

CHAPTER I - OVERVIEW AND ADMINISTRATION

1.01 Long Term Support in Wisconsin

The Medicaid Home and Community Based Waiver (HCBW) programs were authorized by Congress in 1981, and began in Wisconsin in 1983 with the Community Integration Program. The Medicaid waivers represented a significant step, taken to mitigate the Medicaid program's institutional bias that had led to the extensive development and utilization of nursing homes and Intermediate Care Facilities for the Mentally Retarded (ICF-MR), also called Facilities for the Developmentally Disabled (FDD). Recognizing the problem, Wisconsin had taken its own steps to reverse the trend toward institutionalization with the creation of the Community Options Program (COP).

Created in 1981, COP was developed to provide eligible persons a safe community alternative to institutional placement. In addition, COP was designed to bring a system of care management and service coordination to the complex world of community services while placing the consumer in the center of the service planning process. The program intent is to forge a working partnership between the participant and the care manager/support and service coordinator (CM/SSC), in which they jointly develop a plan that addresses the participant's identified needs and meets her/his desired individual outcomes. While keeping the participant's preferences in mind, the care manager or support and service coordinator, participant and other team members seek the most cost-effective means to meet those individual outcomes in an integrated community setting.

The Medicaid waiver programs are built upon a foundation of primary program values. These values support individual choice, the enhancement of relationships, the building of accessible, flexible service systems, the achievement of optimum physical and mental health for the participant, and the promotion of presence, participation and optimal social functioning in the community. The program values further seek to ensure that participants are treated with respect and assure that service systems empower the individual, build on their strengths, enhance individual self worth and supply the tools necessary to achieve maximum independence and community participation.

The Medicaid waiver programs covered in this manual include:

- Brain Injury Waiver (BIW)
- Children's Long Term Support Waivers (CLTS)
- Community Integration Program 1A Waiver (CIP 1A)
- Community Integration Program 1B Waiver (CIP 1B)
- Community Integration Program II Waiver (CIP II)
- Community Options Program Waiver (COP-W)
- Community Opportunities and Recovery (COR)

There are several other community waiver programs that serve similar populations that are not addressed by this manual. These include the managed care programs, Family Care, PACE, Partnership and the self directed supports Medicaid waiver program, IRIS (Include, Respect, I Self-Direct.)

Policies described in this manual are grounded in Chapter 46 Wisconsin Statutes and DHS administrative rules and in provisions contained in the several Medicaid waiver applications submitted to and approved by the federal Centers for Medicare and Medicaid Services (CMS).

1.02 State Medicaid Agency Authority

This revision of the Medicaid Waivers Manual implements revised policies that address the State – County relationship in the operation of the Medicaid waivers. Previously, the state delegated certain authority to county agencies to make local decisions, set priorities and develop county program policy. The Department, working with the federal Centers for Medicare and Medicaid Services in the waiver renewal process, has agreed to rescind that policy and assume sole authority in all Medicaid Waiver policy and program operations. Sole authority with the State Medicaid Agency (DHS) means that county agencies may not set local policy, determine waiver program priorities or enact and enforce local terms in the agency- service provider relationship.

Manual holders will note new requirements for: Medicaid Waiver wait list operations (Chapter I); for waiver program provider agreements (Chapter IV) and for assessment content (Medication Monitoring) in Chapter VI. These changes, and others, bring our waiver policy and program practice into compliance with the federal mandate for sole State Medicaid Agency authority. The requirements are outlined in the manual and in DLTC Numbered Memos, cited where applicable.

1.03 The Medicaid Waiver Mandate

By statute (s. 46.27 (6r) (a), regular COP (State only) funds may not be used for long-term support services that may be funded under one of the Medicaid Home and Community Based Waiver programs. The waiver mandate is intended to increase the total resources available to serve participants while maximizing the use of federal funds to support the provision of community-based services. Waiver funds must be used when:

- The participant is eligible or becomes eligible for the waiver; and
- The agency has Medicaid waiver resources available; and
- The services to be provided are covered by the waiver.

A. Eligibility

The waiver agency must seek Medicaid waiver funding unless the applicant is found to be ineligible for the Medicaid community waivers. The mandate **does not apply** when:

1. The person does not meet Medicaid waiver level of care eligibility requirements; or
2. The person does not meet Medicaid financial eligibility requirements; or
3. The person does not meet Medicaid waiver program nonfinancial eligibility requirements, including residency status, etc.; or
4. The person does not meet the Medicaid waiver target group criteria; or
5. The person's preferred living arrangement is appropriate to meet his/her needs but is not an allowable living arrangement under the applicable Medicaid waiver (see [Chapter II](#) of this manual).

B. Availability

Medicaid waiver resources are considered available if:

1. The agency has unused CIP 1A, CIP 1B (state-matched) or CIP II slot that can be designated for a locally matched slot in CIP 1B or BIW or CLTS; or
2. The agency has unused COP-Waiver match allocated by the state that is not fully committed to current participants.
3. The agency has unused state funds (COP, Community Aids or other funds) allocated by the state that are not expended. While not a specific obligation of the waiver agency, a child participating in the Family Support Program (FSP) who is also eligible for the waiver should have those FSP funds used to match federal funds under the appropriate waiver.

1.04 Exemptions from the Waiver Mandate

While the mandate does not apply where Medicaid waiver eligibility cannot be established, there are also exemptions to the waiver mandate. Persons exempt from the waiver mandate include:

1. Any person for whom a Medicaid waiver application is being processed is exempt for up to 90 days, provided that within the first ten days after services are initiated:

- a. A referral is made to Income Maintenance for a Medicaid application (unless the person is already receiving Medicaid); and
 - b. Waiver program functional eligibility is established; and
 - c. An initial individual service plan is completed.
2. Any person whose total state share of costs under COP would be less than the state share of costs under the Medicaid community waiver. Documentation of this exception must be placed in the participant's record.
 3. Any person whose total cost of care for COP-funded services is less than \$100 per month may be exempted with no cost-effectiveness documentation required.
 4. Any person who will receive services (other than care management/support and service coordination) or equipment that are not allowed by the waivers.
 5. Any single parent of minor children whose income places them in category C, (medically needy) using the Medicaid community waiver cost sharing worksheet (The F-20919, available from the DHS Forms Library at [F-20919.doc](#)) or CARES.
 6. Persons who meet the hardship criteria and are exempt from participation in the Medicaid Purchase Plan (MAPP). For MAPP hardship information see the numbered memo at [DSLNMemo2000-08.htm](#).

Note: Any person exempt from the waiver mandate may still apply for Medicaid state plan (Medicaid card) services.

1.05 Registering Applicants on HSRS

County agencies are required to register on the Human Services Reporting System (HSRS) applicants of any age who, based on a preliminary review of functional and financial eligibility, are likely to meet the criteria for COP or Medicaid waivers participation but who are not yet receiving funding. The purpose of using HSRS to register these applicants is to build a statewide registry containing standardized information that may be used to do effective program planning. Persons to be entered on this HSRS applicant registry include those who are:

- Currently in an institution and who request COP or Medicaid waivers services; or,
- Currently receiving **no** publicly funded community long-term care services; or,
- Currently receiving **some** publicly funded community long-term care services, but **not** from COP or a Medicaid waiver program.

Note: Participants who are already receiving COP or Medicaid waiver funded services are **not** to be placed on this registry.

1.06 Medicaid Waiver Program Wait Lists

A. Wait List Policy

This section describes DHS wait list policy for the Medicaid Waiver programs. (See also DLTC Numbered Memo 2009-11 at [N Memo2009-11.pdf](#).) County waiver agencies may not create or adopt wait list policy or prescribe and enforce wait list priorities that deviate from this DHS policy.

1. Wait Lists for Assessments and Individual Service Plans:

The only permissible circumstance in which a wait list for assessments and individual service plans may be established is when the agency has expended all funds available for assessments and plan development. Any applicant denied an assessment or an individual service plan for this reason **must** be provided the opportunity to be placed on the waiver program wait list.

DHS reminds county waiver agencies that all waiver applicants must be offered timely Medicaid waiver financial and functional eligibility determinations using the appropriate LTC-FS or BIW eligibility criteria. Waiver agencies may estimate the likely cost of the services the person needs and would receive if funds were available. If the person is placed on the waiver wait list for this purpose, the cost of services needed must be both estimated and applied to this person.

2. Wait Lists for Waiver Program Participation:

The only permissible circumstances in which a waiting list for waiver program participation may be established are when the county agency has:

- a. Determined that the cost of providing the community services identified in the assessment will cause the agency to exceed local, state and federal funds available (service funds are available if they have not yet been expended or committed to current participants); or,
- b. Determined that serving the applicant will prevent the agency from meeting significant proportions requirements under Ch. 46.27 (3) e.

Any eligible applicant who is denied participation for the reasons described above must be provided the opportunity to be placed on the wait list and be registered on HSRS (See Section 1.05 above).

B. Procedures for Placing Persons on the Wait List

The following procedures must be used when placing persons on the waiver program wait list:

1. The agency shall make a preliminary determination of financial and functional eligibility as well as the need for long term care services.
2. The agency shall document the contact with the person or other referral source and the date of placement on the wait list.
3. If the applicant has not been denied an assessment (see Section 1.06 A (1)), the agency shall make an offer of an assessment which, if accepted, must be completed within 45 days. If the applicant agrees, the assessment may be delayed until a time nearer to when funds for Medicaid community waiver services will become available.
4. The agency shall update the wait list every six months and provide each applicant placed on the wait list with a notification of her/his status on the list as well as an estimate of when funding for services may become available.
5. The agency shall ensure that participants from another county who move into the county are placed on the wait list while funding for their service plan from their county of origin continues. (See [Chapter II](#), Section 2.09). Priority may not be given to long term county residents over new arrivals. Persons must be served based on the date of placement on the wait list not the length of county residency.

C. Procedures for Serving Persons from County Waiting Lists

Whenever waiver resources become available to serve an applicant, the individual who is the next person on the waiting list must be offered the opportunity to receive Medicaid Waiver services. The only exceptions to the “first come – first served” standard are persons meeting the **crisis** criteria (See below.) When serving persons from the wait list the following requirements apply.

1. The individual must receive all of the services necessary to meet assessed need as identified in his/her current assessment.
2. The high cost of a person’s assessed service needs cannot be used as a reason to bypass that person to serve someone with lower service costs.
3. When full program funding is not available for the next person on the wait list, the agency must wait for sufficient funds to become available to provide for **all** assessed needs and assure health and safety.

4. Once service funds become available, the application, eligibility and service planning process described in Chapter VI of the manual must occur for that person on the Medicaid Waiver wait list.

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

The only exception that can be made to the first-come, first-served Medicaid Waiver wait list policy allowing waiver agencies to bypass others is when a person meets one of the **crisis** need criteria. These criteria are to be applied in all such circumstances and may not be modified or expanded by the county waiver agency. The only permissible reasons a person may bypass the Medicaid Waiver wait list and be served out of first-come, first-served order are as follows:

1. Crisis conditions are present in the person'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 individual in his/her current living situation; or
 - b. The death of the individual's primary caregiver or the sudden inability of that caregiver/support person to provide necessary supervision and support and there no alternative caregiver available; or
 - c. The lack of an appropriate residence or placement for the individual due to a loss of housing; or
 - d. The person 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 person's behavior or the discovery that the person has been behaving in a manner that places the individual, or the people with whom the individual shares a residence, or the community at large at risk of harm.
2. An exception may also be made if there is a finding by the county waiver agency that the health and safety of the individual is in jeopardy due to the primary caregiver's physical or mental health status; or
3. A determination by the county waiver agency that the person is at imminent risk of a more restrictive placement in an ICF-MR or nursing home or other institutional setting; or

4. A finding by the county waiver agency that other emergency or urgent conditions exist that place the individual at risk of harm and a variance is approved by state Quality Assurance (QA) staff.

E. Requesting a Variance to the Wait List Policy

When a waiver agency determines that one of the crisis criteria listed in Section 106 D exists, the agency must request a variance and receive approval from the appropriate state QA staff prior to initiating services. The agency shall complete and submit a variance request form (See [F00076.doc](#).) The completed form includes identifying information about the applicant and a narrative summary describing the reason for the requested exception under Section 1.06 D above. The narrative must clearly describe the specific nature of the crisis situation for the individual involved.

The variance may be requested prior to, or as part of the service plan application process. The forms may be faxed, mailed or electronically submitted to the appropriate waiver program QA staff (See the F-00076 form for directions.) If approved, the county waiver agency must maintain documentation of the variance request and approval in the participant record. Agency adherence to the DHS wait list variance policy will be subject to monitoring by state quality assurance record review and program audit processes.