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DATE: January 22, 2010

TO: Medicaid Waiver Manual Holders

FROM: Beth Wroblewski, Director
Bureau of Long Term Support

RE: Summary of January, 2010 Medicaid Waiver Manual Revisions

The Bureau has completed an extensive revision of the Medicaid Waivers Manual. The changes range from simple updates to more significant policy and process revisions. The newly revised Chapters deployed to the waiver manual today include Chapter I, *Overview and Administration*; Chapter II, *Waiver Eligibility*; Chapter III, *Financial Eligibility*; Chapter IV, *Allowable Services and Provider Requirements*; Chapter V, *Use of Waiver Funds in Substitute Care*; Chapter VI, *The Waiver Application Packet* and Chapter VII, *Recertification, Individual Service Plan Review and Update*.

These revisions to the Medicaid Waiver Manual continue the ongoing process to keep the manual current and consistent with evolving state and federal policy. They also address changes to the program that have been made in response to new mandates from the Centers for Medicare and Medicaid Services (CMS). Unless otherwise specified, the effective date of the revisions to the Chapters listed above is the date of deployment.

The following pages contain a summary chart, briefly highlighting the major changes included in this release. To get the complete picture of the revisions, manual holders are urged to take time to read the newly revised material at their **earliest convenience**. Questions or concerns regarding the new material should be directed to your state waiver contact for the individual waiver program or the BLTS central office.

Medicaid Waiver Manual Contacts:

General Manual Issues/Questions:
Kevin Lafky, Bureau of Long Term Support

CIP II/COP-W Waivers:
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CIP 1A/1B, BIW Waivers:
Area Quality Specialists
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Children's Long Term Support Programs:
Children's Services Specialists

**New and Updated Material, Medicaid Waivers Manual Chapters
I, II, III, IV, V, VI and VII and Associated Appendices
January, 2010**

Chapter	Section Number	Summary of Addition/Revision
Chapter I Overview and Administration	Section 1.02	State Medicaid Agency Authority: The section addresses the most significant policy change to the Medicaid Waiver programs. To comply with new federal direction, the state must assume and exert sole authority in all Medicaid Waiver policy and program administration. State compliance with the federal mandate effectively eliminates individual county discretion and authority to set local policies or priorities. The impact of this change will be apparent throughout this revision.
	Section 1.06 A – C	Medicaid Waiver Wait Lists: The section contains revisions setting a single, statewide wait list policy and process for serving persons from the list. County agencies may no longer establish local wait list policies or priorities. The changes are made in direct response to federal direction requiring the state to assume sole program authority. (See also DLTC NMemo2009_11.pdf .)
	Section 1.06 D	In this provision a new statewide variance process for making exceptions to the state’s “first come, first served” wait list policy is described.
Chapter II Waiver Eligibility	Throughout	New links to the Appendices and the DHS Forms Library have been included. Form numbers have been changed to coincide with the Department re-numbering project. ¹
	Section 2.02 E	Information describing the COR waiver target group is now in the manual.

¹ In 2008 the Department began a project to renumber forms and publications. For example, the DDE-445 is now the F-20445 and the DDE-919 is now the F-20919 and so forth... Additional information is available at <http://dhs.wisconsin.gov/forms/renumber.htm> . The site also includes a link to the Department Forms Library.

Chapter	Section Number	Summary of Addition/Revision
Chapter II, continued	Section 2.07	Updated information about program Level of Care requirements, including the COR waiver and changes to reflect the evolution of the CARES system have been added.
	Section 2.09	The waiver programs participant moves polices have been updated.
Chapter III – Financial Eligibility	Throughout	New links to the Manual Appendices, DHS forms and other resources (e.g., At A Glance COP Bulletin, Medicaid Handbook, etc.) have been added. Income eligibility limits have been updated.
	Section 3.03B (2)	New language: CM/SSCs are reminded that deductions and disregards from applicant income used in the financial eligibility and cost sharing calculations are not optional . Local agencies do not have discretion over which expenses will be collected, counted or allowed.
	Section 3.03 B (2)a	New: Due to a change to Wisconsin’s Medicaid state plan, certain medical/remedial expenses can no longer be counted. These expenses are listed in section 3.03B (2) a. (See also DLTC/NMemo2008-02.pdf)
Chapter IV – Allowable Services and Provider Requirements	Sections 4.01 – 4.03	New: This revision includes substantial changes to the waiver service provider requirements to bring the state into compliance with federal mandates. The most significant are the requirements that all waiver service providers enter into an agreement with the State Medicaid Agency (DHS) and that all providers register on the state’s Medicaid Waiver Provider Registry .

Chapter	Section Number	Summary of Addition/Revision
Chapter IV, continued	Section 4.02 A	Provider Standards Certification: The section describes new guidelines for agencies to ensure providers are qualified. Agencies must periodically review and document that providers meet all applicable waiver program standards.
	Section 4.02 B	Provider Agreements: Medicaid Waiver Service providers are now required to have an agreement with the State Medicaid Agency (DHS). (See Appendix P and DLTC NMemorandum 2009_12.) In 2010, in order to receive payment all providers must submit completed agreements to DHS.
	Section 4.02 C & D	State Medicaid Agency Authority: Per CMS, the State Medicaid Agency (DHS) is the sole waiver policy authority. Local agencies may no longer establish local waiver provider/service policy.
	Section 4.03 A	Ensuring Access: Provider Choice The section contains direction to local agencies as to the creation of the State's Medicaid Waiver Provider Registry Intended to improve consumer choice, all providers must be listed on the registry. Now operational, the registry will enable interested consumers to choose from a list of all available providers. Additional information is available at DLTC NMemorandum 2009_12.
Chapter V – Use of Funding In Substitute Care	Throughout	The Chapter has been updated with new links to the DHS forms library and the relevant Appendices.
	Section 5.03 A	The text in this section has been updated, clarifying that the standard methodology for determining income available to contribute to room and board (the F-20920) is not applicable to Children's Foster Care Settings.

Chapter	Section Number	Summary of Addition/Revision
Chapter V, continued	Section 5.06 B	<p>Waiver Specific Requirements: CIP II, COP-W and COR The revision of Section 5.06 contains a number of revised policies that resulted from significant statutory changes made to Ch. 46 and Ch. 50.</p> <p>5.06 B (3) Describes the changes to the criteria that must be met prior to use of funds in CBRFs. The five criteria have been reduced to four.</p> <p>5.06 B (4) Addresses the new preadmission referral requirements for substitute care facilities and for waiver agency follow up. Applies to CIP II/COP-W and COR waiver programs. (See also DLTC NMemo2009_07.pdf .)</p>
	Section 5.06 (E, F & G)	<p>These sections contain revised text addressing the changes to the CIP II/COP-W and COR CBRF variance provisions; including differing variance requirements by placement type and size and CBRF use restrictions based on target group.</p>
	Section 5.07	<p>Includes revised language relative to purchasing substitute care services. Addresses new provider agreements and limits on local contracting authority.</p>
Chapter VI – The Waiver Application Packet	Throughout	<p>New links to the manual appendices and to required or optional forms and other resources have been inserted.</p>
	Section 6.01	<p>New information about the COR waiver application requirements has been added.</p>
	Section 6.02 A Section 6.02 B	<p>Recent adjustments to the CIP 1A/B and CLTS application packet content requirements are explained.</p> <p>The functional eligibility documentation requirements have been revised. In almost all cases, agencies now need to submit a copy of the entire functional screen.</p>

Chapter	Section Number	Summary of Addition/Revision
Chapter VI, continued	Section 6.02 D	New: The assessment content guide has been expanded to include new areas that should be addressed in a comprehensive assessment. New additions to the guide are medication monitoring, restrictive measures in place, risk related to applicant choices and conflict(s) of interest identified.
	Section 6.02 D(3)	Responding to CMS direction, a new section has been added providing guidance to CM/SSCs regarding expanded Medication Monitoring responsibilities .
	Section 6.02 E(1)	The COR – only requirement for a Crisis Back-up Plan is addressed.
	Section 6.02 E(2)	New guidance for CM/SSCs regarding their responsibility to address Participant Rights and Applicant/Participant Choice in the service plan development/review processes has been added. Agencies are instructed to assure participants are informed and have the opportunity to choose between any available qualified service providers.
	Section 6.02 G	New: Expanded information and guidance for local CIP 1A/1B & BIW agency staff regarding Restrictive Measures has been included. A link to the revised “ Guidelines ” document is provided.
	Section 6.04 A	The new CIP 1A/1B & BIW Application Checklist is introduced.
Chapter VII – Recertification, Individual Service Plan Review and Update	Throughout	New Links to manual appendices, required and optional forms and other resources have been added to the chapter.

Chapter	Section Number	Summary of Addition/Revision
Chapter VII, continued	Section 7.01	<p>This section introduces a much more prescriptive Chapter VII. Section 7.01 addresses the required components of the recertification, plan review and ISP update activities - applicable to all programs.</p> <p>Documentation requirements for each activity are addressed in Sections 7.03, 7.04 and 7.05.</p>
	Section 7.01 A	<p>The section spells out the required Recertification tasks for all programs; reminds CM/SSCs that it is a face to face activity involving a re-determination of financial eligibility, level of care and a reassessment of participant needs and desired outcomes.</p> <p>A properly completed recertification also addresses participant satisfaction with the service plan and service providers.</p>
	Section 7.01 B	<p>The Plan Review requirements have been updated with expanded direction to CM/SSCs. County waiver staff are reminded that the review consists of a face to face discussion with the participant/legal representative that may not be waived.</p>
	Section 7.01 B (continued)	<p>The Plan Review contact should include a purposeful review of the services in place; within which the participant is informed that they may review the Medicaid Waiver Provider Registry, request changes to the type and frequency of services provided or to the providers themselves.</p>
	Section 7.01 C	<p>The Service Plan Update requirements are discussed. The emphasis here is that the ISP must be kept current.</p>
	Section 7.02 A	<p>Brain Injury Waiver Recertification requirements are addressed. State level monitoring and Corrective Action processes discussed.</p>

Chapter	Section Number	Summary of Addition/Revision
Chapter VII, continued	Section 7.02 B (4)	New direction is provided regarding the agency's ongoing responsibility to assure waiver service providers continue to meet standards.
	Section 7.02 C	Waiver agencies are reminded that the process of Recertification is more than an annual paperwork exercise. CM/SSCs need to make a review of provider quality and participant satisfaction a part of the discussion.
	Section 7.02 D	The CLTS Waivers Recertification Checklist is introduced. The form must accompany recertification requests.
	Section 7.02 E	The COR Waiver recertification requirements are described. This includes a review of the Crisis Back up Plan in place.
	Section 7.05	An updated 'Quick Reference Guide' for ISP Updates is provided.
Waiver Manual Appendices	Title	Summary of Addition/Revision
Appendix M	Participant Rights and Responsibilities	Appendix M has been revised to add new provisions discussed in the revised Chapter VIII. Other technical revisions.
Appendix A Appendix C Appendix I	<ul style="list-style-type: none"> ▪ Level of Care ▪ Financial Eligibility ▪ Service Planning 	These appendices have been updated with links to new, or more current forms, and documents.
Appendix P	<ul style="list-style-type: none"> ▪ Provider Issues 	The Appendix now contains up to date Medicaid Waiver Provider Agreements and other new forms/ links .