near-constant supervision; Has physical or mental health diagnoses that require intensive intervention or care; Has ongoing involvement with multiple systems (e.g. juvenile justice, substance abuse treatment, hospitals/institutions, etc.) See outlier rate request document for further details. Service Availability-request an outlier rate when access to a service is limited, when no caregiver is located within a reasonable distance of the participant or is within a reasonable distance & will not accept the rate. See Outlier Rate Request Guidelines document. Provider Type-some rates differ between individual & agency providers. Rates include employee wages & withholdings, with higher non-salary costs for the agency provider type (e.g., overhead, supervision, training, fringe/benefit costs). Services may be paid at rates lower than the state-based rate, in circumstances where a service provider's usual & customary service rate is lower than the state-based rate for a particular service. Market rates are used when certain goods or services under a service category are purchased at the price set by the market: Personal Supports-caregiver living expenses, chore services; Counseling & Therapeutic Services-therapeutic equipment, supplies & camps; respite camps; Transportation–ancillary costs (parking fees, tolls, etc.); Mentoring–ancillary costs associated with the service; Participant & Family-Directed Goods & Services—goods purchased under this service (i.e. units designated as Each); Remote Supports & Equipment—technology or equipment purchases.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

DMS contracts with a Third Party Administrator (TPA) responsible for paying waiver service claims submitted by providers. Locally-contracted waiver agencies authorize services based on the participant's Individualized Service Plan (ISP). The waiver agencies issue a prior authorization to both the service provider and the TPA. The TPA receives a list of waiver enrollees, as well as a monthly file of Medicaid eligible participants with private health insurance to assist with coordination of benefits (COB).

Waiver providers submit their service claims directly to the TPA. The TPA is responsible for ensuring COB compliance, and then pays claims that conform to the waiver agency's authorization and either the statewide rate methodology or market rates. The TPA pays providers by check or EFT from a bank account held by the Wisconsin Department of Administration. DMS reviews a daily invoice and, once approved, submits it for processing. The State pays contractually approved administrative expenses billed by the TPA. If the locally-contracted waiver agency is responsible for the non-federal share of any expenses, the State issues an annual invoice equal to the locally-contracted waiver agency's share of the non-federal expenses to offset non-federal expenses initially paid by the State via the TPA. The federal portion of the claims is reported to CMS quarterly.

The flow of billing for participant and family-directed services is the same as other services, with the exception that some of these services are paid for through a fiscal agent. The fiscal agent submits claims to the Department's TPA vendor on the providers' behalf as the billing provider, and receives payment for those claims, then issues payment to the rendering providers.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

○ ***No. state or local government agencies do not certify expenditures for waiver services.***

◉ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☒ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

DHS and locally-contracted waiver agencies share the certification of public expenditures validation process. This includes the contracted Third Party Administrator (TPA) receiving data from the DHS system on a daily basis to confirm current participant enrollment, as well as the enrolled providers eligible to be paid for the delivered services. Locally-contracted waiver agencies submit prior authorizations for all waiver services to the TPA. The TPA is contractually required to ensure that all payments, adjustments, and other financial transactions made through the TPA must be made on behalf of clients enrolled in the HCBS waiver program, to enrolled providers, for approved services, and in accordance with the payment rules and other policies of the Department.

Using the daily invoices from the TPA, DHS staff verifies the amount paid from the bank account matches the invoices submitted and that the bank account contains sufficient funds to cover the service claim payments. Any variances must be clarified with the TPA and if a payment was not appropriate, the Department must request a refund from or through the TPA. DHS reconciliation is completed monthly when bank statements arrive. Finally, DMS conducts a final fiscal reconciliation process, which is used to ensure that participants were eligible for waiver services when they received them and that the appropriate funding source is applied to the appropriate services. DMS' fiscal reconciliation process occurs annually. Waiver agencies are responsible for verifying that DMS' reconciliation is correct.

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The locally-contracted waiver agency conducts internal reviews to verify that each claim is reimbursable under the waiver by determining that: the participant was eligible for services, the authorized services only include those listed on the child's approved Individualized Service Plan (ISP), and the provider actually delivered the service to the participant.

The TPA only pays claims for individuals enrolled in the waiver program. On a daily basis, the TPA receives a file of enrolled waiver participants, which includes the participant's program start date and end date (when applicable), their target group and the applicable responsible waiver agency. The TPA will reject service authorizations and claims for any person not included on the enrollment list. A review of the claims data is completed during the annual site visit review and Single State Audit to ensure only the services on the ISP were paid, where applicable.

DHS has established multilayered quality assurance processes to ensure billed services have been rendered to the participant.
-The DHS-contracted TPA vendor requires attestations from providers to ensure services have been delivered as part of their claims processing and adjudication protocol.
-During the annual record review process, the DHS-contracted quality review organization receives a list of all service claims for the selected participant. These service claims are compared to the participant's Individual Service Plan (ISP) for accuracy in ensuring the child's needs have been fully met.
-Annual surveys are also conducted with the participants and families to ensure services have been appropriately delivered.

The contracted TPA vendor has developed a service recovery protocol when waiver service overpayments have been identified. Overpayments may be identified by the following entities:
1. DHS
2. Contracted TPA vendor
3. Locally-contracted waiver agencies
4. Providers

When DHS identifies inappropriate service payments during the annual fiscal reconciliation process, recoupments are processed through the TPA claims correction process when possible. Recoupments processed through the TPA claims corrections are recovered directly from the service provider.

DHS also has a process to recoup inappropriate payments directly from locally-contracted waiver agencies through the Community Aids Reporting System (CARS). DHS ensures that CARS adjustments for inappropriate payments are reflected in the federal Medicaid reporting.

When the TPA claims department identifies or is notified by DHS, a waiver agency or provider about an overpayment:
1) TPA collections department creates a record in the database.
2) TPA collections department issues a notice to the provider requesting return of the overpayment:
a) Day 1 - initial letter
b) Day 45 - second letter
c) Day 60 - final letter
d) TPA turns collection duties to DHS for any collections beyond 90 days
e) Overpayment recovery amounts are processed, adjudicated, and the encounter data is updated in the data warehouse.

If the provider does not return the overpayment amount voluntarily; the TPA will recoup it directly from the provider's future claims.

The state-established rate methodology will be validated using several approaches. The TPA validates authorizations and claims payments in alignment with the policies and procedures governing the state established rate schedule..

DHS monitors authorizations and claims data to understand how the rate schedule is impacting service utilization and access. This includes analysis of how care levels and outlier rates are being applied. DHS monitoring also informs ongoing rate schedule maintenance and helps determine if rates need to be adjusted to address participant access or budget issues.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and*

providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ◉ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- ☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***
- ☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***
- ☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

  Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The Waiver Provider Medicaid Agreement includes a provision detailing payment processes through the DHS contracted third-party administrator (TPA). The State-held bank account and the payment file from the TPA, based upon encounter entry of approved claims, avoids a conflict of interest as it is independent of the entities/persons delivering services or goods. Based on the participant's authorized ISP, which was developed jointly by the parent/guardian and the Support and Service Coordinator, the fiscal agent processes claims for expenditures that meet all required authorizations, answers inquiries from waiver agencies and providers, solves related problems, and provides the Department with a weekly certification of expenditures through the State's encounter reporting system.

DHS contracts with the TPA to perform all of the functions identified above. When deficiencies are identified, DHS works with the contractor to achieve remediation. If necessary, a corrective action plan is implemented followed by a re-review. The TPA submits paid claims through the DHS encounter reporting system and certifies that the submitted claims are true and accurate. To ensure financial integrity and accountability, DHS performs claims data quality checks related to the encounter reporting and certified paid claims against participants' authorized individualized budgets, and to determine if there is documentation that the services for paid claims were included in the ISP and were rendered. Where deficiencies are identified, remediation is required, according to the terms of the contract.

In addition, the TPA conducts its own internal quality check to ensure that payments were made correctly. These include:
- Assuring prior authorization for every claim paid under the waiver program. This assurance is met by the TPA requiring that claims data submitted from the provider is exact and within the code parameters on the authorization in order for a payment to be made (service code/modifiers, provider number, dates of service, participant ID, units of service allowed). Any data element that does not match will cause the claim to be denied.
- Assuring that high dollar claims get additional review. This assurance is met by a code modifier that will force a claim to pend when billed charges are over $15,000 for professional services and $30,000 for institutional services. The TPA will review the claim to ensure the billed charges were submitted as intended. This edit prevents inappropriate escalated charges and/or entry errors.
- Assuring that the correct rate is applied. This assurance is met by using pricing logic to pay the authorized rate regardless of charge amount or pay the lower of rate or billed charges.
- Assuring there are not duplicate payments. This assurance is met using duplicate logic editing that compares new claims against pended and previous paid claims. Any new claim that matches a pended or paid claim will either auto reject or pend for review.
- Assuring that retroactive changes are enforced. This assurance is met through retro code change protocols. If a retro change to a record causes a previous processed claim to overpay, the TPA reviews claim history and requests refunds. These retro changes can include enrollment, COB indicator, rate changes, provider ID change, or participant ID number change.
- Assure basic claim validation. This assurance is met by using a variety of other claim validation edits to ensure claims are processed accurately. These include assuring participant eligibility, COB, provider eligibility, proper HIPAA coding, disallowing claims for future dates, etc.

Provider Payment – Banking Process:
The TPA makes payments for provider claims directly from a State-controlled bank account. The TPA transmits a daily invoice to DMS for approval to fund the State-controlled bank account for the daily invoice dollar amount. The approved invoices are submitted to the Department of Administration, which administers the account. The payment account is a zero-balance account funded by the State and cannot receive external deposits. A separate receivables account was established for deposits and this account cannot be drawn upon.

Money Refunds:
The receivables account cannot be used to make payments. When the TPA makes a payment or collects a receivable, the TPA records the process in their system, which is certified and reported monthly to the State encounter-data system. The monies put back into the bank account are transactions processed through MMIS.

Payments:
When a provider fails to cash a check, the TPA returns the funds to the State after 180 days and the State is responsible for maintaining those funds. A provider has six years under State law to claim the payment and would claim the payment from the State Agency directly.

Billing Process:
Providers are informed about the billing process through TPA training materials and forms from DHS and the TPA, as well as the locally-contracted waiver agencies.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

○ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

◉ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

The Department has submitted a renewal for the Section 1915(b)(4) Waiver Fee-for Service Selective Contracting waiver to the Centers for Medicare and Medicaid Services, designating locally-contracted waiver agencies or their sub-contracted case management entities as the sole provider for the delivery of their Support and Service Coordination. Additionally, locally-contracted waiver agencies may receive payment for allowable services provided through foster care, purchased products and supplies from third-party entities and vendors for which the waiver agencies receives no benefit from the vendor, and prepayment for wavier allowable services from subcontractors where the waiver agencies makes the payment to the vendor.. Locally-contracted waiver agencies receive payment for delivered waiver services through the TPA claims process.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ◉ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how***

payments to these plans are made.

- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***
- ☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

- ☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

○ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

◉ ***Applicable***

Check each that applies:

☒ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

The waiver program is operated by locally-contracted waiver agencies, which are mainly county government agencies that have the ability to levy taxes through both property and county sales tax processes. These funds, if utilized through the waivers, are transferred through intergovernmental transfer and tracked through CARS. A waiver agency must show adequate non-federal match in order to claim the FFP. Wis. Stat. 46.22 gives counties authority to levy taxes for social service expenditures.

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Locally-contracted waiver agencies must demonstrate that the waiver costs incurred for those participants residing in children's foster care and adult family homes do not include room or board expenses. If room and board expenses for foster care or adult family home services are more than the child's or youth's available resources, the expenses cannot be authorized through the waiver. In this case, alternate sources of funding for the cost of room and board may be considered.

The method of calculating the cost of room and board is the same for children's foster care and adult family homes: subtract the total room and board costs from the overall facility rate and divide this total by the number of people residing in the home.

Items and cost specifically related to room and board costs include the following: housing, food, property taxes, household supplies specific to the child or youth, electricity, water and sewer, and heating fuel utilities, household telephone, and cable television.

Locally-contracted waiver agencies are responsible for maintaining facility-specific documentation and child or youth-specific documentation that itemizes costs for children's foster care and adult family home services. For both of these services, care and supervision costs, any applicable administrative costs, and room and board costs must be included on the child's or youth's Individual Service Plan (ISP). The ISP needs to clearly indicate the foster care and adult family home costs that are authorized through the waiver and any costs that are funded through an alternate source. Documentation of these itemized costs must be updated at least annually.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	10437.30	19698.26	30135.56	300813.24	21073.30	321886.54	291750.98
2	10670.52	20350.23	31020.75	307674.95	21780.59	329455.54	298434.79
3	10899.71	21005.30	31905.01	315232.97	22550.23	337783.20	305878.19
4	11124.35	21665.78	32790.13	320991.48	23203.56	344195.04	311404.91
5	11349.16	22334.65	33683.81	327551.41	23926.68	351478.09	317794.28

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care: Hospital	Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	17115	6065	946	10104
Year 2	18192	6447	1005	10740
Year 3	19147	6785	1058	11304
Year 4	19996	7086	1105	11805

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care: Hospital	Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 5	20750	7353	1147	12250

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average Length of Stay is calculated by dividing the total number of projected enrollment days for the year by the number of projected unduplicated participants served during the year.

All eligible children requesting waiver services are assumed to enroll in the month following their request. Monthly eligible waiver requests are estimated based on historical enrollment and waitlist experience in the current waiver.

The total number of enrollment days for each year is calculated by summing each months estimated enrollment days. Each month's enrollment days are estimated by multiplying the number of calendar days in that month by the prior month's estimated ending enrollment. This total is then adjusted based on new enrollment and ending enrollment estimates. New enrollment adds half of the month's calendar days for each new enrollee whereas each person ending enrollment removes half of the month's calendar days per participant. Monthly new enrollment is based on historical enrollment and waitlist experience for the current waiver. Monthly disenrollment is based on historical disenrollment experience in the current waiver.

The number of unduplicated participants served during the year is calculated by adding the number of members expected to be enrolled at the start of the year to the projected new enrollment during the year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The Factor D estimate is generally based on actual SFY 2020 waiver service costs. This is the most complete reporting year available following implementation of a statewide service rate schedule for the Children's Waiver.

Alternate data sources were used for the following services:
Eight new services have been added, including Grief and Bereavement Counseling; Safety Planning and Prevention; Participant and Family-Directed Broker Services; Participant and Family-Directed Goods and Services; Remote Supports and Equipment; Translation and Interpretation Services; Discovery and Career Planning; and Health and Wellness. Cost and utilization entries for new services are based on similar services in the existing children's waiver and other Wisconsin Medicaid programs. Adjustments were made assuming Safety Planning and Prevention will reduce utilization for Personal Supports and Family/Unpaid Caregiver Supports and Services; Remote Supports and Equipment will reduce utilization for Assistive Technology and Communication Aids; and Health and Wellness will reduce utilization for Counseling and Therapeutic Services.

Four existing services have been renamed and two existing services have been combined to form one. Consumer Education has been renamed to Empowerment and Self-Determination Supports; Supported Employment has been renamed to Community/Competitive Integrated Employment; Supportive Home Care has been renamed to Personal Supports; Training for Parents/Guardians & Families of Children with Disabilities has been renamed to Family/Unpaid Caregiver Supports and Services; and Housing Counseling and Relocation Services have been combined to form Housing Support Services. Utilization and costs for these services are estimated to remain consistent with their historical basis.

Costs are trended forward using the Consumer Price Index for All Items. A trend of 0.89% is applied to July 2020 through December 2020 and a trend 1.78% is applied in all other years.

The unduplicated participant count in the derivation is projected using the same method to derive Average Length of Stay as described above.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' ***is based on actual SFY2020 service costs paid by the State Medicaid plan for waiver members. State plan service costs in Factor D' are pulled from the same SFY2020 Medicaid fee-for-service paid claims data in the State's MMIS.***

Costs are trended forward using the Consumer Price Index for Medical Care. A trend of 1.43% is applied to July 2020 through December 2020 and a trend of 2.85% is applied in all other years.

The unduplicated participant count used in the derivation is projected using the same method to derive Average Length of Stay as described above.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is based on a blend of SFY2020 Medicaid institutional costs for children residing in State Centers, Institutes for Mental Disease (IMDs), ICF-IIDs, and Nursing Facilities as well as inpatient hospital stays to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. A trend of 0.89% is applied to July 2020 through December 2020 and a trend 1.78% is applied in all other years.

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay (ALOS) between the institutional populations and the waiver population. With the institutional population having a lower ALOS than the waiver participants, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional populations are adjusted by the ratio of the institutional ALOS to the wavier ALOS, which increases Factors G and G' ***for the waiver population relative to the institutional population.***

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these*

estimates is as follows:

Factor G' ***is based on a blend of SFY2020 Medicaid non-institutional costs for children residing in State Centers, Institutes for Mental Disease (IMDs), ICF-IIDs, and Nursing Facilities as well as inpatient hospital stays to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. Costs are trended forward using the Consumer Price Index for Medical Care. Costs are trended forward using the Consumer Price Index for Medical Care. A trend of 1.43% is applied to July 2020 through December 2020 and a trend of 2.85% is applied in all other years.***

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay (ALOS) between the institutional populations and the waiver population. With the institutional population having a lower ALOS than the waiver participants, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional populations are adjusted by the ratio of the institutional ALOS to the wavier ALOS, which increases Factors G and G' for the waiver population relative to the institutional population.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Community/Competitive Integrated Employment	
Day Services	
Discovery and Career Planning	
Respite	
Support and Service Coordination	
Financial Management Services	
Participant and Family-Direction Broker Services	
Adaptive Aids	
Adult Family Home	
Assistive Technology and Communication Aids	
Child Care Services	
Children's Foster Care	
Community Integration Services	
Counseling and Therapeutic Services	
Daily Living Skills Training	
Empowerment and Self-Determination Supports	
Family/Unpaid Caregiver Supports and Services	
Grief and Bereavement Counseling	
Health and Wellness	
Home Modifications	
Housing Support Services	
Mentoring	
Participant and Family-Directed Goods and Services	
Personal Emergency Response System (PERS)	
Personal Supports	
Remote Supports and Equipment	

Waiver Services	
Safety Planning and Prevention	
Specialized Medical and Therapeutic Supplies	
Translation and Interpretation Services	
Transportation	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community/Competitive Integrated Employment Total:							**24691.43**
Community/Competitive Integrated Employment	☐	Months	15	3.15	522.57	**24691.43**	
Day Services Total:							**56483.25**
Day Services - Days	☐	Days	13	661.98	2.62	**22547.04**	
Day Services - Hours	☐	Hours	25	109.56	12.39	**33936.21**	
Discovery and Career Planning Total:							**237290.86**
Discovery and Career Planning - Days	☐	Days	88	12.90	104.51	**118639.75**	
Discovery and Career Planning - Hours	☐	Hours	88	25.80	52.26	**118651.10**	
Respite Total:							**62335481.98**
Respite - Days	☐	Days	3271	20.58	175.15	**11790604.08**	
Respite - Hours	☐	Hours	8722	300.42	19.29	**50544877.90**	
Support and Service Coordination Total:							**42539631.43**
Support and Service Coordination	☐	Hours	15852	29.29	91.62	**42539631.43**	
Financial Management							**3783638.47**

GRAND TOTAL:	**178634347.47**
Total: Services included in capitation:	
Total: Services not included in capitation:	178634347.47
Total Estimated Unduplicated Participants:	**17115**
Factor D (Divide total by number of participants):	**10437.30**
Services included in capitation:	
Services not included in capitation:	10437.30
Average Length of Stay on the Waiver:	317

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services Total:							
Financial Management Services	☐	Months	6863	9.33	59.09	3783638.47	
Participant and Family-Direction Broker Services Total:							2899538.47
Participant and Family Direction Broker Services - Days	☐	Days	1144	9.33	135.87	1450211.16	
Participant and Family Direction Broker Services - Hours	☐	Hours	1144	18.65	67.93	1449327.31	
Adaptive Aids Total:							6146030.46
Other	☐	Each	4758	3.22	226.93	3476740.07	
Vehicle Modifications	☐	Each	184	1.90	7635.27	2669290.39	
Adult Family Home Total:							215461.46
Adult Family Home	☐	Days	6	98.53	364.46	215461.46	
Assistive Technology and Communication Aids Total:							246602.78
Assistive Technology and Communication Aids	☐	Each	297	24.58	33.78	246602.78	
Child Care Services Total:							956228.21
Child Care Services - Days	☐	Days	82	49.45	39.03	158262.75	
Child Care Services - Hours	☐	Hours	299	264.76	10.08	797965.46	
Children's Foster Care Total:							7081583.00
Children’s Foster Care - Days	☐	Days	106	170.55	142.56	2577242.45	
Children’s Foster Care - Months	☐	Months	269	19.86	843.14	4504340.55	
Community Integration Services Total:							4675168.86
Community Integration Services - Days	☐	Days	22	74.02	77.19	125699.28	
Community Integration Services - Hours	☐	Hours	562	137.02	59.08	4549469.58	
Counseling and Therapeutic Services Total:							4399601.68

GRAND TOTAL:		178634347.47
Total: Services included in capitation:		
Total: Services not included in capitation:		178634347.47
Total Estimated Unduplicated Participants:		17115
Factor D (Divide total by number of participants):		10437.30
Services included in capitation:		
Services not included in capitation:		10437.30
Average Length of Stay on the Waiver:	317	

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Counseling and Therapeutic Services - Days	☐	Days	1978	25.94	85.23	4373093.34	
Counseling and Therapeutic Services - Hours	☐	Hours	3	2.63	82.94	654.40	
Counseling and Therapeutic Services - Each	☐	Each	85	2.04	149.10	25853.94	
Daily Living Skills Training Total:							11492589.00
Daily Living Skills Training	☐	Hours	2451	154.14	30.42	11492589.00	
Empowerment and Self-Determination Supports Total:							910987.66
Empowerment and Self Determination Supports - Days	☐	Days	1044	8.64	74.14	668754.66	
Empowerment and Self Determination Supports - Hours	☐	Hours	138	17.08	102.77	242233.00	
Family/Unpaid Caregiver Supports and Services Total:							1279460.06
Family/Unpaid Caregiver Supports and Services - Days	☐	Days	180	7.17	170.30	219789.18	
Family/Unpaid Caregiver Supports and Services - Hours	☐	Hours	482	30.83	71.31	1059670.88	
Grief and Bereavement Counseling Total:							41522.40
Grief and Bereavement Counseling	☐	Days	31	16.02	83.61	41522.40	
Health and Wellness Total:							2010810.92
Health and Wellness - Days	☐	Days	659	25.95	94.06	1608524.76	
Health and Wellness - Hours	☐	Hours	659	12.98	47.03	402286.15	
Home Modifications Total:							6098764.32
Home Modifications	☐	Each	740	2.41	3419.74	6098764.32	
Housing Support Services Total:							51548.39
Housing Support Services - Each	☐	Each	18	12.87	213.49	49457.09	
Housing Support Services - Hours	☐	Hours	22	1.07	88.84	2091.29	

GRAND TOTAL:	178634347.47
Total: Services included in capitation:	
Total: Services not included in capitation:	178634347.47
Total Estimated Unduplicated Participants:	17115
Factor D (Divide total by number of participants):	10437.30
Services included in capitation:	
Services not included in capitation:	10437.30
Average Length of Stay on the Waiver:	317

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Mentoring Total:							**391634.25**
Mentoring - Each	☐	Each	3	19.44	23.53	**1372.27**	
Mentoring - Hours	☐	Hours	230	72.02	23.56	**390261.98**	
Participant and Family-Directed Goods and Services Total:							**1241557.42**
Participant and Family-Directed Goods and Services - Days	☐	Days	342	6.44	83.61	**184149.35**	
Participant and Family-Directed Goods and Services - Each	☐	Each	513	37.11	39.41	**750265.12**	
Participant and Family-Directed Goods and Services - Hours	☐	Hours	342	21.48	41.81	**307142.95**	
Personal Emergency Response System (PERS) Total:							**309685.87**
Personal Emergency Response System (PERS) - Each	☐	Each	484	1.33	159.41	**102615.41**	
Personal Emergency Response System (PERS) - Months	☐	Months	798	7.22	35.94	**207070.47**	
Personal Supports Total:							**12163592.77**
Personal Supports - Days	☐	Days	36	23.12	159.96	**133137.91**	
Personal Supports - Hours	☐	Hours	1385	397.54	21.85	**12030454.86**	
Remote Supports and Equipment Total:							**886852.30**
Remote Supports and Equipment - Each	☐	Each	396	6.43	209.03	**532248.91**	
Remote Supports and Equipment - Months	☐	Months	396	10.71	83.61	**354603.39**	
Safety Planning and Prevention Total:							**1278111.79**
Safety Planning and Prevention - Days	☐	Days	297	8.58	167.22	**426120.04**	
Safety Planning and Prevention - Hours	☐	Hours	297	34.31	83.61	**851991.75**	
Specialized Medical and Therapeutic Supplies Total:							**2036772.39**
Specialized Medical and Therapeutic Supplies	☐	Each	4359	18.16	25.73	**2036772.39**	

GRAND TOTAL:		**178634347.47**
Total: Services included in capitation:		
Total: Services not included in capitation:		178634347.47
Total Estimated Unduplicated Participants:		**17115**
Factor D (Divide total by number of participants):		**10437.30**
Services included in capitation:		
Services not included in capitation:		10437.30
Average Length of Stay on the Waiver:	317	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Translation and Interpretation Services Total:							**1110351.59**
Translation and Interpretation Services - Days	☐	Days	79	28.02	156.77	**347022.94**	
Translation and Interpretation Services - Hours	☐	Hours	79	168.10	57.48	**763328.65**	
Transportation Total:							**1732674.02**
Transportation - Miles	☐	Miles	1952	824.58	0.56	**901364.89**	
Transportation - Trips	☐	Trips	707	93.80	12.33	**817683.68**	
Transportation - Each	☐	Each	29	8.64	54.38	**13625.45**	

GRAND TOTAL:	**178634347.47**
Total: Services included in capitation:	
Total: Services not included in capitation:	178634347.47
Total Estimated Unduplicated Participants:	**17115**
Factor D (Divide total by number of participants):	**10437.30**
Services included in capitation:	
Services not included in capitation:	10437.30
Average Length of Stay on the Waiver:	317

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community/Competitive Integrated Employment Total:							**26891.35**
Community/Competitive Integrated Employment	☐	Month	16	3.16	531.87	**26891.35**	
Day Services Total:							**61316.92**
Day Services - Days	☐	Days				**24440.61**	

GRAND TOTAL:	**194118170.55**
Total: Services included in capitation:	
Total: Services not included in capitation:	194118170.55
Total Estimated Unduplicated Participants:	**18192**
Factor D (Divide total by number of participants):	**10670.52**
Services included in capitation:	
Services not included in capitation:	10670.52
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			14	656.30	2.66		
Day Services - Hours	☐	Hours	27	108.31	12.61	36876.31	
Discovery and Career Planning Total:							257780.66
Discovery and Career Planning - Days	☐	Days	94	12.89	106.37	128884.27	
Discovery and Career Planning - Hours	☐	Hours	94	25.78	53.19	128896.39	
Respite Total:							67729412.73
Respite - Days	☐	Days	3477	20.67	178.27	12812191.81	
Respite - Hours	☐	Hours	9271	301.76	19.63	54917220.92	
Support and Service Coordination Total:							46223799.34
Support and Service Coordination	☐	Hours	16849	29.42	93.25	46223799.34	
Financial Management Services Total:							4110818.58
Financial Management Services	☐	Months	7295	9.37	60.14	4110818.58	
Participant and Family-Direction Broker Services Total:							3150375.71
Participant and Family Direction Broker Services - Days	☐	Days	1216	9.37	138.29	1575665.20	
Participant and Family Direction Broker Services - Hours	☐	Hours	1216	18.73	69.14	1574710.52	
Adaptive Aids Total:							6693584.74
Other	☐	Each	5057	3.24	230.97	3784369.54	
Vehicle Modifications	☐	Each	196	1.91	7771.17	2909215.20	
Adult Family Home Total:							234137.33
Adult Family Home	☐	Days	6	105.20	370.94	234137.33	
Assistive Technology and Communication Aids Total:							267908.21
Assistive Technology and Communication Aids	☐	Each	316	24.66	34.38	267908.21	

GRAND TOTAL:	**194118170.55**
Total: Services included in capitation:	
Total: Services not included in capitation:	194118170.55
Total Estimated Unduplicated Participants:	**18192**
Factor D (Divide total by number of participants):	**10670.52**
Services included in capitation:	
Services not included in capitation:	10670.52
Average Length of Stay on the Waiver:	319

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Care Services Total:							**1039167.76**
Child Care Services - Days	☐	Days	88	49.19	39.73	**171980.05**	
Child Care Services - Hours	☐	Hours	318	265.79	10.26	**867187.72**	
Children's Foster Care Total:							**7694487.12**
Children's Foster Care - Days	☐	Days	113	170.81	145.10	**2800652.00**	
Children's Foster Care - Months	☐	Months	286	19.94	858.14	**4893835.12**	
Community Integration Services Total:							**5080052.15**
Community Integration Services - Days	☐	Days	23	75.59	78.56	**136582.06**	
Community Integration Services - Hours	☐	Hours	598	137.48	60.13	**4943470.10**	
Counseling and Therapeutic Services Total:							**4781182.70**
Counseling and Therapeutic Services - Days	☐	Days	2103	26.05	86.75	**4752438.26**	
Counseling and Therapeutic Services - Hours	☐	Hours	3	2.81	84.42	**711.66**	
Counseling and Therapeutic Services - Each	☐	Each	91	2.03	151.75	**28032.78**	
Daily Living Skills Training Total:							**12487969.87**
Daily Living Skills Training	☐	Hours	2605	154.84	30.96	**12487969.87**	
Empowerment and Self-Determination Supports Total:							**990464.41**
Empowerment and Self Determination Supports - Days	☐	Days	1109	8.69	75.46	**727223.87**	
Empowerment and Self Determination Supports - Hours	☐	Hours	147	17.12	104.60	**263240.54**	
Family/Unpaid Caregiver Supports and Services Total:							**1390579.20**
Family/Unpaid Caregiver Supports and Services - Days	☐	Days	192	7.18	173.33	**238945.80**	
Family/Unpaid Caregiver Supports and	☐	Hours	513	30.93	72.58	**1151633.39**	

	GRAND TOTAL:	**194118170.55**
	Total: Services included in capitation:	
	Total: Services not included in capitation:	*194118170.55*
	Total Estimated Unduplicated Participants:	**18192**
	Factor D (Divide total by number of participants):	**10670.52**
	Services included in capitation:	
	Services not included in capitation:	*10670.52*
	Average Length of Stay on the Waiver:	*319*

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services - Hours							
Grief and Bereavement Counseling Total:							**45129.38**
Grief and Bereavement Counseling	☐	Days	33	16.07	85.10	**45129.38**	
Health and Wellness Total:							**2184887.81**
Health and Wellness - Days	☐	Days	701	26.04	95.74	**1747641.79**	
Health and Wellness - Hours	☐	Hours	701	13.03	47.87	**437246.02**	
Home Modifications Total:							**6628960.97**
Home Modifications	☐	Each	787	2.42	3480.61	**6628960.97**	
Housing Support Services Total:							**56040.83**
Housing Support Services - Each	☐	Each	19	13.02	217.29	**53753.20**	
Housing Support Services - Hours	☐	Hours	23	1.10	90.42	**2287.63**	
Mentoring Total:							**425403.93**
Mentoring - Each	☐	Each	3	20.76	23.95	**1491.61**	
Mentoring - Hours	☐	Hours	244	72.48	23.97	**423912.33**	
Participant and Family-Directed Goods and Services Total:							**1348998.49**
Participant and Family-Directed Goods and Services - Days	☐	Days	364	6.46	85.10	**200107.54**	
Participant and Family-Directed Goods and Services - Each	☐	Each	546	37.22	40.11	**815120.23**	
Participant and Family-Directed Goods and Services - Hours	☐	Hours	364	21.55	42.55	**333770.71**	
Personal Emergency Response System (PERS) Total:							**336026.98**
Personal Emergency Response System (PERS) - Each	☐	Each	515	1.33	162.25	**111133.14**	
Personal Emergency Response System (PERS) - Months	☐	Months	848	7.25	36.58	**224893.84**	
Personal Supports Total:							**13218594.92**

GRAND TOTAL:	**194118170.55**
Total: Services included in capitation:	
Total: Services not included in capitation:	*194118170.55*
Total Estimated Unduplicated Participants:	**18192**
Factor D (Divide total by number of participants):	**10670.52**
Services included in capitation:	
Services not included in capitation:	*10670.52*
Average Length of Stay on the Waiver:	*319*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Supports - Days	☐	Days	39	22.78	162.80	144634.78	
Personal Supports - Hours	☐	Hours	1472	399.36	22.24	13073960.14	
Remote Supports and Equipment Total:							962853.31
Remote Supports and Equipment - Each	☐	Each	421	6.45	212.75	577711.99	
Remote Supports and Equipment - Months	☐	Months	421	10.75	85.10	385141.32	
Safety Planning and Prevention Total:							1388576.70
Safety Planning and Prevention - Days	☐	Days	315	8.63	170.20	462680.19	
Safety Planning and Prevention - Hours	☐	Hours	315	34.54	85.10	925896.51	
Specialized Medical and Therapeutic Supplies Total:							2213210.04
Specialized Medical and Therapeutic Supplies	☐	Each	4633	18.24	26.19	2213210.04	
Translation and Interpretation Services Total:							1206603.36
Translation and Interpretation Services - Days	☐	Days	84	28.13	159.56	377027.52	
Translation and Interpretation Services - Hours	☐	Hours	84	168.79	58.51	829575.84	
Transportation Total:							1882955.05
Transportation - Miles	☐	Miles	2075	828.20	0.57	979553.55	
Transportation - Trips	☐	Trips	751	94.28	12.55	888593.71	
Transportation - Each	☐	Each	31	8.63	55.35	14807.79	

GRAND TOTAL:		194118170.55
Total: Services included in capitation:		
Total: Services not included in capitation:		194118170.55
Total Estimated Unduplicated Participants:		18192
Factor D (Divide total by number of participants):		10670.52
Services included in capitation:		
Services not included in capitation:		10670.52
Average Length of Stay on the Waiver:	319	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that*

service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community/Competitive Integrated Employment Total:							**28842.60**
Community/Competitive Integrated Employment	☐	Months	16	3.33	541.34	**28842.60**	
Day Services Total:							**65932.31**
Day Services - Days	☐	Days	15	647.01	2.71	**26300.96**	
Day Services - Hours	☐	Hours	28	110.32	12.83	**39631.36**	
Discovery and Career Planning Total:							**277173.56**
Discovery and Career Planning - Days	☐	Days	99	12.93	108.27	**138593.18**	
Discovery and Career Planning - Hours	☐	Hours	99	25.86	54.13	**138580.38**	
Respite Total:							**72810259.53**
Respite - Days	☐	Days	3659	20.74	181.44	**13769057.03**	
Respite - Hours	☐	Hours	9758	302.83	19.98	**59041202.50**	
Support and Service Coordination Total:							**49702945.25**
Support and Service Coordination	☐	Hours	17734	29.53	94.91	**49702945.25**	
Financial Management Services Total:							**4417721.57**
Financial Management Services	☐	Months	7678	9.40	61.21	**4417721.57**	
Participant and Family-Direction Broker Services Total:							**3386887.68**
Participant and Family Direction Broker Services - Days	☐	Days	1280	9.40	140.75	**1693504.00**	
Participant and Family Direction Broker Services - Hours	☐	Hours	1280	18.80	70.37	**1693383.68**	
Adaptive Aids Total:							**7195190.67**
Other	☐	Each	5323	3.25	235.08	**4066825.23**	

	GRAND TOTAL:	**208696719.99**
	Total: Services included in capitation:	
	Total: Services not included in capitation:	208696719.99
	Total Estimated Unduplicated Participants:	**19147**
	Factor D (Divide total by number of participants):	**10899.71**
	Services included in capitation:	
	Services not included in capitation:	10899.71
	Average Length of Stay on the Waiver:	321

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modifications	☐	Each	206	1.92	7909.50	3128365.44	
Adult Family Home Total:							251705.03
Adult Family Home	☐	Days	7	95.24	377.55	251705.03	
Assistive Technology and Communication Aids Total:							287977.50
Assistive Technology and Communication Aids	☐	Each	332	24.79	34.99	287977.50	
Child Care Services Total:							1116926.54
Child Care Services - Days	☐	Days	92	49.70	40.43	184862.13	
Child Care Services - Hours	☐	Hours	334	267.30	10.44	932064.41	
Children's Foster Care Total:							8274186.10
Children’s Foster Care - Days	☐	Days	119	171.33	147.68	3010939.71	
Children’s Foster Care - Months	☐	Months	301	20.02	873.42	5263246.39	
Community Integration Services Total:							5461438.63
Community Integration Services - Days	☐	Days	25	73.46	79.96	146846.54	
Community Integration Services - Hours	☐	Hours	629	138.06	61.20	5314592.09	
Counseling and Therapeutic Services Total:							5138394.49
Counseling and Therapeutic Services - Days	☐	Days	2213	26.14	88.29	5107384.03	
Counseling and Therapeutic Services - Hours	☐	Hours	3	2.96	85.92	762.97	
Counseling and Therapeutic Services - Each	☐	Each	96	2.04	154.45	30247.49	
Daily Living Skills Training Total:							13424897.26
Daily Living Skills Training	☐	Hours	2742	155.38	31.51	13424897.26	
Empowerment and Self-Determination Supports Total:							1064305.20
Empowerment and Self	☐					781307.90	

GRAND TOTAL:	**208696719.99**
Total: Services included in capitation:	
Total: Services not included in capitation:	208696719.99
Total Estimated Unduplicated Participants:	**19147**
Factor D (Divide total by number of participants):	**10899.71**
Services included in capitation:	
Services not included in capitation:	10899.71
Average Length of Stay on the Waiver:	321

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Determination Supports - Days		Days	1168	8.71	76.80		
Empowerment and Self Determination Supports - Hours	☐	Hours	155	17.15	106.46	282997.30	
Family/Unpaid Caregiver Supports and Services Total:							1495121.01
Family/Unpaid Caregiver Supports and Services - Days	☐	Days	202	7.21	176.42	256941.62	
Family/Unpaid Caregiver Supports and Services - Hours	☐	Hours	540	31.04	73.87	1238179.39	
Grief and Bereavement Counseling Total:							48499.87
Grief and Bereavement Counseling	☐	Days	34	16.47	86.61	48499.87	
Health and Wellness Total:							2348963.67
Health and Wellness - Days	☐	Days	738	26.13	97.44	1879027.11	
Health and Wellness - Hours	☐	Hours	738	13.07	48.72	469936.56	
Home Modifications Total:							7127772.42
Home Modifications	☐	Each	828	2.43	3542.56	7127772.42	
Housing Support Services Total:							60273.03
Housing Support Services - Each	☐	Each	20	13.07	221.16	57811.22	
Housing Support Services - Hours	☐	Hours	25	1.07	92.03	2461.80	
Mentoring Total:							457428.41
Mentoring - Each	☐	Each	3	21.93	24.38	1603.96	
Mentoring - Hours	☐	Hours	257	72.69	24.40	455824.45	
Participant and Family-Directed Goods and Services Total:							1450598.59
Participant and Family-Directed Goods and Services - Days	☐	Days	383	6.49	86.61	215283.88	
Participant and Family-Directed Goods and Services - Each	☐	Each	574	37.40	40.83	876522.11	
Participant and Family-Directed Goods and	☐					358792.60	

GRAND TOTAL:	**208696719.99**
Total: Services included in capitation:	
Total: Services not included in capitation:	208696719.99
Total Estimated Unduplicated Participants:	**19147**
Factor D (Divide total by number of participants):	**10899.71**
Services included in capitation:	
Services not included in capitation:	10899.71
Average Length of Stay on the Waiver:	321

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services - Hours		Hours	383	21.63	43.31		
Personal Emergency Response System (PERS) Total:							**361639.13**
Personal Emergency Response System (PERS) - Each	☐	Each	542	1.34	165.14	**119937.88**	
Personal Emergency Response System (PERS) - Months	☐	Months	893	7.27	37.23	**241701.26**	
Personal Supports Total:							**14213411.44**
Personal Supports - Days	☐	Days	41	22.89	165.70	**155507.79**	
Personal Supports - Hours	☐	Hours	1549	400.86	22.64	**14057903.65**	
Remote Supports and Equipment Total:							**1035956.56**
Remote Supports and Equipment - Each	☐	Each	443	6.48	216.53	**621579.68**	
Remote Supports and Equipment - Months	☐	Months	443	10.80	86.61	**414376.88**	
Safety Planning and Prevention Total:							**1492675.85**
Safety Planning and Prevention - Days	☐	Days	332	8.65	173.23	**497481.91**	
Safety Planning and Prevention - Hours	☐	Hours	332	34.61	86.61	**995193.94**	
Specialized Medical and Therapeutic Supplies Total:							**2378488.52**
Specialized Medical and Therapeutic Supplies	☐	Each	4877	18.30	26.65	**2378488.52**	
Translation and Interpretation Services Total:							**1297299.07**
Translation and Interpretation Services - Days	☐	Days	89	28.05	162.40	**405423.48**	
Translation and Interpretation Services - Hours	☐	Hours	89	168.28	59.55	**891875.59**	
Transportation Total:							**2023808.52**
Transportation - Miles	☐	Miles	2184	831.14	0.58	**1052821.66**	
Transportation - Trips	☐	Trips	791	94.55	12.77	**955056.17**	

GRAND TOTAL:		**208696719.99**
Total: Services included in capitation:		
Total: Services not included in capitation:		208696719.99
Total Estimated Unduplicated Participants:		**19147**
Factor D (Divide total by number of participants):		**10899.71**
Services included in capitation:		
Services not included in capitation:		10899.71
Average Length of Stay on the Waiver:	321	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation - Each	☐	Each	33	8.57	56.33	15930.69	
					GRAND TOTAL:		208696719.99
					Total: Services included in capitation:		
					Total: Services not included in capitation:		208696719.99
					Total Estimated Unduplicated Participants:		19147
					Factor D (Divide total by number of participants):		10899.71
					Services included in capitation:		
					Services not included in capitation:		10899.71
					Average Length of Stay on the Waiver:		321

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community/Competitive Integrated Employment Total:							30815.75
Community/Competitive Integrated Employment	☐	Months	17	3.29	550.97	30815.75	
Day Services Total:							70306.53
Day Services - Days	☐	Days	15	677.64	2.76	28054.30	
Day Services - Hours	☐	Hours	29	111.56	13.06	42252.23	
Discovery and Career Planning Total:							295499.46
Discovery and Career Planning - Days	☐	Days	103	13.02	110.19	147771.40	
Discovery and Career Planning - Hours	☐	Hours	103	26.03	55.10	147728.06	
Respite Total:							77631185.22
Respite - Days	☐	Days	3822	20.80	184.67	14680821.79	
Respite - Hours	☐					62950363.43	
					GRAND TOTAL:		222442502.04
					Total: Services included in capitation:		
					Total: Services not included in capitation:		222442502.04
					Total Estimated Unduplicated Participants:		19996
					Factor D (Divide total by number of participants):		11124.35
					Services included in capitation:		
					Services not included in capitation:		11124.35
					Average Length of Stay on the Waiver:		321

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		Hours	10191	303.69	20.34		
Support and Service Coordination Total:							**52973237.52**
Support and Service Coordination	☐	Hours	18520	29.61	96.60	**52973237.52**	
Financial Management Services Total:							**4710486.80**
Financial Management Services	☐	Months	8018	9.43	62.30	**4710486.80**	
Participant and Family-Direction Broker Services Total:							**3609590.50**
Participant and Family Direction Broker Services - Days	☐	Days	1336	9.43	143.25	**1804732.26**	
Participant and Family Direction Broker Services - Hours	☐	Hours	1336	18.86	71.63	**1804858.24**	
Adaptive Aids Total:							**7659110.78**
Other	☐	Each	5559	3.26	239.26	**4335951.07**	
Vehicle Modifications	☐	Each	215	1.92	8050.29	**3323159.71**	
Adult Family Home Total:							**268316.53**
Adult Family Home	☐	Days	7	99.75	384.27	**268316.53**	
Assistive Technology and Communication Aids Total:							**307063.25**
Assistive Technology and Communication Aids	☐	Each	347	24.85	35.61	**307063.25**	
Child Care Services Total:							**1191033.83**
Child Care Services - Days	☐	Days	96	49.89	41.15	**197085.46**	
Child Care Services - Hours	☐	Hours	349	267.92	10.63	**993948.37**	
Children's Foster Care Total:							**8818451.13**
Children’s Foster Care - Days	☐	Days	124	172.20	150.31	**3209539.37**	
Children’s Foster Care - Months	☐	Months	315	20.03	888.97	**5608911.77**	
Community Integration Services Total:							**5821715.49**
Community Integration	☐					**156532.80**	

GRAND TOTAL:	**222442502.04**
Total: Services included in capitation:	
Total: Services not included in capitation:	222442502.04
Total Estimated Unduplicated Participants:	**19996**
Factor D (Divide total by number of participants):	**11124.35**
Services included in capitation:	
Services not included in capitation:	11124.35
Average Length of Stay on the Waiver:	321

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services - Days		Days	26	73.98	81.38		
Community Integration Services - Hours	☐	Hours	657	138.43	62.29	5665182.69	
Counseling and Therapeutic Services Total:							5478053.87
Counseling and Therapeutic Services - Days	☐	Days	2311	26.22	89.86	5445014.58	
Counseling and Therapeutic Services - Hours	☐	Hours	3	3.10	87.45	813.28	
Counseling and Therapeutic Services - Each	☐	Each	100	2.05	157.20	32226.00	
Daily Living Skills Training Total:							14309993.18
Daily Living Skills Training	☐	Hours	2864	155.80	32.07	14309993.18	
Empowerment and Self-Determination Supports Total:							1134558.78
Empowerment and Self Determination Supports - Days	☐	Days	1219	8.74	78.17	832827.87	
Empowerment and Self Determination Supports - Hours	☐	Hours	162	17.19	108.35	301730.91	
Family/Unpaid Caregiver Supports and Services Total:							1593834.99
Family/Unpaid Caregiver Supports and Services - Days	☐	Days	211	7.23	179.56	273924.17	
Family/Unpaid Caregiver Supports and Services - Hours	☐	Hours	563	31.18	75.19	1319910.82	
Grief and Bereavement Counseling Total:							51700.55
Grief and Bereavement Counseling	☐	Days	36	16.29	88.16	51700.55	
Health and Wellness Total:							2504126.39
Health and Wellness - Days	☐	Days	770	26.23	99.18	2003148.38	
Health and Wellness - Hours	☐	Hours	770	13.12	49.59	500978.02	
Home Modifications Total:							7578832.96
Home Modifications	☐	Each	865	2.43	3605.62	7578832.96	

GRAND TOTAL:		222442502.04
Total: Services included in capitation:		
Total: Services not included in capitation:		222442502.04
Total Estimated Unduplicated Participants:		19996
Factor D (Divide total by number of participants):		11124.35
Services included in capitation:		
Services not included in capitation:		11124.35
Average Length of Stay on the Waiver:	321	

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Support Services Total:							**64200.01**
Housing Support Services - Each	☐	Each	21	13.03	225.10	**61594.11**	
Housing Support Services - Hours	☐	Hours	26	1.07	93.67	**2605.90**	
Mentoring Total:							**487678.67**
Mentoring - Each	☐	Each	3	22.96	24.81	**1708.91**	
Mentoring - Hours	☐	Hours	268	73.00	24.84	**485969.76**	
Participant and Family-Directed Goods and Services Total:							**1546133.82**
Participant and Family-Directed Goods and Services - Days	☐	Days	400	6.51	88.16	**229568.64**	
Participant and Family-Directed Goods and Services - Each	☐	Each	600	37.47	41.55	**934127.10**	
Participant and Family-Directed Goods and Services - Hours	☐	Hours	400	21.69	44.08	**382438.08**	
Personal Emergency Response System (PERS) Total:							**385267.00**
Personal Emergency Response System (PERS) - Each	☐	Each	566	1.34	168.08	**127478.60**	
Personal Emergency Response System (PERS) - Months	☐	Months	932	7.30	37.89	**257788.40**	
Personal Supports Total:							**15149185.15**
Personal Supports - Days	☐	Days	42	23.40	168.65	**165749.22**	
Personal Supports - Hours	☐	Hours	1618	401.93	23.04	**14983435.93**	
Remote Supports and Equipment Total:							**1103894.92**
Remote Supports and Equipment - Each	☐	Each	463	6.49	220.39	**662243.30**	
Remote Supports and Equipment - Months	☐	Months	463	10.82	88.16	**441651.63**	
Safety Planning and Prevention Total:							**1591646.70**
Safety Planning and Prevention - Days	☐	Days	347	8.67	176.31	**530426.87**	
Safety Planning and	☐					**1061219.83**	

GRAND TOTAL:		**222442502.04**
Total: Services included in capitation:		
Total: Services not included in capitation:		222442502.04
Total Estimated Unduplicated Participants:		**19996**
Factor D (Divide total by number of participants):		**11124.35**
Services included in capitation:		
Services not included in capitation:		11124.35
Average Length of Stay on the Waiver:	321	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Prevention - Hours		Hours	347	34.69	88.16		
Specialized Medical and Therapeutic Supplies Total:							**2536857.93**
Specialized Medical and Therapeutic Supplies	☐	Each	5093	18.36	27.13	**2536857.93**	
Translation and Interpretation Services Total:							**1382796.96**
Translation and Interpretation Services - Days	☐	Days	93	28.11	165.29	**432106.08**	
Translation and Interpretation Services - Hours	☐	Hours	93	168.66	60.61	**950690.88**	
Transportation Total:							**2156927.34**
Transportation - Miles	☐	Miles	2281	833.46	0.59	**1121662.13**	
Transportation - Trips	☐	Trips	826	94.83	13.00	**1018284.54**	
Transportation - Each	☐	Each	34	8.71	57.34	**16980.67**	

GRAND TOTAL:	**222442502.04**
Total: Services included in capitation:	
Total: Services not included in capitation:	222442502.04
Total Estimated Unduplicated Participants:	**19996**
Factor D (Divide total by number of participants):	**11124.35**
Services included in capitation:	
Services not included in capitation:	11124.35
Average Length of Stay on the Waiver:	321

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community/Competitive							**32603.75**

GRAND TOTAL:	**235495153.60**
Total: Services included in capitation:	
Total: Services not included in capitation:	235495153.60
Total Estimated Unduplicated Participants:	**20750**
Factor D (Divide total by number of participants):	**11349.16**
Services included in capitation:	
Services not included in capitation:	11349.16
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integrated Employment Total:							
Community/Competitive Integrated Employment	☐	Months	18	3.23	560.78	**32603.75**	
Day Services Total:							**74425.96**
Day Services - Days	☐	Days	16	660.76	2.81	**29707.77**	
Day Services - Hours	☐	Hours	30	112.16	13.29	**44718.19**	
Discovery and Career Planning Total:							**312749.19**
Discovery and Career Planning - Days	☐	Days	107	13.03	112.16	**156374.59**	
Discovery and Career Planning - Hours	☐	Hours	107	26.06	56.08	**156374.59**	
Respite Total:							**82176540.16**
Respite - Days	☐	Days	3966	20.85	187.96	**15542619.16**	
Respite - Hours	☐	Hours	10575	304.40	20.70	**66633921.00**	
Support and Service Coordination Total:							**56083686.53**
Support and Service Coordination	☐	Hours	19219	29.68	98.32	**56083686.53**	
Financial Management Services Total:							**4986147.06**
Financial Management Services	☐	Months	8321	9.45	63.41	**4986147.06**	
Participant and Family-Direction Broker Services Total:							**3822044.94**
Participant and Family Direction Broker Services - Days	☐	Days	1387	9.45	145.80	**1911022.47**	
Participant and Family Direction Broker Services - Hours	☐	Hours	1387	18.90	72.90	**1911022.47**	
Adaptive Aids Total:							**8105507.05**
Other	☐	Each	5768	3.26	243.52	**4579072.15**	
Vehicle Modifications	☐	Each	223	1.93	8193.58	**3526434.90**	
Adult Family Home Total:							**284043.64**
Adult Family Home	☐	Days	7	103.75	391.11	**284043.64**	

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Services included in capitation:	
Services not included in capitation:	11349.16
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology and Communication Aids Total:							**325075.50**
Assistive Technology and Communication Aids	☐	Each	360	24.91	36.25	**325075.50**	
Child Care Services Total:							**1260913.16**
Child Care Services - Days	☐	Days	100	49.81	41.89	**208654.09**	
Child Care Services - Hours	☐	Hours	362	268.65	10.82	**1052259.07**	
Children's Foster Care Total:							**9335934.43**
Children’s Foster Care - Days	☐	Days	129	172.17	152.99	**3397897.19**	
Children’s Foster Care - Months	☐	Months	327	20.07	904.79	**5938037.24**	
Community Integration Services Total:							**6163349.56**
Community Integration Services - Days	☐	Days	27	74.09	82.83	**165695.62**	
Community Integration Services - Hours	☐	Hours	682	138.71	63.40	**5997653.95**	
Counseling and Therapeutic Services Total:							**5798731.60**
Counseling and Therapeutic Services - Days	☐	Days	2398	26.28	91.46	**5763757.98**	
Counseling and Therapeutic Services - Hours	☐	Hours	4	2.42	89.01	**861.62**	
Counseling and Therapeutic Services - Each	☐	Each	104	2.05	160.00	**34112.00**	
Daily Living Skills Training Total:							**15148469.45**
Daily Living Skills Training	☐	Hours	2972	156.16	32.64	**15148469.45**	
Empowerment and Self-Determination Supports Total:							**1201042.35**
Empowerment and Self Determination Supports - Days	☐	Days	1265	8.76	79.56	**881636.18**	
Empowerment and Self Determination Supports - Hours	☐	Hours	168	17.24	110.28	**319406.17**	
Family/Unpaid Caregiver Supports and Services							**1687304.82**

GRAND TOTAL:		**235495153.60**
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Average Length of Stay on the Waiver:	322	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Family/Unpaid Caregiver Supports and Services - Days	☐	Days	218	7.28	182.75	**290031.56**	
Family/Unpaid Caregiver Supports and Services - Hours	☐	Hours	585	31.21	76.53	**1397273.26**	
Grief and Bereavement Counseling Total:							**54740.86**
Grief and Bereavement Counseling	☐	Days	37	16.49	89.72	**54740.86**	
Health and Wellness Total:							**2650597.09**
Health and Wellness - Days	☐	Days	799	26.29	100.94	**2120316.37**	
Health and Wellness - Hours	☐	Hours	799	13.15	50.47	**530280.72**	
Home Modifications Total:							**8040972.18**
Home Modifications	☐	Each	898	2.44	3669.80	**8040972.18**	
Housing Support Services Total:							**68018.34**
Housing Support Services - Each	☐	Each	21	13.56	229.10	**65238.52**	
Housing Support Services - Hours	☐	Hours	27	1.08	95.33	**2779.82**	
Mentoring Total:							**516246.80**
Mentoring - Each	☐	Each	4	17.91	25.25	**1808.91**	
Mentoring - Hours	☐	Hours	278	73.20	25.28	**514437.89**	
Participant and Family-Directed Goods and Services Total:							**1636735.94**
Participant and Family-Directed Goods and Services - Days	☐	Days	415	6.52	89.72	**242764.38**	
Participant and Family-Directed Goods and Services - Each	☐	Each	623	37.54	42.29	**989053.99**	
Participant and Family-Directed Goods and Services - Hours	☐	Hours	415	21.75	44.86	**404917.58**	
Personal Emergency Response System (PERS) Total:							**408579.85**
Personal Emergency Response System (PERS) - Each	☐	Each	587	1.35	171.07	**135564.42**	

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Services included in capitation:	
Services not included in capitation:	11349.16
Average Length of Stay on the Waiver:	322

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System (PERS) - Months	☐	Month	967	7.32	38.57	273015.43	
Personal Supports Total:							16037072.39
Personal Supports - Days	☐	Days	44	23.23	171.65	175446.90	
Personal Supports - Hours	☐	Hours	1679	402.86	23.45	15861625.49	
Remote Supports and Equipment Total:							1168185.65
Remote Supports and Equipment - Each	☐	Each	480	6.51	224.31	700923.89	
Remote Supports and Equipment - Months	☐	Months	480	10.85	89.72	467261.76	
Safety Planning and Prevention Total:							1684434.56
Safety Planning and Prevention - Days	☐	Days	360	8.69	179.45	561391.38	
Safety Planning and Prevention - Hours	☐	Hours	360	34.77	89.72	1123043.18	
Specialized Medical and Therapeutic Supplies Total:							2684906.84
Specialized Medical and Therapeutic Supplies	☐	Each	5285	18.40	27.61	2684906.84	
Translation and Interpretation Services Total:							1463795.73
Translation and Interpretation Services - Days	☐	Days	96	28.32	168.23	457370.27	
Translation and Interpretation Services - Hours	☐	Hours	96	169.94	61.69	1006425.47	
Transportation Total:							2282298.20
Transportation - Miles	☐	Miles	2367	835.39	0.60	1186420.88	
Transportation - Trips	☐	Trips	857	95.07	13.23	1077914.12	
Transportation - Each	☐	Each	36	8.55	58.36	17963.21	

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