

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 section 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 waiver's 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:

Appendix A.6 – Added a new process for periodic, comprehensive review of locally-contracted waiver agencies.

Appendix B.3.f – Updated processes to select entrants to the waiver to reflect changes with the state's role in enrolling participants.

Appendix B - Updated the procedures for requesting a review of a not functionally eligible screen.

Appendix C1/C3 – Added a new service, In-Home Unpaid Caregiver Training. This specifically covers ongoing trainings. The Family/Unpaid Caregiver Supports and Services has been renamed Conferences and Education for Unpaid Caregivers, to help differentiate from the new services.

Appendix C1/C3 - Removed the child care service. Participants 12 and older can now receive supervision services through the Specialized Youth Care service. This covers supervision in the home or community.

Appendix C1/C3 - Removed Participant and Family Directed Goods and Services to align with the change to self-direction and the removal of budget authority.

Appendix C1/C3 - Day Services has been renamed "Adult Day Services" with the purpose of providing adult day care and day habilitation services to participants 18 and older.

Appendix C.1.d – Added new policies for remote services.

Appendix C - Added a new performance measure that looks at background checks for employees of agencies.

Appendix C-5 - Updated policies for HCBS Settings compliance.

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

Appendix E – Removed budget authority for all services and retained employer authority for daily living skills training, personal supports, respite, specialized youth care, and transportation.

Appendix F – Added a new grievance system.

Appendix G.1 – Redefined the types of law enforcement contact that are reportable incidents.

Appendix G.2 – Prohibited the use of fully enclosed beds.

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

Appendix I - Updated to reflect current and anticipated practices and procedures. Added rate methodologies for new services.

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 section 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*):

CLTS 2027 Waiver Renewal

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.036.05.00

D. Type of Waiver (select only one):

Regular Waiver

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

01/01/27

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: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 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 in 42 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 section 1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under section 1915(b) of the Act.

Specify the section 1915(b) waiver program and indicate whether a section 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 section 1915(b) authorities under which this program operates (check each that applies):

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 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 section 1915(i) of the Act.

A program authorized under section 1915(j) of the Act.

A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility 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 and/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 section 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 section 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. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

No

Yes

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

Geographic Limitation. A waiver of statewide requirements 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 statewide requirements 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 section 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 inpatients 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 section 1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR Part 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. 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 Part 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:

From July 2025 through February 2026, Wisconsin Department of Health Services (DHS) conducted extensive outreach to its program partners, including counties, tribes, participants and families, advocates, and providers. DHS invited partners to provide any ideas they would like the Department to consider in preparing this waiver renewal. The Department received numerous ideas from program partners and incorporated ideas into the waiver renewal application.

Public Comment for this waiver application will be open from May 13, 2026, to June 13, 2026. Tribal Consultation will take place on May 13.

This section will be updated after the public comment period closes with a description of input from the public.

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:

Rathermel

First Name:

Deborah

Title:

Director

Agency:

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

Address:

201 E. Washington Ave.

Address 2:

City:

Madison

State:

Wisconsin

Zip:

53703

Phone:

(608) 266-9366

Ext:

TTY

Fax:

E-mail:

Deborah.Rathermel@dhs.wisconsin.gov

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

Last Name:

[Empty box]

First Name:

[Empty box]

Title:

[Empty box]

Agency:

[Empty box]

Address:

[Empty box]

Address 2:

[Empty box]

City:

[Empty box]

State:

Wisconsin

Zip:

[Empty box]

Phone:

[Empty box]

Ext:

[Empty box]

TTY

Fax:

[Empty box]

E-mail:

[Empty box]

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 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:

[Empty box]

State Medicaid Director or Designee

Submission Date:

[Empty box]

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:

Self-Direction - DHS is making changes to the budget and employer authorities within the self-direction option. Participants will no longer have budget authority for any self-directed service, and employer authority will be limited to the five most commonly self-directed services. These services are respite care, personal supports, daily living skills training, transportation, and the new youth supervision service, which was previously child care services.

Most participants will not see a major change in their services due to this change. The budget the participants received for self-direction came from costing out the services on the ISP, paid at the state's rate schedule. Participants did not have the ability to pay different rates or re-allocate funds within the budget to different services. For employer authority, the five services that will retain employer authority are those that are most commonly self-directed. The five services listed above account for 98% of all self-directed service authorization. About 400 participants will lose the ability to exercise employer authority over a service. Services are still available to any participant who needs them. However, any services outside of respite care, personal supports, youth supervision, daily living skills training, and transportation must be provided by a CLTS-enrolled provider and not a participant-hired worker. Current participant-hired workers have the option to enroll as CLTS providers to continue the service with the participant.

DHS will work with local waiver agencies to ensure that the health and welfare of participants is protected through the transition period before the new waiver goes into effect on January 1, 2027. DHS will provide technical assistance to CWAs to ensure that a participant can transition any ongoing services from self-direction to an enrolled CLTS provider. Participants will be able to keep their current service during the transition period but must transition before the new waiver goes into effect. DHS will begin working with local county waiver agencies before the new waiver's effective date to make sure enough notice is provided to participants so they can transition their services.

Participants and their families will be notified before the change goes into effect. DHS will begin communicating with local waiver agencies about this change when first draft of the waiver is submitted. Families and counties will first be notified through newsletters, teleconferences, and other waiver renewal communications after the final draft of the application is submitted. DHS will engage with waiver agencies through regular waiver renewal updates, program teleconferences, and technical assistance during the implementation period ahead of the new waiver's effective date. DHS will develop the messaging that waiver agencies will share with participants about the changes. Local waiver agencies will communicate these changes to participants before the new waiver goes into effect and will work to update ISPs accordingly.

Participant Directed Goods and Services - With the removal of budget authority from the CLTS self-direction option, we will also be ending the participant and family directed goods and services category. This service can no longer be offered because it requires budget authority to operationalize. Families and counties will first be notified through newsletters, teleconferences, and other waiver renewal communications after the final draft of the application is submitted.

DHS will pull the most up-to-date claims and authorizations to identify participants that may be affected. Based on an earlier review of claims for this service, most claims can likely be billed under other CLTS services that will continue. For example, there were claims paid to equine therapy providers or pest control providers, both of which are explicitly covered under another service. DHS expects little difference between these services with the new waiver. Many claims for this service were also single item purchases. It is expected that these purchases can be authorized under one of the services for purchasing goods, such as Assistive Technology or Specialized Medical Equipment. Once participants are identified, DHS will reach out to each locally contracted waiver agency with a list of affected participants. DHS will provide guidance and technical assistance for transitioning services. DHS will develop the messaging that waiver agencies will share with participants about the changes. Locally-contracted waiver agency will work with the family and transition the authorization to another CLTS-covered service. All participants will be transitioned to CLTS-covered service by the 1/1/27 effective date of the new waiver.

Child Care - DHS will be eliminating the child care benefit, which covers the supplemental cost of child care for CLTS participants under 12 and the full cost of child care for participants 12 and older. The child care service will be partially replaced by the new Youth Supervision service. This service covers supervision for participants 12 and older in the home or community. Supervision can be individual or small group. Many participants were self-directing the child care service to access similar home-based supervision, so DHS expects participants to continue this service in the new waiver under Youth Supervision. Community-based supervision will not utilize traditional child care settings. Instead, supervision can be provided through community-based entities, such as a YMCA or Boys and Girls Club, that are not licensed child care facilities. This should not represent a major change, as many participants 12 and older have aged out of traditional child care settings.

For participants 12 and older, DHS will work with locally contracted waiver agencies to transition participants to the new Youth Supervision service. After the first draft of the waiver application is submitted, DHS will notify families and locally contracted

waiver agencies about the change through waiver renewal newsletters, teleconferences, and other communications. DHS will get up-to-date claims data to identify participants 12 and older that currently use the child care benefit. DHS will then reach out to locally contracted waiver agencies with list of participants eligible to transition services, and technical assistance for how to transition and the guidelines of the new service. DHS will develop the messaging that waiver agencies will share with participants about the changes. All participants will have their services transitioned in preparation of the 1/1/27 implementation date of the new waiver.

For participants under 12, there is not a replacement supervision service. Participants will lose access to the supplemental payment to child care providers. Depending on the setting and the portion of payment the parents have been responsible for, some participants will be able to continue with the same caregivers and child care service, even without the supplemental rate. Some participants may be able to transition their services to a respite camp, which can be provided while a participant's caregiver is working. After the first draft of the waiver application is submitted, DHS will notify families and locally-contracted waiver agencies through newsletters, teleconferences, and other waiver renewal-related communications. DHS will use recent claims to identify participants under 12 that may be losing access to this service. DHS will engage with locally-contracted waiver agencies with the list of participants and provide technical assistance to support SSCs in exploring community services as a replacement. DHS will develop the messaging that waiver agencies will share with participants about the changes. All participants will have their services transitioned in preparation of the 1/1/27 implementation date of the new waiver.

Day Services – The current Day Service will be renamed Adult Day Services and be open only to participants 18 and older that need to access adult day care or adult day habilitation services. DHS does not expect any impact on current services as the utilization for Day Services is very low. There was only one participant that used this service in 2024. It is also expected that any participant 12 and older that may have used Day Services can now access supervision through the new Youth Supervision service. DHS will use recent claims to identify and participants that are using Day Services and work with locally-contracted waiver agencies to transition them to a different CLTS service.

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.:*

DHS contracts with an External Quality Review Organization (EQRO) to assist with discovery and remediation activities related to oversight of locally-contracted waiver agencies. It reviews operational practices for all locally-contracted waiver agencies for purposes of quality reporting and identifying deficiencies. DHS contracts with financial management services (FMS) agencies to execute a specific provider agreement for participant-hired workers.

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.

DHS also provides direct oversight of the EQRO. DHS directs the EQRO to conduct an annual review of operational practices using a DHS approved record review tool. All requirements for operations are defined by DHS through the contract between the state and the EQRO. DHS oversees the FMS agencies that execute provider agreements for participant-hired workers.

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:

DHS oversees locally-contracted waiver agencies through a comprehensive review of operational practices. This review is completed on a rotating basis and ensures that each locally-contracted waiver agency is following waiver requirements and has the capacity to operate their local CLTS program. For the review, locally-contracted waiver agencies are required to provide DHS with policies and procedures related to their operation of the CLTS program, such as staff training/onboarding, service planning processes, or subcontractor materials. Locally-contracted waiver agencies are reviewed and graded according to DHS-established criteria. Each locally-contracted waiver agency may be subject to a corrective action plan or an increased frequency in DHS reviews based on the findings of the review.

DHS also provides more regular oversight for each of the functions listed below, which have been contracted to "Local Non-State Entity." DHS is responsible for conducting and overseeing other regular monitoring and quality assurance strategies for locally-contracted waiver agencies. DHS contracts with an EQRO to conduct oversight of locally-contracted waiver agencies through a record review process. The record review process includes regular sampling of participant records to ensure compliance with several approved performance measures. DHS uses the record review results along with other administrative data and participant survey responses to analyze locally-contracted waiver agency performance and identify areas for improvements. DHS methods of oversight also include 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.

DHS oversees the EQRO for quality assurance and quality improvement functions listed below under the "Contracted Entity." DHS conducts ongoing monitoring and oversight of their work. This includes reviewing all work done by the EQRO to ensure that is consistent with program policies and priorities, meeting with the EQRO regularly, and updating requirements within the EQRO contract annually.

DHS oversees FMS agencies first during the qualification and enrollment process, where DHS determines that they meet the necessary criteria for performing the functions of the service. These qualifications are reviewed again when an FMS provider renews their provider agreement every 3 years. DHS also uses a specific FMS provider agreement that spells out the roles of the provider and delegates to them the ability to execute additional provider agreements with participant-hired workers.

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.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment			
Waiver enrollment managed against approved limits			
Waiver expenditures managed against approved levels			
Level of care waiver eligibility 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 state's quality improvement strategy, provide information in the following fields to detail the state's 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, sign a notification of their rights at least annually. Numerator= Number of records in the sample with evidence that participants or their guardians, as applicable, signed a notification 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(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+ / - 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

A-i-2. Children/youth are enrolled according to DHS-established timeframes. Numerator= Number of children/youth whose enrollment is effectuated within 90 days. Denominator= Total number of children/youth eligible for enrollment.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Program enrollment data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

A-i-3. Locally-contracted waiver agencies must complete Record Review remediation by the end of the review cycle. Numerator = Number of participant records in the sample that were remediated by the end of the review cycle. Denominator = Total number of participant records reviewed in the sample with remediation needed.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+ / - 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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 and 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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 Sub Group	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. Allowable living situations within the community for participants include participants 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 participant, the participant's family, adult long-term care programs, and other community supports to ensure a smooth transition out of the program for participant. The Support and Service Coordinator must take reasonable steps to assure continuity of services as the participant 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 begins by the time the participant is age 14. This includes, among other topics, discussing with participant and the family how parents' legal authority to make decisions for their participant changes when that participant turns 18 years old; providing information about decision-making options to the participant and the family, such as supported decision-making or guardianship, as appropriate; assisting the participant to locate safe and appropriate housing; and assisting the participant to pursue vocational and/or educational opportunities, as appropriate. The SSC is required to discuss with the participant and the family the participant's disability determination and Medicaid source if the participant is planning to transition to an adult long-term care program.

No later than when a participant reaches 17 years and 6 months of age, the locally-contracted waiver agency must refer the participant 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 participant 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 participant'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 participant's Functional Screen and 6) the participant'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 participant, if applicable.

Participants who are not eligible to transition to an adult long-term care program remain eligible for the CLTS waiver through age 21. If a participant 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	36958
Year 2	40918
Year 3	44878
Year 4	48838
Year 5	52798

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	<input type="text"/>
Year 2	<input type="text"/>
Year 3	<input type="text"/>
Year 4	<input type="text"/>
Year 5	<input type="text"/>

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 participants waiting to receive waiver services. The most basic principle is that participants must be served on a first-come, first-served basis.

The Department is responsible for the equitable distribution of waiver funds to enroll eligible participants 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 for tracking the participant's enrollment. If multiple participants have the same referral date, the enrollment 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 participant's Functional Screen within 45 days of the referral date.
4. Each applicant must be provided with a notification of her/his enrollment position, as well as an estimate of when funding for services may become available every six months, if applicable.
5. The Department identifies participants for enrollment on a regular basis. When the locally-contracted waiver agency is informed that a participant is enrolled, they must begin the assessment and service planning process. An assessment and ISP must be completed for a participant within 60 days of enrollment.

When enrolling participants, the following requirements apply:

1. The participant must receive all of the services necessary to meet assessed needs, as identified in the current assessment.
2. Once the Department identifies the participant as enrolled the locally-contracted waiver agency must promptly begin the assessment and service planning process.
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 participant 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 policy is when the participant 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 participant may be served out of the first-come, first-served order:

1. Crisis conditions are present in the participant'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 participant in the current living situation; or
 - b. Death of the participant'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 participant due to a loss of housing; or
- d. Participant 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 participant's behavior or the discovery that the participant has been behaving in a manner that places the participant, 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 participant 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 participant 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 participant, or participant at risk of harm;
5. The locally-contracted waiver agency finds the participant or participant is a vulnerable participant 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 participant is isolated with limited or no adult contact outside the home and is not available to be observed.
 - The participant is nonverbal and has limited ability to communicate.
 - The participant is medically complex, requires significant care from a caregiver or parent, and is highly dependent on others to meet basic needs.
 - The participant is the subject of current or historical participant abuse and neglect reports.
 - The participant has a primary caregiver who is actively abusing substances.
 - The participant 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*):
- Section 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)

Parents and Other Caretaker Relatives (42 CFR § 435.110)

Pregnant Women (42 CFR § 435.116)

Infants and Children under Age 19 (42 CFR § 435.118)

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 section 1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 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 section 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 section 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:

- All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who are 21 years of age or younger specified in 42 CFR 435.21902(a)(10)(A) (ii) and 1905(a)(i) of the Act
- Children in Foster Homes specified in 42 CFR 435.222
- Children receiving Adoption Assistance specified in 1902(a)(10)(A)(ii)(VIII) of the Act
- Other caretaker relatives specified in 42 CFR 435.110
- Pregnant women specified in 42 CFR 435.116
- Children specified in 42 CFR 435.118

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, 2027 (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 section 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 section 1924 of the Act.

Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 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 period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

Spousal impoverishment rules under section 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 section 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 (Section 1634 State/SSI Criteria 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 section 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 period after September 30, 2027 (or other date as required by law).

- b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).**

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 period after September 30, 2027 (or other date as required by law).

- c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 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 section 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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 section 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:

[Empty text box]

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:

[Empty text box]

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 section 1924 of the Act. Describe the circumstances under which this allowance is provided:

Specify:

[Empty text box]

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:

[Empty text box]

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State – January 1, 2014 through September 30, 2027 (or other date as required by law).

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 period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 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 1/2 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 or 42 CFR § 435.735:

- 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:

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 participant'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 an entity under contract with the Medicaid agency.

Specify the entity:

Wisconsin's locally-contracted waiver agencies are responsible for performing the participant'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 participants 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 participant 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 participant having needs similar to people in an intermediate care facility for participants with intellectual disabilities (ICF/IID). The intensity and frequency of required interventions to meet the participant's functional limitations must be so substantial that without the intervention, the participant is at risk for institutionalization within an ICF/IID.

A participant 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, physician, licensed clinical social worker, or licensed professional counselor. In addition, this participant 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 participant is at risk of inpatient psychiatric hospitalization.

A participant with a Hospital or Nursing Home/Physical Disability (PD) Level of Care has a long-term medical or physical condition, which significantly diminishes the participant's functional capacity and interferes with the ability to perform age appropriate activities of daily living at home and in the community. This participant 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 participants. The intensity and frequency of required skilled nursing interventions must be so substantial that without direct, daily intervention, the participant 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: <https://www.dhs.wisconsin.gov/publications/p03027.pdf>

- 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 participant. This typically occurs with a parent/caretaker present. If the participant has an approved diagnosis and is under age six, 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 participant'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 state's quality improvement strategy, provide information in the following fields to detail the state's 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: Applicants have an initial functional screen completed according to DHS

established timelines from the date of referral. Numerator = Number of new applicants whose completed initial functional screen LOC determination was determined according to DHS established timelines from the date of referral. Denominator = Total number of new applicants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Program enrollment data

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input data-bbox="1078 1025 1264 1111" type="text"/>
Other Specify: <input data-bbox="408 1249 647 1335" type="text"/>	Annually	Stratified Describe Group: <input data-bbox="1078 1249 1264 1335" type="text"/>
	Continuously and Ongoing	Other Specify: <input data-bbox="1078 1473 1264 1559" type="text"/>
	Other Specify: <input data-bbox="718 1697 954 1783" type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Functional Screen system

Responsible Party for	Frequency of data	Sampling Approach
-----------------------	-------------------	-------------------

data collection/generation <i>(check each that applies):</i>	collection/generation <i>(check each that applies):</i>	<i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify:	Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

B-i-2: All new enrollees must have an eligible level of care prior to enrollment.

Numerator= Number of new enrollees enrolled in the program who have an eligible level of care. Denominator= Total number of new enrollees.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Program enrollment data

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Functional Screen system

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- 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.

Performance Measure:

B-ii-1: Participants’ level of care is re-evaluated annually. Numerator= Number of participants whose CLTS Functional Screen was completed annually. Denominator= Total number of participants.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Functional Screen system

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

State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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:

B-iii-1: An applicant’s initial functional screen resulted in an appropriate level of care. Numerator = Number of initial applications reviewed in the sample where the functional screen was completed according to the clinical instructions resulting in an appropriate level of care. Denominator = Total number of initial applications reviewed in the sample with a completed functional screen.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Functional Screen system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 state's method for addressing individual problems as they are discovered. Include information

regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

If the results of the Functional Screen are the participant is not functionally eligible, the screener must request an internal review by their agency or entity. Each agency is responsible for quality assurance at the local level. If the results are still in question, the screener must contact DHS for assistance. When specific questions arise and eligibility results cannot be verified, waiver agencies must consult with DHS staff.

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. Locally-contracted waiver agencies are required to share any functional screens as requested by DHS for any reporting or review purposes.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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.

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.

Locally-contracted waiver agencies design and implement an effective limited English proficiency plan to ensure meaningful access to persons with LEP at no cost to the persons with LEP, in compliance with Title VI of the Civil Rights Act of 1964, and Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116, and rules established to implement Section 1557 (81 Fed. Reg. 31376 et seq. [May 18, 2016], amending 45 CFR Part 92 to implement Section 1557). The LEP plan must identify individuals who need LEP language assistance, describe language assistance measures that may be provided, require training for staff to implement the plan, provide a mechanism for notice to persons with LEP who are in need of the services, provide accurate and timely language assistance to persons with LEP at no cost to themselves, and provide for monitoring and updating the LEP Plan.

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.

Locally-contracted waiver agencies operating the waiver program have access to a Language Line, which has 150 different languages for interpretation over the phone; the service also translates individual documents as needed. The Department routinely translates relevant waiver program documents into Spanish and Hmong.

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	Adult Day Services		
Statutory Service	Community/Competitive Integrated Employment - Individual		
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	Adult Family Home		
Other Service	Assistive Technology		
Other Service	Children's Foster Care		
Other Service	Communication Assistance for Community Inclusion		
Other Service	Community Integration Services		
Other Service	Community/Competitive Integrated Employment - Small Group		
Other Service	Conferences and Education for Unpaid Caregivers		
Other Service	Counseling and Therapeutic Services		
Other Service	Daily Living Skills Training		
Other Service	Empowerment and Self-Determination Supports		
Other Service	Grief and Bereavement Counseling		
Other Service	Health and Wellness		
Other Service	Home Modifications		
Other Service	Housing Support Services		
Other Service	In-Home Unpaid Caregiver Training		
Other Service	Mentoring		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Personal Supports		
Other Service	Relocation Services		
Other Service	Safety Planning and Prevention		
Other Service	Specialized Medical and Therapeutic Supplies		
Other Service	Specialized Youth Care		
Other Service	Transportation		
Other Service	Vehicle Modifications		
Other Service	Virtual Equipment and Supports		

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):

Adult Day Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

04 Day Services

Sub-Category 2:

04020 day habilitation

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):

Adult day services are the provision of regularly scheduled activities for part of a day in a non-residential group setting to participants age 18 and older, who need an enriched social or health-supportive experience or need assistance with activities of daily living, supervision, and/or protection.

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. Adult day services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the Individual Service Plan, such as physical, occupational, or speech therapy. Services are typically provided up to five days per week in a non-residential setting separate from the participant’s private residence 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 participant as directed by the participant’s plan.

Adult day care services may include personal care, supervision, light meals, and medical care. Meals provided as part of adult day care may not constitute a full nutritional regimen (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).

The cost for transporting a participant during the provision of adult day services may be funded through transportation services in addition to the adult day services rate. These transportation costs can be funded only as a mileage claim, and not as a per trip cost. Personal care/assistance may be a component part of adult day services.

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, Specialized Youth Care, mentoring or respite care.

This service is limited to participants age 18 and older.

A participant’s Individual Service Plan may include two or more types of non-residential habilitation services (Community

integration services, competitive integrated employment, daily living skills training, discovery and career planning, or mentoring). However, different types of non-residential habilitation services may not be billed during the same period of the day for the same participant.

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other public sources of funding.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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	Community-Based Day Habilitation Agency
Agency	Adult Day Care Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Community-Based Day Habilitation Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Service delivery is 100% community-based, and at least one of the following:

- Accreditation by a nationally recognized accreditation agency, or
- A minimum of two years of experience working with the target population in providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services.

If transportation services are provided, the provider must meet the qualifications for Community Transportation

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Services

Provider Category:

Agency

Provider Type:

Adult Day Care Provider

Provider Qualifications

License (specify):

Certificate (specify):

Must hold a valid Adult Day Care Center certification pursuant to Wis. Admin. Code § DHS 105.14.

Other Standard (specify):

HCBS Compliant per 42 CFR § 441.301(c)(4)

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Supported Employment

Alternate Service Title (if any):

Community/Competitive Integrated Employment - Individual

HCBS Taxonomy:

Category 1:

03 Supported Employment

Sub-Category 1:

03010 job development

Category 2:

03 Supported Employment

Sub-Category 2:

03021 ongoing supported employment, individual

Category 3:

03 Supported Employment

Sub-Category 3:

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 participant to be successful in integrating into the job setting.

Community/Competitive Integrated Employment offers support to individuals 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 expected to develop natural supports in the workplace to decrease reliance on paid supports.

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.

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

does not include volunteer work.

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. Incidental personal care/assistance provided by the supported employment staff may be a component part of Community/Competitive Integrated Employment.

Community/Competitive Integrated Employment supports does not include facility-based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.

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.

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and other sources of funding.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed
- Remote/via Telehealth

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	On the job support person
Agency	Supported Employment Agency

Appendix C: Participant Services

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

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

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 - Individual

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 rehabilitative 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:

exploring employment goals and interest to identify a career direction;

community-based formal or informal situational assessments;

task analysis activities;

skills training/mentoring, work trials, apprenticeships, internships, and volunteer experiences;

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;

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;

interviewing, video resumes and other job-seeking activities;

transitioning the participant into employment supports for individualized competitive integrated employment or self-employment

when assisting a participant who is already employed, activities to support the participant in explore other careers or opportunities.

career exploration and educational camps

career exploration and educational activities, workshops, lessons, and seminars

DCP services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined during the service planning process. Participants receiving this service must have employment-related goals in their Individual Service Plan; the general habilitation activities must be designed to support such employment goals. Competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities is considered to be the successful outcome of this service.

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

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and other public sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Prevocational Provider
Agency	Supported Employment Agency

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*):

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

09 Caregiver Support

Sub-Category 1:

09011 respite, out-of-home

Category 2:

09 Caregiver Support

Sub-Category 2:

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 participant’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 participant’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 participant, the home of a caregiver, or in other community settings.

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

Respite care cannot provide supervision while primary caregivers are working, except when a participant is attending a

camp.

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Accredited Day Camps
Agency	Accredited Overnight Camps
Agency	Respite Agency
Individual	Adult Family Home
Agency	Group Homes for Children
Individual	Other person appropriately qualified as approved by the State and as related to the unique service being provided
Agency	Community-Based Residential Facility
Agency	Shelter Care Facilities
Agency	Licensed Day Camps
Individual	Family Child Care Center
Agency	Residential Care Center (RCC) for Children and Youth
Individual	Participant-hired worker appropriately qualified as approved by a financial management service agency and as related to the unique service being provided.
Agency	Other agency appropriately qualified as approved by the State and as related to the unique service being provided
Agency	Foster Homes
Individual	Foster Homes
Agency	Family Child Care Center
Agency	Licensed Overnight Camps

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):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Accredited Day Camps

Provider Qualifications

License (specify):

Certificate (specify):

Accreditation by the American Camp Association (ACA)

Other Standard (specify):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Accredited Overnight Camps

Provider Qualifications

License (specify):

Certificate (specify):

Accreditation by the American Camp Association (ACA)

Other Standard (specify):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s psychiatric/behavioral treatment plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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:

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):

Employees working with the participant are required to receive specialized training related to the child's unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child's 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the participant served, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Licensed Day Camps

Provider Qualifications

License (specify):

Wis. Admin. Code ch. DCF 252

Wis. Admin. Code ch. ATCP 78

Certificate (specify):

Other Standard (specify):

Employees working with the participant are required to receive specialized training related to the child's unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child's 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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):

Employees working with the participant are required to receive specialized training related to the child's unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child's 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Participant-hired worker appropriately qualified as approved by a financial management service agency and as related to the unique service being provided.

Provider Qualifications

License (specify):

Certificate (specify):

[Empty text box]

Other Standard (specify):

Providers working with the participant are required to receive specialized training related to the child’s unique needs, to effectively address the needs of the participant served, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the child’s psychiatric/behavioral treatment plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS agency conducts a provider screening and credential verification process for participant-hired workers, including completing a caregiver background check and verifying qualifications for participant-specific training related to the service provided.

Frequency of Verification:

The FMS agency conducts provider screening and credential verification when the participant-hired worker is hired and every three 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):

[Empty text box]

Certificate (specify):

[Empty text box]

Other Standard (specify):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Foster Homes

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (specify):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Employees working with the participant are required to receive specialized training related to the child's unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child's 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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:

Licensed Overnight Camps

Provider Qualifications

License (specify):

Wis. Admin. Code ch. ATCP 78

Certificate (specify):

Other Standard (specify):

Employees working with the participant are required to receive specialized training related to the child's unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child's 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

01 Case Management

Sub-Category 1:

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 participant 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. Service Coordinators authorize all covered waiver services, and coordinate or facilitate access to all services and supports for

participants regardless of service delivery method.

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

Support and Service Coordinators facilitate and coordinate access to all services and supports, both formal and informal, which are needed by the participant 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 participant 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 participant's identified outcomes.

Support and Service Coordinators assess the family's needs so they may adequately support the participant. The Support and Service Coordinator facilitates establishing and maintaining the participant and family's individualized support system. Services provided include assuring effective implementation of the participant 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 participant transitioning to middle school and assisting the participant pursue vocational and/or education opportunities. It also includes supporting transition planning processes for participants transitioning into an adult long-term care program; discussing options if the participant is not transitioning to an adult long-term care program; and discussing changes to parents' legal authority to make decisions for their participant when that participant turns 18 years old, among other transition responsibilities.

Cross-system coordination activities performed by the Support and Service Coordinators may include providing information for coordination with other services and resources: court-ordered, juvenile justice, or child protective services; referring and assisting the participant to access public benefits, energy assistance, or other poverty-related services, and any goods or services covered by a third party.

General activities of Support and Service Coordination include 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 responsible for assessing and reassessing the participant's health, safety, and functional capacity. Support and Service Coordinators are mandated reporters for child abuse and neglect and must issue referrals to child protection and child welfare services, when warranted. Support and Service Coordinators provide crisis and incident intervention and resolution.

Support and Service Coordinators also compile and maintain required documentation.

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.

When a participant is determined functionally eligible for the waiver program and indicates they intend to enroll in the program, Supports and Service Coordination can be provided up to 90 days (or longer with prior DHS approval) prior to the date the participant is enrolled in the waiver program to allow for services delivered for the purpose of establishing participant eligibility and enrollment. Other services or items that support the participant in relocating from an ineligible setting to an eligible setting may be purchased up to 90 days (or longer with prior DHS approval) prior to the date the participant is enrolled in the waiver program.

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed or Certified Social Worker
Individual	Other person 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: Statutory Service

Service Name: Support and Service Coordination

Provider Category:

Individual

Provider Type:

Licensed or Certified Social Worker

Provider Qualifications

License (specify):

Wis. Stat. ch. 457.08

Certificate (specify):

Wis. Stat. ch. 457.08

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.

All SSCs must receive training on HCBS Settings compliance. SSCs must also comply with professional development training requirements set by DHS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Locally-contracted waiver agencies are responsible for verifying that all SSCs meet the provider qualifications for this service.

Frequency of Verification:

For SSCs that are employees of the locally-contracted waiver agency, verification occurs upon hire and every three years, thereafter, at a minimum. For any sub-contracted SSCs, verification occurs with contract cycles.

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):

Support and Service Coordinators must meet any one of the following standards:

- 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(s) for which they are employed.
- 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(s) for which they are employed.
- An associate's degree in a human services-related field and two years of experience working with persons of the specific target group(s) for which they are employed.
- Any combination of training in a health or human services-related field and experience in long-term care case management and/or case management for individuals with disabilities or special needs that totals four years. Examples include but are not limited to: one year of coursework/training in a human services-related field and three years of experience in long-term care case management, or four years of experience in long-term support case management.

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.

All SSCs must receive training on HCBS Settings compliance. SSCs must also comply with professional development training requirements set by DHS.

Verification of Provider Qualifications

Entity Responsible for Verification:

Locally-contracted waiver agencies are responsible for verifying that all SSCs meet the provider qualifications for this service.

Frequency of Verification:

For SSCs that are employees of the locally-contracted waiver agency, verification occurs upon hire and every three years, thereafter, at a minimum. For any sub-contracted SSCs, verification occurs with contract cycles.

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):

[Empty text box for alternate service title]

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-dir

Category 2:

[Empty text box for category 2]

Sub-Category 2:

[Empty text box for sub-category 2]

Category 3:

[Empty text box for category 3]

Sub-Category 3:

[Empty text box for sub-category 3]

Category 4:

[Empty text box for category 4]

Sub-Category 4:

[Empty text box for 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 participant 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 participant’s authorized individual service plan (ISP).

These services function as a safeguard for the participant 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 Service providers may perform a variety of activities, including:

- Verify caregiver’s citizenship
- Train caregivers on the requirements for the CLTS waiver program service(s) the caregiver will directly provide to the participant as outlined in the applicable service definition.
- 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. Participants and families are not limited to the caregivers on the list maintained by the FMS; they choose their own caregivers and refer them to FMS.

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 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.

FMS is limited to only CLTS services that allow for self-directed employer authority,

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

12 Services Supporting Self-Direction

Sub-Category 1:

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
- 3) information, coaching, and mentoring about participant and family-direction, including roles and responsibilities.

The Participant and Family-Direction Broker assists the participant and family in meeting their participant-direction responsibilities, particularly their employer authority 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 responsibilities may not be delegated to this service.

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

Broker services are limited to CLTS services that allow for self-directed employer authority. 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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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 agency may be considered a qualified participant and family-direction broker only when it demonstrates adequate knowledge of the local service delivery system and local resources available to the participant.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 local service delivery system and local resources available to the participant.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

02 Round-the-Clock Services

Category 2:

02 Round-the-Clock Services

Category 3:

02 Round-the-Clock Services

Category 4:

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

Sub-Category 2:

02013 group living, other

Sub-Category 3:

02021 shared living, residential habilitation

Sub-Category 4:

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.

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,” “Specialized Medical and Therapeutic Supplies” or “Communication Assistance for Community Inclusion,” respectively.

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Provider Category	Provider Type Title
Agency	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:

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):

HCBS Compliant per 42 CFR 441.301(c)(4)

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 screened, qualified, and enrolled are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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):

HCBS Compliant per 42 CFR 441.301(c)(4)

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 screened, qualified, and enrolled are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

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):

Assistive Technology are items, pieces of equipment, software or application, service dog , product systems, or services that increase, maintain, or improve functional capabilities of the participant at home, work, and in the community. An assistive technology service directly assists the participant in the selection, acquisition, or use of an assistive technology device.

This service includes:

a) the evaluation of the assistive technology needs of the participant, including a functional evaluation of the impact of

- providing appropriate assistive technology and services to the participant in the customary environment of the participant;
- b) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;
- 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 on the use of the assistive technology for the participant, or where appropriate, the family members, guardians, advocates or authorized representatives of the participant; and
- f) training or technical assistance on the use of the assistive technology for professionals or other individuals, who provide services to, employ or are otherwise substantially involved in the major life functions of participants

Electronic devices must meet UL or FCC standards.

Assistive Technology covers the purchase of a trained service dog. As per the Americans with Disabilities Act, service animals are dogs trained to perform major life tasks to assist people with physical disabilities. For a person to legally qualify to have a service dog, the participant must have a disability that substantially limits the participant's ability to perform at least one major life task without assistance. The locally-contracted waiver agency must maintain documentation of clinical appropriateness completed by a qualified professional. The assessment of appropriateness must contain:

- A description of the participant's disability-related functional impairment.
- Identification of the specific tasks the service dog is expected to perform.
- An explanation of how those tasks directly address the identified functional need.

For behavioral or mental health needs, the assessment must demonstrate that the service dog is trained to take a specific action in response to a clearly defined condition, cue, or behavior that prevents or mitigates an immediate health or safety risk. Generalized emotional or behavioral benefits alone are not sufficient.

Locally contracted waiver agencies should also assess the participant and caregiver capacity for the responsibility of owning a service animal.

To qualify as a service dog, the dog must be individually trained by an accredited service dog trainer 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.

Costs are limited to the following:

- Purchase of a fully trained service dog from an accredited provider with experience providing structured training for service dogs;
- Post-purchase training with a reputable provider experienced in providing structured training for service dogs to partner a service dog with the participant owner;
- Ongoing maintenance costs of a fully trained service dog that include preventative, acute, and primary veterinary care and items necessary for the service dog to perform its task or work.

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. This service excludes costs related to a dog that does not meet the definition of a service dog (i.e. emotional support dog, therapy dog, dog training to become a service dog, household pet).

The locally contracted waiver agency may provide periodic review to ensure that the service dog continues to meet the participant's needs. Funding may be discontinued if the service dog is no longer able to perform its trained tasks or is no longer aligned with the participant's assessed needs. A service dog cannot be trained to perform a task considered to be a restrictive measure.

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Veterinary Clinic
Individual	Other individual appropriately qualified as approved by the State and as related to the unique service
Individual	Service Dog Trainer
Agency	Service Dog Training Agency
Agency	Durable Medical Equipment Provider
Agency	Other agency appropriately qualified as approved by the State and as related to the unique service
Agency	Pharmacy

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Veterinary Clinic

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Employing or contracting with licensed veterinarians (Wis. Stat. § 89.06)

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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

Provider Category:

Individual

Provider Type:

Other individual appropriately qualified as approved by the State and as related to the unique service

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Provider is required to have demonstrated skills related to the specific area of content for the identified outcome of the participant. 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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

Provider Category:

Individual

Provider Type:

Service Dog Trainer

Provider Qualifications

License (specify):

Certificate (specify):

Accredited by Assistance Dogs International

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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

Provider Category:

Agency

Provider Type:

Service Dog Training Agency

Provider Qualifications

License (specify):

Certificate (specify):

Accredited by Assistance Dogs International

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License (specify):

Certificate (specify):

WI. Admin. Code DHS 105

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Provider is required to have demonstrated skills related to the specific area of content for the identified outcome of the participant. 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License (specify):

WI. Stat. Ch. 450.06

WI. Stat. Ch. 450.065

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

02 Round-the-Clock Services

Sub-Category 1:

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.

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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.

HCBS Compliant per 42 CFR 441.301(c)(4)

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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.

HCBS Compliant per 42 CFR 441.301(c)(4)

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Communication Assistance for Community Inclusion

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17020 interpreter

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14031 equipment and technology

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 communication aids necessary to facilitate and assist participants with hearing, speech, communication, or vision impairment, including 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). This service assists the individual to effectively communicate with service providers, family, friends and the general public; decrease reliance on paid staff; increase personal safety; enhance independence; increase community inclusion; and improve social and emotional well-being.

Communication Assistance for Community Inclusion include any device that addresses these objectives such as augmentative and alternative communication systems, hearing or speech amplification devices, and cognitive retraining aids and the repair and/or servicing of such systems. This service also includes 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 participants disabilities or needed to access a disability-related service or event. Applications for mobile devices or other technology also are covered under this service, when the use provides assistance related to the participant 's disabilities.

Communication Assistance for Community Inclusion includes interpreter services, which 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.

This service 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:

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.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

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

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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
Individual	Authorized Dealers
Agency	Pharmacy
Individual	Individual Sign Language Interpreters
Individual	Other individual appropriately qualified as approved by the State and as related to the unique service
Individual	Foreign language interpreters
Agency	Medical Supply Company
Agency	Other agency appropriately qualified as approved by the State and as related to the unique service being provided
Agency	Providers of Communication Aids

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication Assistance for Community Inclusion

Provider Category:

Individual

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License (specify):

Certificate (specify):

Wis. Admin. Code ch. DHS 105

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Communication Assistance for Community Inclusion

Provider Category:

Individual

Provider Type:

Authorized Dealers

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Communication Assistance for Community Inclusion

Provider Category:

Agency

Provider Type:

Pharmacy

Provider Qualifications

License (specify):

WI. Stat. Ch. 450.06

WI. Stat. Ch. 450.065

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Communication Assistance for Community Inclusion

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Communication Assistance for Community Inclusion

Provider Category:

Individual

Provider Type:

Other individual appropriately qualified as approved by the State and as related to the unique service

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Provider is required to have demonstrated skills related to the specific area of content for the identified outcome of the participant. 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Communication Assistance for Community Inclusion

Provider Category:

Individual

Provider Type:

Foreign language interpreters

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Allowable foreign language interpreter services are those provided by a person recognized by DHS as proficient in the translation of the applicable language and instructed by the agency as to the privacy and confidentiality of the 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Communication Assistance for Community Inclusion

Provider Category:

Agency

Provider Type:

Medical Supply Company

Provider Qualifications

License (specify):

Certificate (specify):

Wis. Admin. Code ch. DHS 105

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Communication Assistance for Community Inclusion

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):

Provider is required to have demonstrated skills related to the specific area of content for the identified outcome of the participant. 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Communication Assistance for Community Inclusion

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

04 Day Services

Sub-Category 2:

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 necessary to support the participant and family within a community setting.

Community Integration Services benefits families with participants 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 Community Integration Services team coordinator is required to facilitate coordination of the multidisciplinary team and the participant’s integration into their community.

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

1. The minimum service requirements are that the Community Integration Services coordinator shall convene quarterly team reviews, or sooner if requested by the SSC, that includes the parent or guardian and the participant (if deemed appropriate), relevant service provider agency staff/supervisor (when applicable), the overseeing SSC.
2. Community Integration providers shall complete a written report every six months or sooner if the participant’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. 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 participant, all providers shall ensure that all standards described in the transportation service are met. . 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.

When a participant is determined functionally eligible for the waiver program and indicates they intend to enroll in the program, services or items that support the participant in relocating from an ineligible setting to an eligible setting may be purchased up to 90 days (or longer with prior DHS approval) prior to the date the participant is enrolled in the waiver program.

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

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

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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
Individual	Licensed or Certified Social Worker
Agency	Community Integration Services Agency

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 authorize qualified providers who are less experienced if the provider attests that they will receive 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Individual

Provider Type:

Licensed or Certified Social Worker

Provider Qualifications

License (specify):

Wis. Stat. ch. 457.08

Certificate (specify):

Wis. Stat. ch. 457.08

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Community Integration Services Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

Frequency of Verification:

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:

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:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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*):

Community/Competitive Integrated Employment – Small Group assist a participant to attain sustained employment and work experiences that foster further career development and individual, integrated community-based employment, in a job that meets the participant’s personal and career goals. This service must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces.

These services and training activities are provided in a regular business, industry, or community setting for groups of two to eight workers with disabilities. The outcome of Community/Competitive Integrated Employment – Small Group 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 – Small Group does not include volunteer work.

Community/Competitive Integrated Employment – Small Group 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; 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 participant to be successful in integrating into the job setting.

Community/Competitive Integrated Employment – Small Group 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 – Small Group 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.

Incidental personal care/assistance provided by the supported employment staff may be a component part of Community/Competitive Integrated Employment – Small Group.

Community/Competitive Integrated Employment – Small Group supports does not include facility-based, or other similar types of vocational services furnished in specialized facilities that are not a part of the general workplace. Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses.

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.

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. The waiver is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and other public sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	On the job support person
Agency	Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community/Competitive Integrated Employment - Small Group

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community/Competitive Integrated Employment - Small Group

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Conferences and Education for Unpaid Caregivers

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

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*):

Conferences and Education for Family/Unpaid Caregivers covers conferences and education that enhance an unpaid caregiver's ability to help the participant live their best possible life. This service provides conferences, educational opportunities, and materials to an unpaid caregiver of a participant to support and care for the participant.

For purposes of this service, unpaid caregiver is defined as any person who provides uncompensated care or support to the waiver participant.

This service may help an unpaid caregiver to learn general education through a one-time or short-term training, conference or event, about: 1) understanding and accepting the disability of the participant 2) achieving greater competence and confidence in providing support 3) developing and accessing community and other resources and supports 4) developing or enhancing key parenting strategies and 5) increasing methods for coping and learn techniques to manage challenges.

This service includes:

- Conferences
- Resource materials
- Online training
- Support groups
- Registration and training fees associated with formal instruction.

Training furnished to persons who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the Individual Service Plan. This service must be aimed at assisting unpaid caregivers who support the participant to understand and address participant's needs. This service covers the costs of registration fees associated with conferences, online trainings, and events, in areas relevant to the participant's outcomes identified in the Individual Service Plan.

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 the costs of travel, meals and overnight lodging to attend a training event or conference.
- This service does not cover teaching self-advocacy, which is covered under Empowerment and Self-Determination Supports.
- This service must be directly related to the person's role in caring for the participant and tied to the participant's disability-related needs. This service may not cover services that are typically the responsibility of individuals not enrolled in the CLTS Waiver Program. This service excludes the funding for support and services that are solely related to the caregiver's own mental health needs.
- This service excludes services that are harmful. This service excludes funding for items, trainings, services, or supports that support the usage of an unapproved restrictive measure.

When a participant is determined functionally eligible for the waiver program and indicates they intend to enroll in the program, services or items that support the participant in relocating from an ineligible setting to an eligible setting may be purchased up to 90 days (or longer with prior DHS approval) prior to the date the participant is enrolled in the waiver program.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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: Conferences and Education for Unpaid Caregivers

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):

DHS implements a centralized provider screening and credential verification process. The DHS quality monitoring and record review process ensures only screened, qualified, and enrolled providers are authorized to deliver Waiver 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 enroll as a waiver provider and every three years, thereafter, at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Conferences and Education for Unpaid Caregivers

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

11 Other Health and Therapeutic Services

Sub-Category 1:

11120 cognitive rehabilitative therapy

Category 2:

11 Other Health and Therapeutic Services

Sub-Category 2:

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 participants 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 participant 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. Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.

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.

Therapies Allowed Under this Service:

- Aquatic Therapy
- Art Therapy
- Dance Therapy
- Deaf and hard of hearing education and orientation that fulfill a medical, social, or functional need for the participants who are deaf or hard of hearing.
- Equine Assisted Therapy or Hippotherapy
- Massage Therapy
- Music Therapy
- Recreational Therapy
- Vision education and orientation, and mobility training for participants who are blind or visually impaired.

Counseling and therapeutic services must meet a clearly defined outcome, be proven effective for the participant's condition or outcome and be cost-effective. Counseling and therapeutic services providers must submit regular progress reports to the locally-contracted waiver agency.

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.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Massage or Bodywork Therapist
Individual	Art Therapist
Individual	Certified Orientation and Mobility Specialist (COMS)
Individual	Teacher of the Deaf or Hard of Hearing
Individual	Therapeutic Recreation Specialist
Individual	Dance Therapist
Individual	Hippotherapist
Individual	Equine-Assisted Therapist
Individual	Music Therapist
Individual	Teacher of the Visually Impaired (TVI)
Agency	Counseling and Therapeutic Agency

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Certificate (specify):

Wis. Stat. ch. 440

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Certified Orientation and Mobility Specialist (COMS)

Provider Qualifications

License (specify):

Certificate (specify):

Certification from the Academy for Certification of Vision Rehabilitation and Education Professionals, or certification from the National Blindness Professional Certification Board

Other Standard (specify):

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Teacher of the Deaf or Hard of Hearing

Provider Qualifications**License (specify):**

Wis. Admin. Code PI 34.050

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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:

Dance Therapist

Provider Qualifications

License (specify):

Certificate (specify):

Wis. Stat. ch. 440

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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):

Required credentials are a certification by a professional organization that an individual has demonstrated competence with field-tested standards

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Required credentials are a certification by a professional organization that an individual has demonstrated competence with field-tested standards

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Certificate (specify):

Wis. Stat. ch. 440

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Teacher of the Visually Impaired (TVI)

Provider Qualifications

License (specify):

Wis. Admin. Code PI 34.051

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Counseling and Therapeutic Agency

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Employing or contracting with professionals with current state licensure or certification in a field of practice covered under this service. 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

08 Home-Based Services

Sub-Category 1:

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 participant’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 participant. Services may include incidental personal care as a part of habilitation services.

Daily living skills training may include education and skill development, such as:

- Accessing and using community resources
- Community mobility
- Computer and technology use
- Driving evaluation, lessons, and other related fees
- Food preparation
- Home upkeep and maintenance
- Money management
- Personal hygiene
- Social emotional skills
- Transportation usage

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, including substitute task performance, which may be covered under personal supports. This service does not cover general supervision, which may be covered under personal supports or specialized youth care.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other public sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Participant-hired workers appropriately qualified as approved by a financial management service agency and as related to the unique service being provided.
Agency	Providers of Daily Living Skills Training
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: Daily Living Skills Training

Provider Category:

Individual

Provider Type:

Participant-hired workers appropriately qualified as approved by a financial management service agency 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 with less experience may be authorized to provider daily living skills training if they attest that they will receive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the individual service plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS agency conducts provider screening for participant-hired workers, including completing a caregiver background check and verifying qualifications for participant-specific training related to the service provided.

Frequency of Verification:

The FMS agency conducts provider screening and credential verification when the participant-hired worker is hired and every three 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):

Direct support professionals or employees providing daily living skills training must have a minimum of two years' experience working with the target population. However, the waiver agency may authorize qualified providers who are less experienced if they attest that they will receive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the individual service 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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:

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 with less experience may be authorized to provide daily living skills training if they attest that they will receive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the individual service plan.

Providers are knowledgeable in the adaptation and use of specialized equipment and in the modification of participant environments and that they complete regular training/continuing education coursework to maintain/update their level of expertise.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

13 Participant Training

Sub-Category 2:

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 participant and their unpaid caregivers acquire skills to exercise control and responsibility over their other supportive services. Exercising control and responsibility over supportive services helps the participant and the participant’s unpaid caregivers build an interdependent care network within their community and promotes self-determination. Empowerment and Self-Determination Supports provide training programs, workshops, conferences, and other educational or self-determination building events that help the participant and their unpaid caregivers develop self-advocacy skills, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. Services are directly related to building the capacity to manage support services through self-advocacy skill acquisition. Empowerment and Self-Determination Supports are provided to the participant. The participant’s unpaid caregivers may receive this service as a means of accompanying the participant to the conference or event.

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. This service is not intended for regular, direct, and ongoing supports.

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 and their unpaid caregivers attend allowable training/education events.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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: 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 screened, qualified, and enrolled are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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):

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 screened, qualified, and enrolled are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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 counseling of the participant and/or family in coming to terms with and adjusting to the possible death of the participant and the aftercare of the family due to the death of the participant. 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 participant has a life-threatening illness or if the participant 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 participant who has a life-limiting diagnosis with the outcome of death, and in dealing with the loss of the participant. Enabling the participant and family members to express and cope with emotions improves the likelihood that the participant 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 prior to the participant’s death while the participant is on the waiver but may continue after the death of the participant 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 participants death. The service may be billed once the family has shown interest in receiving the service and prior to the participants death.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Individual	Licensed Social Worker
Individual	Licensed Professional Counselor
Agency	Hospice
Individual	Spiritual Counselor
Agency	Any agencies appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Individual	Licensed Psychologist

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 133

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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. Examples include but are not limited to persons with hospice-related certification or experience.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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. Examples include but are not limited to persons with hospice-related certification or experience.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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:

HCBS Taxonomy:

Category 1:

Sub-Category 1:

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 primary purpose of Health and Wellness services is to support the participants 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. This service covers registration or enrollment costs required to participate in a health and wellness activity. The service also covers health club or gym memberships for the participant or their families.

a) Healthy Lifestyles – community-based classes, lessons, events or other educational opportunities that promote a healthy lifestyle aimed to help keep the participant in the community. This could include activities that address nutrition, physical activity, and sensory regulation.

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.

-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 participant’s life.

Training 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:

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

Health and wellness supports and services may not be experimental or aversive in nature, nor may they otherwise jeopardize the health and safety of the participant.

This service excludes health-related items, including the purchase of food and any ingested herbs, treatments, or supplements. This service also excludes equipment, supplies, and uniforms for participating in a health and wellness activity. Adaptive items that are required to participate in a health and wellness activity may be covered under Assistive Technology.

This service excludes entrance fees for activities that are primarily recreational such as zoos, museums, water parks, movies, theaters, concerts, professional or minor league sporting events, outdoor play structures, and passes for family admission to recreation centers.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

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 providers meeting the definition of a caregiver must receive specialized training related to the participant's unique needs to effectively address the needs of the participant, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the participant's 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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 direct support professional or employee meeting the definition of a caregiver must receive specialized training related to the participant’s unique needs to effectively address the needs of the participant, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the participant’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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).

Any direct support professional or employee meeting the definition of a caregiver must receive specialized training related to the participant’s unique needs to effectively address the needs of the participant, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the participant’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 providers meeting the definition of a caregiver must receive specialized training related to the participant’s unique needs to effectively address the needs of the participant, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the participant’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Socialization and Sexuality Provider

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Any provider meeting the definition of a caregiver must receive specialized training related to the participant’s unique needs to effectively address the needs of the participant, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the participant’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

14 Equipment, Technology, and Modifications

Sub-Category 1:

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 participant'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, 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. This service also covers the cost of conducting an accessibility assessment to determine the need for a home modification.

Home modifications may include adaptations, including, but not limited to:

- Accessible cabinetry, counter tops, or other work surfaces
- Adaptive doorbells, locks/security items, or devices
- Adaptive lighting/light switches
- Doors/doorways, door handles/door opening devices
- Faucets/water controls
- Flooring and/or floor covering to address health and safety
- Grab bars, handrails, accessible closets
- Medically necessary heating, cooling, or other ventilation system
- Plumbing, electrical modifications related to adaptations
- Porch/stair lift
- Ramps (fixed), ramp extensions and platforms
- Shower, sink, tub and toilet modifications
- Smoke/fire alarms and fire safety adaptations
- 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.

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.

Permanent or structural modification to rented living arrangements require approval from the landlord or property owner.

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

When a participant is determined functionally eligible for the waiver program and indicates they intend to enroll in the program, services or items that support the participant in relocating from an ineligible setting to an eligible setting may be purchased up to 90 days (or longer with prior DHS approval) prior to the date the participant is enrolled in the waiver program.

This service category excludes:

- Modifications of improvements that are of general home maintenance and upkeep, including those that are exclusively for the purpose of bringing a home up to local and state housing or building code requirements (i.e. roof repair, flooring replacement, sidewalks, etc.)
- Modifications to the home which are of general utility and are not of direct medical or remedial benefit to the participant (e.g. household appliances, whole house generators, or central air conditioning systems).

-Modifications made to living arrangements that are owned or leased by agency providers of other waiver services.

-Modifications that do not meet standards of manufacture, design, or installation.

-Funding for the installation and other monthly/cost of internet services (when necessary, this service may only be authorized for participants who already have access to necessary internet services).

-Materials that exceed the industry standard or are for cosmetic benefit only.

-Modifications within a home that is found to not be structurally sound, as determined by assessor or contractor.

-Modifications that add to the total square footage of a home, except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Residential elevators or enclosed vertical platforms can be authorized only after all other alternative home modification options have been considered.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other public sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Contractor
Individual	Heating & Air Conditioning
Agency	Building Supply Company
Individual	Engineer
Individual	Electrician
Individual	Plumber
Agency	Independent Living Center
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: Home Modifications

Provider Category:

Provider Type:

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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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:

Provider Type:

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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Wis. Admin. Code § 305.40

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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

17 Other Services

Sub-Category 1:

17030 housing consultation

Category 2:

17 Other Services

Sub-Category 2:

17990 other

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):

Housing Support Services are supports to help participants and families navigate housing opportunities; address or overcome barriers to housing; 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 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.).

When a participant is determined functionally eligible for the waiver program and indicates they intend to enroll in the program, services or items that support the participant in relocating from an ineligible setting to an eligible setting may be purchased up to 90 days (or longer with prior DHS approval) prior to the date the participant is enrolled in the waiver program.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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
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: 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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):

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

In-Home Unpaid Caregiver Training

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

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):

This service is intended to develop, strengthen and maintain healthy, stable relationships among the participant and the people who have a substantial unpaid role in caring for the participant. Services are intended to be ongoing training with a focus in one or more of the following areas:

- The acquisition of coping skills by building upon the strengths of the participant and the people who have a substantial unpaid role in caring for the participant;
- Supporting with direct instruction during times of difficulty due to loss, change, transition, or the participant’s complex medical or behavioral needs;
- Working to improve communication with and support of one another;
- Working on strategies for healthy approaches to reducing stress and balancing responsibilities;
- Coaching in the home or community that helps increase caregiver capacity to support the participant’s disability related needs, reduce behavioral support needs, or improve the participant’s functional capabilities and independent living skills.

For the purposes of this service, unpaid caregiver is defined as any person who provides uncompensated care or support to the waiver participant.

The enrolled participant may or may not be present during the provision of this service, as determined by the participant’s individual service plan. Services must include the development and implementation of a plan to meet the participant’s individual service plan outcome. Services are primarily intended for the home environment but may include community settings as determined by the outcomes.

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

This service must be directly related to the person’s role in caring for the participant and tied to the participant’s disability-related needs. This service may not cover services that are typically the responsibility of individuals not enrolled in the CLTS Waiver Program. This service excludes support and services that are solely related to the parent or unpaid caregiver’s own mental health needs.

This service excludes services that are harmful. This service excludes funding for items, trainings, services, or supports that support the usage of an unapproved restrictive measure.

This service does not cover training for foster parents, which may be covered under the children’s foster care service. Kinship caregivers are eligible for training under this service.

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 preventative health care services for children under age 21. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Certified Peer Specialist
Individual	Certified Parent Peer Specialist
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: In-Home Unpaid Caregiver Training

Provider Category:

Individual

Provider Type:

Certified Peer Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Peer specialists must complete any DHS-required training courses and complete an exam to receive certification.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: In-Home Unpaid Caregiver Training

Provider Category:

Individual

Provider Type:

Certified Parent Peer Specialist

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Parent peer specialists must complete any DHS-required training courses and complete an exam to receive certification.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: In-Home Unpaid Caregiver Training

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):

Provider must have a bachelor’s degree in a human services or educational field with two years' related experience, or a master’s degree in a human services or educational field with one year of related experience.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider

and every three years, thereafter, at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: In-Home Unpaid Caregiver Training

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):

Provider must have a bachelor’s degree in a human services or educational field with two years' related experience, or a master’s degree in a human services or educational field with one year of related experience.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2:

04 Day Services

Sub-Category 2:

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 participant’s or participant’s ability to interact in their community in socially advantageous ways.

The mentor provides the participant 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 participant 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 participant’s or participant’s individual service plan. Costs for meals and admission fees for the mentor and participant may be included.

The locally-contracted waiver agency must ensure that documentation of the mentor’s participant-specific training is documented in the participant’s record.

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.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other public sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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):

Direct support professional or employees providing mentoring services must be 18 years or older. Providers working with the participant are required to receive specialized training related to the participant’s unique needs to effectively address the needs of the participant, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the participant’s psychiatric/behavioral treatment plan.

Providers shall be involved in frequent and ongoing communication with the Support and Service Coordinator, and family, regarding participant specific updates, information, and concerns.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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.

Providers working with the participant are required to receive specialized training related to the participant’s unique needs to effectively address the needs of the participant, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the participant’s psychiatric/behavioral treatment plan.

Providers shall be involved in frequent and ongoing communication with the Support and Service Coordinator, and family, regarding participant specific updates, information, and concerns.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

14 Equipment, Technology, and Modifications

Sub-Category 1:

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 participant 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:

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Community Based Electronic Communications Unit
Individual	Community Based Electronic Communications Unit
Agency	Telephone service including cellular

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

08 Home-Based Services

Sub-Category 1:

08020 home health aide

Category 2:

Sub-Category 2:

Category 3:

08 Home-Based Services

Sub-Category 3:

08050 homemaker

Category 4:

08 Home-Based Services

Sub-Category 4:

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.

The scope of Personal Supports may include performing incidental personal care, including activities of daily living or instrumental activities of daily living. However, such activities may not comprise the entirety of the service.

a. Personal Supports covers the use of a caregiver in the home or community to provide assistance with functional skills and may help a participant who has difficulties with these types of skills accomplish tasks including: life safety, medication and health management, communication skills, mobility, appropriate social behaviors, and problem-solving.

b. Personal supports cover services that consist of the performance of basic household tasks within the participant's primary residence (i.e., cleaning, laundry, or household care) and provided by a qualified homemaker.

Chore services must be related to a participant's disability or the primary caregiver's capacity or inability to complete household tasks due to the participant's disability-related needs. Chore services increase a caregiver's capacity to provide other supports to the participant. Chore services can be provided only when another caregiver, relative, landlord, or other third-party is not capable or responsible for their provision. Chore services cannot be used for home repairs and maintenance that is typically the responsibility of a homeowner or landlord.

c. Personal supports covers 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, and spreads disease to humans

Pest control service must be related to a participant's disability or related to protecting the health and safety of the participant and supporting the participant to remain in their home and community. This could include situations where pests hinder the participant's ability to receive HCBS services in their home.

Pest control services can be provided only when another third-party is not responsible for paying for this service. Examples of a third-party could be a landlord, local public health department, or child welfare agency.

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.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Licensed individual commercial pesticide applicator
Agency	Home Health Agency
Individual	Personal Care Worker
Individual	Certified individual commercial pesticide applicator
Individual	Licensed Practical Nurse
Agency	Commercial pesticide application business
Individual	Registered Nurse
Agency	Other agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Individual	Nurse Aide
Individual	Participant-hired worker appropriately qualified as approved by a financial management service agency and as related to the unique service being provided.
Agency	Supportive Home Care Agency

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):**

Employees working with the participant are required to receive specialized training related to the child's unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child's 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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):

Providers working with the participant are required to receive specialized training related to the child's unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the child's 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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):

Providers working with the participant are required to receive specialized training related to the child's unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the child's 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

Providers working with the participant are required to receive specialized training related to the child’s unique needs to

effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

[Empty box]

Certificate (specify):

Wis. Stat. ch. 50,

Wis. Admin. Code ch. DHS 129

Other Standard (specify):

Providers working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Participant-hired worker appropriately qualified as approved by a financial management service agency and as related to the unique service being provided.

Provider Qualifications

License (specify):

[Empty box]

Certificate (specify):

[Empty box]

Other Standard (specify):

Providers working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the child’s psychiatric/behavioral treatment plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS agency conducts provider screening for participant-hired workers, including completing a caregiver background check and verifying qualifications for participant-specific training related to the service provided.

Frequency of Verification:

The FMS agency conducts provider screening and credential verification when the participant-hired worker is hired and every three 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):

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled d providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Relocation Services

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition 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):

Relocation services are services and essential items needed to establish a community living arrangement for participants who are relocating from an institution or other provider-operated congregate living arrangement (examples include but are not limited to a foster home, group home, or homeless shelter), or who are moving out of the family home to a more independent setting. This service includes participant-specific services, supports or goods that will be put in place in preparation for the participants relocation to a safe, accessible and affordable community living arrangement. Only initial costs to prepare the living arrangement are covered.

Relocation services may include the purchase of the following when necessary, specifically for the participant, including 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.

Relocation services may include the payment of a security deposit, utility connection costs and telephone installation charges. This service includes payment for moving the participants 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.

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

Services or items covered by this service may not be purchased more than 180 days prior to the date the participant relocates to the community living arrangement. 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.).

Coverage of security deposits is limited to relocations involving only the participant; security deposits for relocations involving a participant’s family are not covered.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Moving companies, public utilities, real estate agencies, vendors of home furnishings

Provider Category	Provider Type Title
Individual	Individual movers/individual landlords

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Relocation 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):

Reputable contractor with Compliance history. Compliance history with Wisconsin or any other state's licensing requirements or federal certification requirements, including any license revocation or denial. Fraud or substantial or repeated violations of applicable laws and rules in the operation of any business. Financial history and financial stability, including:

- Financial history and financial viability of the owner or related organization.
- Outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines.

Individual movers must meet permit requirements under Wis. Stat. 194.04

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Relocation Services

Provider Category:

Individual

Provider Type:

Individual movers/individual landlords

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Reputable contractor with Compliance history. Compliance history with Wisconsin or any other state's licensing requirements or federal certification requirements, including any license revocation or denial. Fraud or substantial or repeated violations of applicable laws and rules in the operation of any business. Financial history and financial stability, including:

- Financial history and financial viability of the owner or related organization.
- Outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines.

Individual movers must meet permit requirements under Wis. Stat. 194.04

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider's application to enroll as a waiver provider and every three 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:

09 Caregiver Support

Sub-Category 1:

09020 caregiver counseling and/or training

Category 2:

10 Other Mental Health and Behavioral Services

Sub-Category 2:

10040 behavior support

Category 3:

17 Other Services

Sub-Category 3:

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 participants safe in their homes and communities. This service includes safety planning and emergency preparedness and involves 1) working with the participant 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 participant and family in the event of a safety or emergency event at home or in the community. 3) classes, items, and supplies identified in the safety plan as necessary for safety and emergency preparedness for the participant.

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.

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 the participant and family. As appropriate, Safety Planning and Prevention 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 participant safe and included in their home and community.

For emergency situations where the participant 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 participant, 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 in implementing the safety plan 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 short-term 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 also includes consultations with service providers and potential providers to identify strategies that can meet the unique safety needs of the participant and identify additional supports necessary to keep participants safe in their homes and communities. For example, when a participant 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.

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

When a participant is determined functionally eligible for the waiver program and indicates they intend to enroll in the program, services or items that support the participant in relocating from an ineligible setting to an eligible setting may be purchased up to 90 days (or longer with prior DHS approval) prior to the date the participant is enrolled in the waiver program.

Training under this service must be short-term and related to educating the provider on implementing the service plan.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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 providers appropriately qualified
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided
Individual	Licensed Professional Counselor
Individual	Licensed Psychologist
Individual	Licensed Marriage and Family Therapist
Individual	Licensed Social Worker
Agency	Cardiopulmonary Resuscitation (CPR) Instructor
Individual	Licensed Applied Behavior Analyst

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 Marriage and Family Therapist

Provider Qualifications

License (specify):

Wis. Stat. ch. 457.10

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

[Empty text box]

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

14 Equipment, Technology, and Modifications

Sub-Category 2:

14032 supplies

Category 3:

[Empty text box]

Sub-Category 3:

[Empty text box]

Category 4:

[Empty text box]

Sub-Category 4:

[Empty text box]

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 devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living, maintain the participant’s health, manage a medical or physical condition, improve functioning, enhance independence or successfully access, navigate, and participate in their home and community. This service category also includes specialized medical and therapeutic supplies typically referred to as adaptive aids,

including adaptive equipment needed to participate in an activity covered under the Health and Wellness Service.

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.

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.

Specialized Medical and Therapeutic Supplies also covers:

- Over the counter medications with a National Drug Code (NDC) if not covered under the State Plan drug benefit and when prescribed by any licensed and authorized prescriber.
- Medically necessary prescribed skin conditioning lotions/lubricants when not covered under the State Plan.
- Prescribed Vitamin D, a prescribed multivitamin, and prescribed calcium supplements.

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:

Any equipment or supplies must be related to the participant’s disability. CLTS does not cover replacements unless the item has exhausted its useful life or has been rendered unsafe or unusable due to damage or defect. This service cannot cover items that would normally be purchased for a participant of the same functional age without a disability.

This service excludes the purchase of any food or ingested herbs.

When a participant is determined functionally eligible for the waiver program and indicates they intend to enroll in the program, services or items that support the participant in relocating from an ineligible setting to an eligible setting may be purchased up to 90 days (or longer with prior DHS approval) prior to the date the participant is enrolled in the waiver program.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

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

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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 as related to unique service being delivered to the child
Agency	Medical Supply Company
Individual	Durable Medical Equipment Provider
Individual	Other individual appropriately qualified as approved by the State as related to unique service being delivered to

Provider Category	Provider Type Title
	the child
Agency	Pharmacy

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:

Other agency 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):

Provider is required to have demonstrated skills related to the specific area of content for the identified outcome of the participant. 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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):

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Durable Medical Equipment Provider

Provider Qualifications

License (specify):

Certificate (specify):

Wis. Admin. Code ch. DHS 105

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 individual 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):

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Pharmacy

Provider Qualifications

License (specify):

WI. Stat. Ch. 450.06

WI. Stat. Ch. 450.065

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 Youth Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04070 community integration

Category 2:

08 Home-Based Services

Sub-Category 2:

08040 companion

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 Youth Care covers supervision services for participants age 12 or older that have aged out of traditional child care settings but still require supervision due to their disability. The purpose of this service is for participants to receive needed supervision while parents or guardians are working or in educational services. Specialized Youth Care can be provided on an individual or group basis. Group services may be provided with other individuals that may or may not have a disability, however, reimbursement is limited to the waiver participant. Participants may receive Specialized Youth Care within their homes or in the community.

Specialized Youth Care includes 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 may include a provider assisting the participant to utilize technology.

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

This service is limited to participants age 12 or older. Participants age 11 and under are ineligible for Specialized Youth Care as child care for that age range is a typical expense for working parents.

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

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Participant-hired worker appropriately qualified as approved by a financial management service agency and as related to the unique service being provided.
Agency	Other 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: Specialized Youth Care

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 working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Youth Care

Provider Category:

Individual

Provider Type:

Participant-hired worker appropriately qualified as approved by a financial management service agency and as related to the unique service being provided.

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the provider must have training specific to the child’s psychiatric/behavioral treatment plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The FMS agency conducts provider screening for participant-hired workers, including completing a caregiver background check and verifying qualifications for participant-specific training related to the service provided.

Frequency of Verification:

The FMS agency conducts provider screening and credential verification when the participant-hired worker is hired and ever three years, thereafter, at a minimum.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Youth Care

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):

Service delivery is 100% community based and is used by the general public.

Employees working with the participant are required to receive specialized training related to the child’s unique needs to effectively address the needs of the child, and to ensure their health, safety and welfare. If these unique needs are related to emotional and behavioral needs the employee must have training specific to the child’s 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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider

and every three 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:

15 Non-Medical Transportation

Sub-Category 1:

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 participant’s mobility in the community and increases their inclusion, independence, and participation in the community.

Payment for transportation under the waiver is limited to the costs of nonemergency, nonmedical transportation needed to access a waiver service included in the participant’s Individual Service Plan or access other activities and resources identified in the Individual Service Plan. Additionally, the fare or other transportation charges for an attendant, if needed, to accompany the participant 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 and receive mileage reimbursement if they meet the provider qualifications and specific circumstances necessitate the parents providing the rides. Specific circumstances include:

- (a) the lack of an available qualified provider in the participant’s region;
- (b) the lack of a qualified provider who can furnish services at necessary times and places; and
- (c) the unique ability of a relative or legal guardian to meet the needs of a person.

Payment may only be made to parents for extraordinary transportation needs related to the participant’s disability that exceeds normal transportation a parent would customarily provide to a participant without a disability.

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 under the vehicle modifications service).
- Excludes transportation services to and from medical providers.
- Costs for the participant or the family to maintain a vehicle are excluded.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance or other sources of funding.

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

- Participant-directed as specified in Appendix E**
- Provider managed**
- Remote/via Telehealth**

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	Specialized Transportation Agency
Individual	Private Drivers
Agency	Public Carriers e.g. taxi cabs, mass transit
Individual	Participant-hired worker appropriately qualified as approved by a financial management service agency and as related to the unique service being provided.
Agency	Transportation Network Agency

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 Agency

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 screened, qualified, and enrolled are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Individual

Provider Type:

Private Drivers

Provider Qualifications

License (specify):

Operator's 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:

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

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Individual

Provider Type:

Participant-hired worker appropriately qualified as approved by a financial management service agency and as related to the unique service being provided.

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Driver 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:

The FMS agency conducts a provider screening and credential verification process for participant-hired workers, including completing a caregiver background check and verifying qualifications for participant-specific training related to the service provided.

Frequency of Verification:

The FMS agency conducts provider screening and credential verification when the participant-hired worker is hired and every three 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:

Transportation Network Agency

Provider Qualifications

License (specify):

Wis. Stat. § 440.41 and 440.415

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 screened, qualified, and enrolled are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Vehicle Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

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):

Vehicle modifications are physical adaptations or alterations to the vehicle that is the participant’s primary means of transportation. Vehicle modifications accommodate the specialized needs of the participant and enable the participant to integrate more fully into the community and ensure the health, welfare, and safety of the participant.

This service includes the purchase of vehicle modifications 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. Examples include van/vehicle lift/transfer unit (manual, hydraulic, or electronic) and vehicle hand controls.

The cost of materials, installation, maintenance, and repair of allowable vehicle modification, and extended warranties necessary for a vehicle modification are included in this service. The cost of testing, inspection, and/or evaluation to determine the appropriateness of a vehicle modification is also included.

This service excludes:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant;
2. Purchase or lease of a vehicle; however, this service can be used to fund the portion of new or used vehicle purchase that directly relates to the cost of the accessibility adaptation.
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
4. Modifications to vehicles that are owned or leased by providers of waiver services.
5. Materials that exceed the industry standard or are for cosmetic benefit only, including autonomous vehicle technology.

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

When a participant is determined functionally eligible for the waiver program and indicates they intend to enroll in the program, services or items that support the participant in relocating from an ineligible setting to an eligible setting may be purchased up to 90 days (or longer with prior DHS approval) prior to the date the participant is enrolled in the waiver program.

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

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

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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	Motor Vehicle Modifier

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Vehicle Modifications

Provider Category:

Individual

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License (*specify*):

Certificate (*specify*):

WI. Admin. Code DHS 105

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Motor Vehicle Modifier

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Provider must be registered as a “Vehicle Modifier” with the National Highway Traffic Safety Administration (49 CFR 595.6) Provider must meet requirements outlined in 49 CFR 595.7 Provider must install equipment according to manufacturer’s requirements and instruction.

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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:

Virtual Equipment and Supports

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

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 is limited to items and services that facilitate accessing waiver services being delivered remotely and increase, maintain, or improve the participant’s functional capabilities at home, work, and in the community. Virtual equipment and supports functions for participants to get the items and services they need to access waiver services through delivery methods other than in-person.

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. This limitation does not apply to ongoing service charges for a device covered under this service or to virtual equipment and supports-related subscription. This service excludes the ongoing costs of internet services. 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:

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. In addition, the waiver is the payer of last resort and coordination of benefits (COB) must occur with private health insurance and other sources of funding.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Remote/via Telehealth

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

Provider Category	Provider Type Title
	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: Virtual Equipment and 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):

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Virtual Equipment and Supports

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Virtual Equipment and 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):

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Virtual Equipment and Supports

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 screened, qualified, and enrolled providers are authorized to deliver Waiver services.

Frequency of Verification:

DHS conducts provider screening and credential verification upon the provider’s application to enroll as a waiver provider and every three 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 section 1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under section 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.*

As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management). *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 and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Adult Day Services
Community/Competitive Integrated Employment - Individual
Discovery and Career Planning
Respite
Support and Service Coordination
Financial Management Services

Service
Participant and Family-Direction Broker Services
Assistive Technology
Communication Assistance for Community Inclusion
Community Integration Services
Community/Competitive Integrated Employment - Small Group
Conferences and Education for Unpaid Caregivers
Counseling and Therapeutic Services
Daily Living Skills Training
Empowerment and Self-Determination Supports
Grief and Bereavement Counseling
Health and Wellness
Home Modifications
Housing Support Services
In-Home Unpaid Caregiver Training
Mentoring
Personal Emergency Response System (PERS)
Safety Planning and Prevention
Specialized Medical and Therapeutic Supplies
Specialized Youth Care
Vehicle Modifications
Virtual Equipment and Supports

1. Will any in-person visits be required?

Yes.

No.

2. By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.

The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc. Explain:

Remote service delivery and the placement of devices for this service delivery method must respect the privacy of the participant, especially in instances of toileting, dressing, and other personal cares. Participants must give informed consent to the service provider before the remote services begin. Providers must develop and implement their own methods of informed consent to verify that a participant agrees to receive services remotely. These methods must comply with all federal and state regulations and guidelines. Providers must maintain documentation of the informed consent.

All providers must follow HIPAA confidentiality requirements for remote services. When a CLTS provider uses remote services that involve protected health information (PHI), the provider must conduct an accurate and thorough assessment of the potential risks and vulnerabilities to PHI confidentiality, integrity, and availability. Each provider must assess and implement the reasonable and appropriate security measures for their situation.

How the telehealth service delivery will facilitate community integration. Explain:

Remote services can facilitate community integration by providing participants with greater access to CLTS waiver services and providers that improve their ability to live, work, and participate in the community. Participants can use remote services to access services and providers that were previously limited by geographic distance. To ensure that remote services facilitate community integration, all services must be provided with functional equivalency. That is, the service is amenable to virtual delivery and of sufficient audio and visual fidelity and clarity as to be functionally equivalent to an in-person visit. With proper functional equivalence, remote service delivery provides participants an alternative to more restrictive settings while promoting access to services and providers in the broader community.

How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual. *Explain:*

For participants who have a clear and proper functional equivalence, remote service delivery enhances successful delivery of services when hands-on, in-person, physical assistance is not required. Without clear functional equivalence, services cannot be delivered remotely. This means that where a participant requires hands-on assistance for a specific service, they may not receive that same service remotely, as this would not be functionally equivalent, healthy, nor safe. However, the participant may receive other, non-duplicative services remotely while receiving their hands-on service, if appropriate and clearly documented on their existing service plan.

How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service. *Explain:*

Participants must have the equipment and access to technology needed to participate in services remotely. Before implementation of remote service delivery, the service provider must demonstrate a comprehensive training to the participant, family members, all required team members, and any individuals living with the participant, as applicable. This training must include providing all necessary user guides and tutorials on how to use the remote service platforms, devices, and technologies.

How the telehealth will ensure the health and safety of an individual. *Explain:*

During each in-person visit and annual plan review performed by the SSC, the health and safety of the participant utilizing remote service delivery will be evaluated by the SSC and participant. They will assess whether the service continues to meet the participant's goals and ensure that the services being provided continue to maintain functional equivalence.

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.

For services provided in a provider's home, all members of the household over the age of 18 must complete a background check. 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.

Provider agencies are responsible for completing a caregiver background check for all employees working as caregivers. The required checks must be complete upon hire or the authorization of a caregiver and repeated every three years at a minimum. This requirement is verified by DHS through the record review process and random sampling of agency provider files to verify that a valid caregiver background check has been completed for employees working as caregivers.

DHS is responsible for completing background checks for sole proprietor/individual providers who are caregivers. Financial management agencies are responsible for conducting background checks for any participant-hired workers. These checks must also be done upon enrollment as a participant-hired worker and every 3 years, at a minimum.

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.

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; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was

added to the abuse registry. 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 that 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.

All provider agencies must ensure that a caregiver background check is completed for all employees working as a caregiver. The state conducts background checks for sole proprietors and individual providers. Financial management agencies are responsible for conducting background checks for all participant-hired workers. 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 or 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.)

Each caregiver must complete a caregiver background check upon hire or authorization as a caregiver, and checks are repeated every three 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.

DHS verifies the completion of agency provider background checks through the annual record review process that looks at a random sample of provider files for employees that work as caregivers.

A provider that is added to the caregiver misconduct registry cannot continue to provide CLTS services. When a participant has a service provider that is added to the caregiver misconduct registry, the SSC will ensure continuity of care by working to find replacement staffing, either through a CLTS-enrolled provider or a participant-hired worker, if applicable. SSCs can also consult the participant's emergency backup plan that ensures continuity of care, and revise as needed.

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:

<https://www.dhs.wisconsin.gov/caregiver/cbcprocess.htm>

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

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 or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *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 types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is "*extraordinary care*", exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring 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.*

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 types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures 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.

Other policy.

Specify:

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.

Parents may provide transportation services and receive mileage reimbursement if they meet the provider qualifications and specific circumstances necessitate the parents providing the rides. Specific circumstances include:

- (a) the lack of an available qualified provider in the participant's region;
- (b) the lack of a qualified provider who can furnish services at necessary times and places; and
- (c) the unique ability of a relative or legal guardian to meet the needs of a person.

Payment may only be made to parents for extraordinary transportation needs related to the participant's disability that exceeds normal transportation a parent would customarily provide to a child without a disability.

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 are 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, certification, or required experience
- Agency's physical service address
- Geographic area the provider wishes to serve
- Provider's email and website addresses
- A completed and signed Medicaid Provider Agreement
- A completed background check, if applicable

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.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one:*

No, the state does not choose the option to provide HCBS in acute care hospitals.

Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions. *By checking the boxes below, the state assures:*

The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;

The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;

The HCBS must be identified in the individual's person-centered service plan; and

The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.

And specify: (a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting; (b) How the 1915(c) HCBS will assist the individual in returning to the community; and (c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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-2: Providers continuously meet required licensure and/or certification standards and are listed on the Provider Registry. Numerator = Number of providers who are listed on the Provider Registry and continuously maintained licensure and/or

certification. Denominator = Number of providers required to be continuously licensed and/or certified reviewed in the population.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Encounter claim records

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

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Registry

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

<i>(check each that applies):</i>		
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 who are listed on the Provider Registry and obtained appropriate licensure and/or certification. Denominator = Number of providers required to be licensed and/or certified reviewed in the population.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Registry

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

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Encounter claim records

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

C-i-3: Providers that require a caregiver background check adhere to all program background check policies. Numerator = Number of providers in the sample whose caregiver background checks followed program policy. Denominator = Total number of providers reviewed in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+ / - 5%"/>
Other Specify:	Annually	Stratified Describe Group:

<input type="text"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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: Non-licensed/non-certified providers 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+ / - 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Provider Registry

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 meet state and waiver training requirements for the services they are authorized to provide. Numerator = Number of providers in the sample that have the state and waiver required training for the services they are authorized to provide. Denominator = Total number of providers reviewed in the sample with state and waiver required training.

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: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

DHS and the EQRO monitor compliance related to willing and qualified providers. For instances of non-compliance with requirements for background checks and training, the provider is required to remediate the issue and demonstrate that the non-compliance was remediated.

Providers that fail to comply with the provider qualification requirements receive technical assistance and guidance from DHS when the individual problem is identified. DHS works with the provider to ensure that the issue is resolved. For continued instances of non-compliance, DHS may seek to remove the provider from the CLTS provider registry.

ii. Remediation Data Aggregation

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

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 in which 1915(c) HCBS are received. (*Specify and describe the types of settings in which waiver services are received.*)

The SMA has assessed and determined that the following settings meet the requirements of 42 CFR § 441.301(c)(4):

The SMA has determined that these settings are not provider-owned or provider-controlled residential settings; are integrated in the greater community or, in the case of residences in rural settings, are the participant's choice and are consistent with the characteristics of such communities; does not segregate or isolate participants receiving Medicaid HCBS from the broader community of non-participants not receiving Medicaid HCBS, except with respect to private residences in rural areas where such is the participant's preference; provides opportunities for regular interaction in daily activities with non-participants; facilitates participant's choice in services, daily activities, and assumption of typical, age appropriate social roles; and supports rights to dignity, respect, autonomy, and freedom from coercion. More details regarding means by which the SMA ascertains that these waiver settings meet federal HCBS Setting requirements, at the time of this submission and ongoing, are included in answer #2 below.

Private residences not owned or controlled by service providers and not regulated under Wisconsin law or policy as residences for persons with disabilities.

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 to provide child care

Places of integrated, competitive employment

Community sites predominantly used by the general public for typical community activities, unless specifically prohibited by 42 CFR § 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; service establishments; streets; and other public accommodations.

The second category of settings are settings that are subject to further review to determine if they are in compliance with the HCBS Settings requirements. The following settings are reviewed for compliance with the HCBS Settings Rule on an ongoing basis by the SMA or by contracted entities under the direction of the SMA. In order to accept Medicaid waiver funding and prior to rendering services or supports, the setting must be initially determined to be compliant with the HCBS Settings requirements and must continue to maintain compliance throughout their time providing services or supports. More details regarding means by which the SMA ascertains these waiver settings meet federal HCBS Setting requirements, at the time of this submission and ongoing, are included in answer #2 below.

Licensed 3-4 bed adult family homes (AFHs)

Certified 1-2 bed adult family homes (AFHs)

Adult day care centers: A nonresidential group setting that provides services for part of a day to adults who need an enriched social or health supportive experience or who need assistance with activities of daily living, supervision, and/or protection.

Day habilitation- facility based service settings: A non-residential setting, separate from the member's private residence or other residential living arrangement, that provides activities and supports to foster the acquisition of generalized skills and opportunities for the member to participate in integrated community-based activities

Children's Foster Homes

Level 5 Exceptional Treatment Foster Homes

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 in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring)*

across residential and non-residential settings in which waiver HCBS are received.)

The SMA ascertains that all waiver settings meet federal HCBS Setting requirements, at the time of this submission and ongoing, through the following means:

1. Integrated community settings or private residences from #1: While these settings are viewed as integrated in the community, the SMA does not assume that in each instance they meet the HCBS settings rule requirements. To ensure these settings meet requirements at the time of submission and ongoing, as part of the ongoing person-centered planning process used by locally-contracted waiver agencies, all settings in which waiver services are delivered, including those described above, will be reviewed by the locally-contracted waiver agency or assessed by another entity delegated by the SMA, to ensure that the setting is not designed in such a way that it isolates the individual from the greater community. This review occurs at the time of development of the initial person-centered plan and at reviews of that plan on, at least, an annual basis. The review includes periodic face-to-face meetings with the participant in home and community settings.

2. Compliance for 3-4 Bed AFHs: To ensure initial compliance, every 3-4 bed AFH receiving Medicaid waiver funding for residential services completes a self-assessment to attest to compliance with the HCB Settings requirements. If the reviewer identified internal inconsistencies or other ambiguous responses, the setting is contacted by phone or email and is interviewed regarding any unclear responses. If remediation requirements are identified during the desk review or subsequent followup, the setting is required to submit verification of remediation before an HCBS Settings Compliance determination is made. Settings that meet all compliance criteria, both with and without remediation, receive a letter from the SMA confirming their compliance and the HCBS compliance designation is included on the SMA Division of Quality Assurance (DQA)'s public-facing Provider Search (<https://www.dhs.wisconsin.gov/guide/provider-search.htm>). This same process will be used for future settings requesting HCBS compliance.

Licensed settings and settings that are certified by the state licensing authority, the Division of Quality Assurance, (DQA) (3-4 bed AFHs and adult day care providers) are subject to periodic compliance site visits (at least every 3 years for 3-4 bed AFHs) by DQA. To ensure ongoing compliance with the HCBS Settings Requirements, as part of these periodic licensing or certification reviews, DQA also reviews the setting for continued HCBS compliance. Settings found to have deficiencies in licensing or certification requirements are required to implement corrective actions and can lose their license or certification when noncompliance continues or is egregious. Any provider that loses its license or certification cannot continue to be a qualified waiver service provider regardless of their HCBS compliance status. Providers are required to address any HCBS rule deficiencies. Failure to adequately remediate results in removal as an HCBS waiver provider.

3. Compliance for 1-2 bed AFHs: Certified 1-2 bed AFHs are certified by contracted staff under the direction and supervision of the SMA. The HCBS requirements are incorporated into the Wisconsin Medicaid Standards for Certified 1-2 Bed AFH. To ensure initial compliance, the certification entity is required to review compliance with the state standards for any setting that intends to serve HCBS waiver members. In order to receive Medicaid funding, each setting completes an initial review of compliance by contracted staff under the direction and supervision of the SMA. If a setting is found to not meet requirements, they are required to submit verification of remediation before an HCBS Settings Compliance determination is made. To ensure ongoing compliance, these settings are recertified on an annual basis. The recertification process includes verification of the HCBS Settings Requirements and remediation of any items not successfully remediated. If an AFH application for certification or recertification has been denied or if an AFH certification has been revoked, the AFH is no longer eligible to serve as an HCBS waiver provider. A list of 1-2 bed AFHs that have been found compliant with the HCBS settings rule is maintained on the Current list of certified 1-2 bed AFH found on the DHS webpage for 1-2 bed Certified AFHs (<https://www.dhs.wisconsin.gov/regulations/afh/1-2bed/certified-1-2bed-afh.xlsx>).

4. Compliance for Non-residential settings (Day habilitation- facility based service settings, adult day care centers): Contracted staff under the direction and supervision of the SMA complete desk reviews consisting of materials submitted and a validation visit to ensure that all HCBS Settings requirements are in place. For current and future adult day care center settings requesting review, the responsibility for conducting the reviews has transition to DQA. DQA follows the same process followed by the contracted staff under the direction and supervision of the SMA. If during the review for a non-residential setting, a setting is found to not meet requirements, the provider is required to submit verification of remediation before an HCBS Settings Compliance determination is made. Settings that meet all compliance criteria, both with and without remediation, receive a letter from the SMA. A list of nonresidential settings that have been found Application for 1915(c) HCBS Waiver: WI.0484.R04.00 - Jan 01, 2026 Page 189 of 299 12/08/2025 compliant with the HCBS settings rule is on the HCBS Nonresidential Settings Compliance List found on the SMA HCBS webpage

(<https://www.dhs.wisconsin.gov/hcbs/nonres-compliance-list.xlsx>) for all non-residential providers other than adult day care centers. The compliance status for adult day care centers is included on the DQA public-facing Provider Search (<https://www.dhs.wisconsin.gov/guide/provider-search.htm>). To ensure ongoing compliance, these settings have their compliance status verified at least once every three years. The ongoing verification process includes verification of the HCBS Settings Requirements and remediation of any items not successfully remediated. The review process for all new and existing providers will include an off-site review of provider documents and an onsite visit. Settings that are not found to be compliant with the HCBS settings rule, are required to submit acceptable remediation plans. If the non-residential provider fails to achieve compliance with the HCBS settings rule within the designated timeframe, the provider is no longer eligible to serve as an HCBS waiver provider.

5. Compliance for Children's Foster Homes and Level 5 Exceptional Treatment Foster Homes

Level 5 Exceptional Treatment Foster Homes are licensed by the Wisconsin Department of Children and Families and HCBS settings compliance is verified by contracted staff under the direction and supervision of the SMA. In order to receive Medicaid funding, contracted staff complete an initial review of compliance for each setting. If a setting is found to not meet requirements, they are required to submit verification of remediation before an HCBS Settings Compliance Determination is made. To ensure ongoing compliance, these settings are reviewed by staff under the direction and supervision of the SMA every three years. The subsequent compliance review and determination includes verification of the HCBS Settings Requirements and remediation of any items that are non-compliant at the onset of the subsequent review.

Children's Foster Homes are licensed by the Wisconsin Department of Children and Families and HCBS settings compliance is verified by the locally-contracted waiver agencies under the direction of the SMA. In order to receive Medicaid funding, locally-contracted waiver agencies complete an initial review of compliance for each setting at the time of development of the initial person-centered plan. If a setting is found to not meet requirements, they are required to submit verification of remediation before the locally-contracted waiver agency authorizes the setting to claim/receive CLTS Program funding. To ensure ongoing compliance, these settings are reviewed by the locally-contracted waiver agencies at least annually. The review includes periodic face-to-face meetings with the participant in home and community settings.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. (see Appendix D-1-d-ii)

Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

Facilitates individual choice regarding services and supports, and who provides them.

Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

No, the waiver does not include provider-owned or controlled settings.

Yes, the waiver includes provider-owned or controlled settings. (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

Each individual has privacy in their sleeping or living unit:

Units have entrance doors lockable by the individual.

Only appropriate staff have keys to unit entrance doors.

Individuals sharing units have a choice of roommates in that setting.

Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

Individuals have the freedom and support to control their own schedules and activities.

Individuals have access to food at any time.

Individuals are able to have visitors of their choosing at any time.

The setting is physically accessible to the individual.

Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan(see Appendix D-1-d-ii of this waiver application).

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. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(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. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *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. Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:

DHS has submitted a 1915(b)(4) application, 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 locally-contracted waiver agencies are uniquely qualified to develop and implement the service plan due to their knowledge and familiarity of local resources, and proximity to participants and providers.

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 that promote a participants transition from an ineligible setting.

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, or prepayment for waiver allowable services that promote a participants transition from an ineligible setting.

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.

For instances of conflict of interest with the services listed above, the participant or their family can access a resolution process through the State.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- Direct oversight of the process or periodic evaluation by a state agency;**
- Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

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 using a decision-making framework called Deciding Together.

The participant 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.

Families are also able to access information regarding the waiver program requirements and covered services on the DHS website:

<https://www.dhs.wisconsin.gov/clts/waiver/family/index.htm>.

Families also receive a handbook upon enrollment that explains what services and supports are available and the ISP development process:

<https://www.dhs.wisconsin.gov/publications/p03689.pdf>

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. i. 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; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. 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 participant's parent(s) or guardian, and the participant, as appropriate to the participant's age and ability. The purpose of the ISP assessment is to gather current, comprehensive information about the participant to determine which services, supports, and environmental modifications will benefit the participant, build on the participant's strengths, and maximize the participant's independence and community participation.

When a participant chooses to enroll in the waiver, the SSC is responsible for initiating the development of an ISP. An ISP is initiated by the participant and SSC when they identify supports and services to address the participant's identified outcomes. Support and Service Coordination may be the only service authorized through the waiver for the participant while the SSC and participant and family continue to develop a full range of services to address the participant's goals and outcomes. 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 participant is enrolled in the waiver. Initial and updated ISPs are placed in the participant's file. Participants' records are available to the program's quality assurance entity via online systems.

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 participant and family's capacities, resiliency, and unique abilities, and promotes self-determination and inclusion in all facets of family and community life. The SSC must provide the participant the information and supports necessary to allow them to engage, to the maximum extent possible, in the service planning process and make informed choices and decisions.

The SSC who completes the assessment must have the skills needed to facilitate the participant and family's identification of individual outcomes. The SSC assists the participant 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 assessment includes identifying the participant and family's needs as well as desired individual outcomes. The individual outcomes identified are participant-specific, based on the participant 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 assessment is the basis for the service plan development. This ensures that the ISP is tailored to meet the participant and family's identified outcomes and the needs of the participant. The services and supports provide an alternative to institutional care.

The following topical areas are explored and documented as a result of the assessment:

- Background and social history
- Physical and medical health history
- Individual outcomes important to the participant 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 participant'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 participant and the family, and their ability to understand and assert them
- Formal and informal supports available to the participant and family
- A review of the participant and family's interest and ability to self-direct supports.

The ISP results from the 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 service planning team must identify the participant's ISP outcomes before determining the CLTS Waiver Program supports and services in the ISP (i.e., authorized services), as the outcomes are the basis for determining the supports and services that will help the participant achieve their overall goals. The services and the service providers listed on the ISP reflect the 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 participant 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 participant's and family's desired outcomes and priorities. Outcomes summarize the participant'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 participant and family meet their goals.
- A description of the waiver's supports and services to be used, including frequency, intensity, cost, provider information, care levels for applicable services, and any unique restrictions or specifications.
- Supports and services in place for the participant 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.

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 participants outcomes will be shared with essential service providers included on the participant'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.

The ISP represents an agreement between the waiver agency, the family, and the participant as to how the program will meet the identified needs of the participant, and in so doing, help the participant reach their desired outcomes. To document this agreement, the SSC receives signatures from the participant, if possible, and the participant's parent(s) or legal representative. The locally-contracted waiver agency also 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 is an evolving instrument that adapts to

meet changes in the participant 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 participant 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 with the participant and evaluated by the parent(s)/guardian, participant (based on the age of the participant), 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 shall 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 will 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.

- ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:

A specific and individualized assessed need for the modification.

Positive interventions and supports used prior to any modifications to the person-centered service plan.

Less intrusive methods of meeting the need that have been tried but did not work.

A clear description of the condition that is directly proportionate to the specific assessed need.

Regular collection and review of data to measure the ongoing effectiveness of the modification.

Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

Informed consent of the individual.

An assurance that interventions and supports will cause no harm to the individual.

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 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 participant and/or family. The Support and Service Coordinator, in coordination with the participant, 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 participant's health, safety, and welfare whenever risks are identified.

The Support and Service Coordinator must also determine whether any service may pose a risk to the participant's health, safety, and welfare, if it is not provided as scheduled. Services which pose a risk to the participant 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 participants 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 participants enrolled 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 participant and the family of their right to choose willing and qualified providers. This takes place at each review of the participant'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 participant and the family includes:

-The full range of services available through the waiver.

-A description of all qualified providers available for the services the participant is authorized to receive. This also includes information about the online CLTS provider registry, which lists all willing and qualified providers for each CLTS service.

-Information about options and processes 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 participant is enrolled in the waiver.

The locally-contracted waiver agencies must ensure that all ISP covered services are prior authorized and issued to waiver providers through the fiscal agent, on a timely basis, to ensure scheduled service delivery to the participant and prompt payment to the provider.

The contract with locally-contracted waiver agencies includes instructions that the locally-contracted waiver agencies share any information with the Department, upon request, which includes ISPs.

A representative sample of the waiver program participant files, including ISPs, 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 participant, including potential risk, and the services and supports included in the service plan to meet the assessed needs and identified outcomes

The Department provides technical assistance, as necessary, to locally-contracted waiver agencies to assess whether or not a plan is reasonably appropriate to meet the participant 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, when the individual's circumstances or needs change significantly, or at the request of the individual, 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, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (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 participant and family to meet their identified outcomes. This includes managing, coordinating, and monitoring the ISP, as well as informal supports, consistent with the participant 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, HCBS settings compliance, and the identified outcomes. A primary responsibility of the Support and Service Coordinator is promoting the participant'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 participant 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 participant)
- Annually, at least one of the face-to-face contacts is required to take place at the participant and family's place of residence.

The determination of the type and frequency of contacts is based on the following variables as applicable:

- The participant's health
- The capacity of the participant and the family to direct the participant's individual service plan
- The strength of in-home supports and the participant'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 participant's individual service plan (for example, history of and/or anticipated frequency of change or adjustment to the plan)
- The frequency and types of 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 participant 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 Safeguard.** Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to

the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation. *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

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 locally-contracted waiver agencies are uniquely qualified to develop and implement the service plan due to their knowledge and familiarity of local resources, and proximity to participants and providers.

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 that promote a participants transition from an ineligible setting.

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, or prepayment for waiver allowable services that promote a participants transition from an ineligible setting.

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.

For instances of conflict of interest with the services listed above, the participant or their family can access a resolution process through the State.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;

An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;

Direct oversight of the process or periodic evaluation by a state agency;

Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and

Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		Sample Confidence Interval = <input type="text" value="+/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

- b. *Sub-assurance: Service plans are updated/revise at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.*

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-ii-1: Initial ISPs are completed according to DHS-established timelines. Numerator = Number of initial ISPs that are completed according to DHS-established timelines. Denominator = Total number of initial ISPs reviewed.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<input type="text"/>	
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Data Source (Select one):

Other

If 'Other' is selected, specify:

Program enrollment data

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. *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-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 ISPs 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 ISPs reviewed in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+/- 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	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: 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-iv-1: Services were delivered consistent with the ISP. Numerator = Number of ISPs in the sample where evidence indicates the waiver services were delivered consistent with the ISP. Denominator = Total number of ISPs 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 = <input type="text" value="+ / - 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>

	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

e. 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.

Performance Measure:

D-v-1: Participants, parents and/or guardians were afforded choice between and among waiver services and providers. Numerator = Number of ISPs reviewed that includes clear documentation that the SSC offered choice of waiver services and providers. Denominator = Total number of ISPs reviewed in the sample.

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
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):
<input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 with responses to the inquiry about input for ISP development.

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 = <input type="text" value="+ / - 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="319 618 794 701" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="865 931 1339 1014" type="text"/>

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.

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, the opportunity to choose their own supports, and the responsibility to make choices and take responsibility for those choices.

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 plan that accurately reflects their identified outcomes.

For participants that receive daily living skills training, personal supports, respite, transportation, or specialized youth care services, they will have the opportunity to elect employer authority for any of these services.

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 payment responsibilities.

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 shares information regarding the components of participant/family directed services with the participant 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 participant and family's outcomes while ensuring the protection of the participant'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 services and providers/vendor options for the participant to choose;
- 5) Facilitating the timely development and revision of the ISP designed to meet the participant's needs, preferences,

goals, and outcomes in the most integrated setting and cost-effective manner;

6) Ensuring that participants 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

7) Monitoring the provision of services and conducting related follow-up activities, including, assisting 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 financial tasks related to managing participant-hired workers, including processing timesheets and payroll. FMS providers assist with employer and financial 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 participant and family's ability to fulfill their employer 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 direct providers to meet the individual needs of the participant; 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 participant and the representative upon assessment planning and at least annually thereafter. During the assessment planning, 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
Transportation		
Respite		
Personal Supports		
Specialized Youth Care		
Daily Living Skills Training		

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 participant for the delivery of waiver services. FMS are provided as a waiver service by non-governmental individual or agency vendors that are qualified and enrolled with Wisconsin Medicaid. 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 qualified and enrolled in Wisconsin Medicaid by the Department of Health Services. FMS providers must submit a waiver program provider agreement and an acknowledgement 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 participant’s family, and are paid in accordance with the statewide rate schedule. The FMS submit their waiver service claims to the contracted fiscal agent.

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:

[Empty rectangular box for specifying other entities]

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 participant’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 participant’s family to ensure services were delivered as expected. In addition, the fiscal agent claims vendor reviews, processes, and adjudicates provider claims. The fiscal agent 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:

[Empty rectangular box for specifying case management details]

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
Community/Competitive Integrated Employment - Individual	
Community/Competitive Integrated Employment - Small Group	
Community Integration Services	
Transportation	
Counseling and Therapeutic Services	
Participant and Family-Direction Broker Services	
Mentoring	
Financial Management Services	
Communication Assistance for Community Inclusion	
Grief and Bereavement Counseling	
Health and Wellness	
Empowerment and Self-Determination Supports	
Conferences and Education for Unpaid Caregivers	
Safety Planning and Prevention	
Vehicle Modifications	
Support and Service Coordination	
Relocation Services	
Discovery and Career Planning	
Respite	
Virtual Equipment and Supports	
Home Modifications	
Personal Emergency Response System (PERS)	
Housing Support Services	
Adult Day Services	
In-Home Unpaid Caregiver Training	
Children's Foster Care	
Specialized Medical and Therapeutic Supplies	
Adult Family Home	
Assistive Technology	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Supports	
Specialized Youth Care	
Daily Living Skills Training	

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)

i. 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 participant’s health and safety, or another person’s safety is threatened;
- Conflicting interests of another person are taking precedence over the desires and interests of the participant; 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 participant and family’s ability to direct their services, then the participant 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 participant 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 participants 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	11087	
Year 2	12275	
Year 3	13463	
Year 4	14651	
Year 5	15839	

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. Financial management services that are qualified and enrolled with Wisconsin Medicaid can complete background checks for these caregivers.

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:

See 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:*

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- 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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- 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

Answers provided in Appendix E-1-b indicate that you do not need to complete this section.

- 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:

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 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. The participant and family, or legal representative, at initial application and annually each year thereafter, sign the document. The participant and family, or legal representative, receive a copy. The original signed document is placed in the participant's file with the waiver agency.

Parents, or other legal representatives, also receive this document whenever eligibility or services are changed, reduced, or denied, including denial of a qualified and enrolled provider. 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 participant when appropriate, understand the information contained in the notification.

If the participant is determined not functionally eligible for the waiver, loses eligibility, or 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 services or 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. 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 participant and family of the right to contact Disability Rights Wisconsin for assistance and advocacy. The family may also contact the CLTS ombuds for additional assistance with the grievance or fair hearing process.

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 participant'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 participant has previously been determined eligible and is receiving services, then eligibility and services must continue if the family requests to continue services through the appeals process. , as long as the participant 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

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

- **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.

Do not complete this item.

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

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

DHS is responsible for operating and overseeing the grievance system for the CLTS Program. DHS sets the policies and procedures that locally-contracted waiver agencies must follow for handling grievances. It also operates an additional level of review if CLTS participants are not satisfied with the resolution of their grievance at the local level.

- **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).

DHS sets the policies that locally-contracted waiver agencies must follow in resolving grievances. Locally-contracted waiver agencies must have a written procedure for their grievance review and resolution process. All grievances must first be registered with a participant's locally-contracted waiver agency. If the participant is not satisfied with the resolution of the grievance at the local level, they may be able to escalate the grievance for review at the state level.

The Types of Grievances that May Be Registered

A local CLTS grievance system can resolve issues related to HCBS settings rule or the mis-implementation of a person-centered plan. Participants may file a grievance against their locally-contracted waiver agency or other CLTS program provider. Grievances are generally issues that are not eligible for the fair hearing process. However, filing a grievance is not a prerequisite or substitute for filing a fair hearing request if the issue is within the scope of the fair hearing process. Participants may contact the CLTS ombuds for assistance with filing grievances.

The Process and Timeline for Addressing Grievances

Locally-contracted waiver agencies must provide participants with information about how to file grievances at enrollment, when a notice of action is issued, and at least annually. Participants must also be informed that filing a grievance does not affect the participant's ability to file a fair hearing request if the issue is within the scope of fair hearings. Locally-contracted waiver agencies must allow grievances to be filed in writing or orally, from a participant or their representatives. Locally-contracted waiver agencies must provide participants reasonable assistance in filing a grievance, and ensure that no retaliatory action is taken against an individual for filing a grievance. Once a grievance has been filed, locally-contracted waiver agencies must also acknowledge the receipt of a grievance.

The participant may file a grievance at any time. Once a grievance has been filed, Locally-contracted waiver agencies must resolve the grievance within 90 days. A locally-contracted waiver agency or beneficiary can extend that deadline by 14 days if more information is needed for resolution. Any grievance where a participant's health and safety are at risk must be resolved as soon as possible.

The Mechanism Used to Resolve Grievances

All grievances must first be resolved through a participant's locally-contracted waiver agency. Each locally-contracted waiver agency must follow a written grievance resolution process. This process must allow a participant or their representative to provide evidence and testimony related to their grievance. Grievances must be reviewed and resolved by an employee of the locally-contracted waiver agency that was not involved in the decision or action related to the grievance. Upon resolution, the locally-contracted waiver agency must issue a resolution notice to the participant. Locally-contracted waiver agencies must maintain basic records for each grievance and its resolution.

If a participant is not satisfied with the resolution of a grievance, and it is an appealable issue, they can escalate the issue through the fair hearing process. It is not eligible for additional review by DHS.

If a participant is not satisfied with the resolution from the locally contracted waiver agency, and it is not an appealable issue, they may request an additional review from DHS within 90 days of resolution at the local level. DHS may choose to accept or deny a request for additional review, per program policy. For any grievances that it chooses to review, DHS will follow its own procedures for grievance resolution to determine the appropriate action and level of involvement of the state. All escalated grievances must be resolved within 90 days. Any grievance where a participant's health and safety are at risk must be resolved as soon as possible. Upon the state's resolution, a resolution notice is issued to the participant or their representative and the locally-contracted waiver agency.

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
- 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 identified on the ISP.
- Law enforcement contact that is related to behavioral/crisis intervention, health and safety risk for the participant, or an investigation of an event or allegation regarding the participant as either the perpetrator or victim.

The locally-contracted waiver agency's incident management protocol must define who is required to report incidents to DHS and the procedure for reporting. The participant's family and/or legal guardian(s), caregivers, and providers are all required to report threats to the participant'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 participant's parent(s) and/or legal guardian(s) if they are not already aware of the incident.

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 participant seen in the course of their professional duties.

Locally-contracted waiver agencies must notify DHS within 3 business days for all 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 a Family Guide to Incident Reporting 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. DHS has also developed a handbook specifically for families that includes information about incidents and the incident reporting process.

Additionally, topics the locally-contracted waiver agency must discuss and ensure that the family understands include:

- How to reduce preventable risk.
- Procedures and requirements in place to identify and remediate any risk to the participant'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 participant's initial application to the program and at least annually thereafter.

The SSC must distribute and discuss information material related to incident reporting, including the Family Guide to Incident Reporting written document.

- 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. Locally contracted waiver agencies are required to report each incident to DHS utilizing the Department's 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. The actions taken to remove risk to the participant's well-being are referred to as remediation actions, and the actions taken to minimize recurrence of an incident are referred to as preventive strategies. DHS collects the incident reports and conducts oversight activities of locally-contracted waiver agencies, as appropriate and determined by the Department.

The locally-contracted waiver agency 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. If the incident continues to pose an active and ongoing risk to the participant, the locally-contracted waiver agency must initiate remediation activities immediately.

Locally-contracted waiver agencies are required to coordinate the actions necessary to remove risk to the participant's safety and wellbeing and minimize recurrence of that risk. During remediation and prevention, the locally-contracted waiver agency works closely with the participant, family, and providers to identify and implement remedial and preventive actions and reevaluates the participant's ISP to identify and implement needed changes.

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) allegations of ANE. Unexplained death of a participant 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) errors in medical or medication management that result in a significant adverse reaction that requires hospitalization 2) hospitalization due to psychiatric emergency 3) Law enforcement contact that is related to behavioral/crisis intervention, health and safety risk for the participant, or an investigation of an event or allegation regarding the participant 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 participant'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 participant'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 drugs used as restraints or seclusion with or without the use of locks. DHS does not allow for the use of personal restraint, such as manual holds or escorts, except in strictly defined emergencies. 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 that may direct the need for additional training, connection to other resources, or further remediations to prevent the use of unnecessary and/or unauthorized use of restraints. DHS will work directly with the CWA to ensure necessary training or remediation is completed. Support and Service Coordinators (SSCs) meet with families regularly to identify the participant's changing needs, changes in behaviors, and methods being used to address the significant or challenging behaviors. The SSC provides families with the supports to address the needs of the participant, assure that the least restrictive measures are being utilized, and connect to other community resources and Medicaid services. The SSC should update the Individual Service Plan, as needed, to support the participant and family.

The locally-contracted waiver agency is responsible to ensure that personal restraints are used only in emergencies where the participant 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 planned 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 approval for the planned use of mechanical restraint including protective equipment. 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 waiver agency monitors the use of the approved mechanical restraint including protective equipment, 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 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 participant's changing needs, changes in behaviors, and methods being used to address significant or challenging behaviors of the participant. The SSC provides families with the supports to address the needs of the participant, 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 participant 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 participant 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 prohibits the use of seclusion with or without the use of locks in any circumstances. 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 participant's changing needs, changes in behaviors, and methods being used to address significant or challenging behaviors of the participant. The SSC provides families with the supports to address the needs of the participant, assure that the least restrictive measures are being utilized, and connect them to other community resources and Medicaid services. The SSC updates the Individual Service Plan, as needed, to support the participant 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, including seclusion, and if the use of a restrictive measure results in an injury. 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 seclusion with or without locks 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 participant or provider and any trends that may suggest additional training needs or other remediations.

The use of fully enclosed beds is considered seclusion and is not permitted within the CLTS program.

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*)

• **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 participant'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 participant's health and healthcare needs, including medication administration.

If the participant 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 participants enrolled in the waiver program reside with their parents who are responsible for the management of their participant'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 participant 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 participant's health care needs, including medication administration. If the participant 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 participant. 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 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.

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)*

- **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 participant. 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 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.

In addition, licensed service settings are regulated by their licensure standards as defined in each service category as described under Appendix C.

- **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.

- **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 participant record are reviewed by the DHS-contracted quality assurance organization, in consort with the Department. This includes a review of all medications taken by the participant. The participant’s assessment must address the management of medications for the individual participant, including the administration of medications by providers other than the participant’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. DHS collects incident reports and analyzes trends in incident reports to determine if an incident would benefit from further follow-up by the State.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.*

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-2: Incident reports are submitted to DHS within required timeframe, based on DHS-established incident reporting requirements. Numerator = Number of incidents reports that were submitted to DHS within the required timeframe. Denominator = Total number of incidents reports

Data Source (Select one):

Other

If 'Other' is selected, specify:

Children’s Incident Tracking and Reporting system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

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 records in the sample with evidence that participants’ parents or guardians 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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+ / - 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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-2: Incidents of ANE & unexplained death are effectively resolved & prevented to the extent possible. N=# of incident reports of ANE & unexplained death where the documented prevention strategy of an incident effectively resolves the incident and prevents further similar incidents to the extent possible. D=Total # of incident reports of ANE & unexplained death.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Children’s Incident Tracking and Reporting system

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other	Annually

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
Specify: <input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

G-ii-1: Incident reports are completed and submitted to DHS for each identified incident. Numerator = Number of records in the sample with identified incidents that had a completed incident report that was submitted to DHS. Denominator = Total number 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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+ / - 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify:

		<input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):

Other

If 'Other' is selected, specify:

Children’s Incident Tracking and Reporting system

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 restraint applications seeking renewal are submitted to DHS according to DHS-established timelines. Numerator = Number of restraint renewal applications that were submitted to DHS within the DHS-established timelines. Denominator = Total number of restraint renewal applications submitted to DHS.

Data Source (Select one):

Other

If 'Other' is selected, specify:

Restrictive Measures Application Log

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

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: <input type="text"/>	Annually
	Continuously and Ongoing

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	
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Data Source (Select one):

Other

If 'Other' is selected, specify:

Restrictive Measures Application Log

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	Annually	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	Continuously and Ongoing	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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-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 with responses to the inquiry about seeing a health professional when needed.

Data Source (Select one):

Participant/family observation/opinion

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid	Weekly	100% Review

Agency		
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+ / - 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

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: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
	<input type="text"/>

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 (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="+ / - 5%"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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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: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. 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 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 takes steps to reduce the chance of

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 may be implemented.

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 <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 Section 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 (QIS) 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 QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, 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 QIS 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 QIS. 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.

DHS uses a continuous quality improvement cycle for the CLTS Program Quality Improvement Strategy (QIS). These continuous quality improvement activities have the goal of monitoring how well the program is operating in accordance with the approved waiver design; meeting statutory and regulatory assurances and requirements; and achieving desired outcomes and goals for participants. DHS monitors CLTS Program performance through a range of data sources including administrative systems, record reviews, and participant experience surveys. Data is collected continuously and analyzed at regular intervals to identify trends and themes, find system deficiencies, develop plans for remediation and program improvement, and continuously monitor for improved performance.

Identifying Performance Deficiencies

Performance measures that fall below the minimum compliance threshold of 86% or show a chronic decreasing trend are considered areas of deficiency and require further investigation. DHS uses additional data analysis as well as qualitative and contextual information gathered from CWAs, families, and other partners to assess the cause of an identified deficiency.

When DHS identifies deficiencies, the following steps may be used to guide the remediation and system improvement processes:

- Review data across state and federal performance measures.
- Evaluate for commonality and thematic areas of deficiency.
- Separate deficiencies between system and individual impact.
- Assess for root cause.
- Develop improvement plan and monitoring tools.
- Implement improvement plan and monitor for improved performance.

When findings identify that deficiencies are the result of practices established by operational agencies, remediation activities are initiated. As described in Appendices A, B, C, D, G, and I, DHS maintains administrative oversight of operational agencies by directing CWAs to complete remediation activities related to specific performance measures as well as requiring remediation during the participant record review process.

When findings identify that deficiencies are due to a systemic issue, systems improvement activities are initiated.

System Improvement Process

DHS uses a variety of strategies within the program improvement process to address systems level deficiencies. All program improvement strategies include improvement design, monitoring plan, and communication plan. This ensures that all implemented system improvement strategies are reviewed regularly and that results are shared transparently with partners.

Prioritizing Areas for Program Improvement

DHS recognizes the need to thoughtfully prioritize system improvements for identified deficiencies. Implementing systemwide improvement efforts requires significant investment in time and resources, so DHS has developed a process for prioritizing improvement efforts.

System deficiencies that impact participant health and safety are prioritized, followed closely by those that would improve participant outcomes or experience. In addition to categorically prioritizing improvement activities, DHS leverages program partner expertise as a primary method to gather qualitative data, identify concerns, and discuss options for system improvement strategies. This multilayered approach ensures that DHS identifies and prioritizes areas of improvement that are most impactful to participant outcomes and program operations.

Developing Program Improvement Strategies

Program improvement strategies are designed to fit the specific program need and may include knowledge sharing through data, policy, or practice clarification; enhancements to DHS administered information systems for program and participant data; or policy updates to the CLTS Policy Manual. As needed, DHS develops and incorporates new performance indicators into the EQRO record review process.

Program improvement strategies are developed collaboratively with feedback from CWAs and other community partners where appropriate. CWA and state advisory councils provide important guidance and insight when

developing program improvement strategies and are leveraged often.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

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.

Embedded within each program improvement strategy is continuous monitoring of progress toward the performance goal. Monitoring and analysis are conducted at least annually, dependent upon the data source. Performance data collected through administrative systems and ongoing record reviews is monitored more frequently than performance data collected through participant and family surveys.

As the state Medicaid agency, DHS maintains direct administrative oversight of the CLTS Program; monitors and analyzes data; identifies deficiencies requiring system changes; directs system design changes; and assesses effectiveness of system improvements. DHS measures program performance on the indicators and data collection methods identified in Appendices A, B, C, D, G, and I and state identified performance measures as detailed in the CLTS Program Quality Guide published on the DHS website.

As the operational agencies for the CLTS Program, CWAS are responsible for operationalizing system improvements led by DHS and providing insight into systems-level efforts. CWAs maintain complete and accurate participant records and update administrative systems to ensure data accuracy and quality in monitoring activities.

The External Quality Review Organization (EQRO) for Wisconsin conducts quality reviews of the CLTS Program at the direction of DHS. The EQRO evaluates the CLTS program through annual participant record reviews and Support and Service Coordinator (SSC) verification.

Data from these sources and activities are included in a holistic analysis to assess the effectiveness of system improvements at least annually.

- 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 participant'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.

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 of Health Services (DHS) has responsibilities in monitoring key aspects of financial accountability. These functions are described below.

DHS contracts with a fiscal agent to process authorized waiver service claims, and DHS administers the fiscal agent contract. DHS provides fiscal oversight of the service utilization data. Service utilization data details are submitted to the Department by CLTS service providers via the state's fiscal agent and entered into the Medicaid Managed Information System (MMIS). The fiscal agent is the exclusive administrator of data in this system related to the CLTS waiver program.

The Department's fiscal agent claims process operates as follows:

- Locally-contracted waiver agencies prepare the participant Individualized Service Plans (ISPs) and authorize services from CLTS-enrolled providers for participants based on their needs and outcomes*
- Locally-contracted waiver agencies submit service authorizations to the fiscal agent 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 fiscal agent.*
- The fiscal agent ensures coordination of benefits (COB) with the health insurance benefit. To assist in this process, Wisconsin's Medicaid fiscal agent/MMIS vendor receives electronic insurance disclosure files from over 100 commercial health insurance companies, the Center for Medicare and Medicaid Services, and the Department of Defense on a monthly basis. After adjudicating any COB, the fiscal agent processes claims with the corresponding authorizations.*
- The fiscal agent processes provider checks or electronic funds transfers and mails them to the rendering providers or deposits them in the providers' supplied account.*

The fiscal agent 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.

Both the Department and locally-contracted waiver agencies conduct fiscal monitoring and an annual fiscal reconciliation of locally-contracted waiver agency revenue.

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 fiscal agent. If a claim was paid incorrectly, waiver agencies or service providers perform a voided claim process through the fiscal agent.

Locally-contracted waiver agencies monitor claims processing against authorizations. Issues with individual claims submissions to the fiscal agent must be corrected through the voided claim process mentioned above. The voided claim process involves the provider submitting documentation to void the claim and then submitting the new revised claim, if appropriate. Locally-contracted waiver agencies or service providers may also submit an adjustment to a claim when the service was appropriate for the participant, but there was a coding error. The fiscal agent has established edits to detect prescribed coding logic, which could result in instances of reversing the claim payment that would require recouping the payment from the provider. The fiscal agent 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 rendered to participants.

- 1. Each month the participant'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 external quality review organization (EQRO) receives a list of all paid service claims for each selected participant. The EQRO 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 waiver participants' parents and guardians which includes several questions regarding satisfactory service delivery to meet the participant's needs.*

DHS contracts with a fiscal agent, 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. DHS is responsible for program operations, administering the fiscal agent contract, and approving payment to the fiscal agent for administrative services.

DHS also has day-to-day accountability and integrity roles. DHS and the EQRO regularly review claims data to ensure providers are properly billing only participants who are eligible for the waiver at the time that services were billed. DHS also conducts year-end waiver agency cost reconciliations.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's 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.

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

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/ductively 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:

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 = <div style="border: 1px solid black; padding: 2px; display: inline-block;">+ / - 5%</div>

<p>Other Specify:</p> <input type="text"/>	<p>Annually</p>	<p>Stratified Describe Group:</p> <input type="text"/>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <input type="text"/>
	<p>Other Specify:</p> <input type="text"/>	

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	<p>Representative Sample Confidence Interval =</p> <input type="text" value="+ / - 5%"/>
<p>Other Specify:</p> <input type="text"/>	<p>Annually</p>	<p>Stratified Describe Group:</p> <input type="text"/>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p>

		<input type="text"/>
	<p>Other Specify:</p> <input type="text"/>	

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
<p>Other Specify:</p> <input type="text"/>	Annually
	Continuously and Ongoing
	<p>Other Specify:</p> <input type="text"/>

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 <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>	<i>100% Review</i>
<i>Operating Agency</i>	<i>Monthly</i>	<i>Less than 100% Review</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>	<i>Representative Sample</i> <i>Confidence Interval =</i> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 100px;">+ / - 5%</div>
<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>	<i>Stratified</i> <i>Describe Group:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<i>Continuously and Ongoing</i>	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<i>State Medicaid Agency</i>	<i>Weekly</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i>	<i>Annually</i>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Specify: <input type="text"/>	
	Continuously and Ongoing
	Other Specify: <input type="text"/>

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 state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

DHS uses several methods to monitor operational functions delegated to the locally-contracted waiver agencies to ensure service plans are being met, ensure access to services for participants, and evaluate purchase of goods and services. These include the (fiscal agent, manual review, record reviews conducted by the contracted quality review organization, and regionally assigned staff.

The fiscal agent is responsible for ensuring waiver services claims are preauthorized, billed, adjudicated and paid appropriately.

DHS is responsible for the annual fiscal reconciliation of locally-contracted waiver agencies revenue. In addition, DHS monitors claims data regularly and continues to follow up on errors using MMIS data until they are resolved. All CLTS claim data including adjustments are available through online reporting system. On a daily basis, the agent obtains from the enrollment system a listing of participants enrolled in the waiver program 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) and the responsible locally-contracted waiver agency. The fiscal agent will reject service authorizations and claims for any person not included on the enrollment list.

The fiscal agent denies claims for any service that is not prior authorized by the locally-contracted waiver agency. The Department uses the record review as a 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, DHS 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
Operating Agency	Monthly
Sub-State Entity	Quarterly

<i>Responsible Party</i> (check each that applies):	<i>Frequency of data aggregation and analysis</i> (check each that applies):
<p>Other Specify:</p> <div data-bbox="317 331 794 414" style="border: 1px solid black; height: 37px; width: 299px;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div data-bbox="863 618 1337 701" style="border: 1px solid black; height: 37px; width: 297px;"></div>

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 statewide CLTS Program Rate Schedule is published on the DHS website. Services may be paid at rates lower than the published statewide maximum rate in circumstances in which a service provider's usual & customary rate is lower than the state-based rate for a particular service.

DHS employs five broad categories of rate determination methods to establish provider payment rates for CLTS Program services: Tiered Rates, Single Rates, Provider Type Based Rates, Provider Type & Participant Acuity Based Rates, and Rates Based on Other Wisconsin Medicaid Services. All rate method categories share similar principles and expense classifications with some category-specific variations. For most CLTS service rates, direct staffing wage costs are the main driver. Base wage costs are determined using matching job categories similar to waiver service job descriptions & standard occupational classification codes from the Bureau of Labor Statistics. Additionally, during the initial stages of the CLTS program statewide rate-setting initiative, the DHS subcontracted analyst—the UW Center for Health Systems Research & Analysis—developed preliminary models of overhead and fringe costs for CLTS service providers, and DHS obtained ongoing county & provider feedback during rate development.

Tiered Rates: Services in this rate method category each have multiple tiers of possible rates, which differ based on the provider's education level or the intensity or quantity of delivered services.

- *Community Integration Services – this service includes two rate tiers based on the provider's education level. 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.*
- *Community/Competitive Integrated Employment – rates are informed by the BLS job classification category & selected to align with rates paid by the Wisconsin Department of Vocational Rehabilitation for job development staff. The rates incentivize individual employment with higher hourly rates. Tiers are based on the number of weekly hours the participant works, with the rate increasing in tandem with hours worked.*
- *Financial Management Services – this service includes two rate tiers, basic and enhanced, based on the level of financial management services provided. The enhanced tier of FMS is comparable to that provided to adult participants under the state's adult self-directed LTC program, and the enhanced FMS rate is set equal to the state's adult self-directed LTC program rate.*
- *Grief and Bereavement Counseling – this service includes three rate tiers based on provider education level, between bachelor's/master's/doctorate level credentials, and rates are set comparable to fee for service rates for similar outpatient mental health counseling services offered under the Medicaid State Plan.*

Single Rates: Services in this rate method category have a single, "flat" maximum rate in all instances.

- *Transportation, Mileage – the rate mirrors the federal standard mileage reimbursement rate & will reflect annual federal updates.*
- *Adult Family Home – rates reflect the average amount paid by the state's adult long term care system PIHPs, per historical encounter data.*
- *Counseling & Therapeutic Services – rates for alternative/activity therapies under this service category pay 85% of provider market rates, up to a maximum of \$178.50 per session.*
- *Support & Service Coordination – A single rate is set for each county using a weighted average hourly rate. The rate includes allowable costs that can be specifically attributed to the provision of CLTS support and service coordination.*

Provider Type Based Rates: Services in this rate method category have rates that differ based on whether the rendering provider is a self-employed individual or an agency that employs direct caregivers. Agency provider rates are higher than Individual provider rates for the same service to reflect the higher overhead & fringe costs incurred by Agency providers as employers, including direct service wages, supervision (when applicable), employee-related cost factors (required tax and benefit obligations), & client and program overhead factors (expenses related to indirect support and service delivery).

- *Daily Living Skills Training – rates use the BLS job classification categories that align with the required staff skill level. The professional category needed is higher than the one used to calculate rates for Respite and Personal Supports.*
- *Discovery and Career Planning – rates are set to equal rates for similar prevocational services offered under the IRIS program.*
- *Health and Wellness – rates are set to correspond similarly to Counseling and Therapeutic Services alternative/activity therapies delivered by unlicensed providers.*
- *Mentoring – rates are informed by the BLS job classification category that aligns with non-professionals with lived*

experience providing the service. The fee schedule sets both individual & agency provider rates assuming a low-to-medium care level.

- Safety Planning and Prevention – rates are based on 2019 encounter data for statewide average rates paid to similar clinical and therapeutic consultations offered in the IRIS program.

Provider Type & Participant Acuity Based Rates – Services in this rate method category have rates that differ both by the rendering provider's type (Individual or Agency, as described above) and by the participant's care level classification. There are three care level classifications: low, medium, & high. The progressively higher rate for each care level is informed by increasing levels of BLS job classification for caregivers to align with the increased need for employee skill, training, and experience. SSCs determine the participant's necessary care level with the family & apply their expertise to assess the participant and family's level (or intensity) of support need. SSCs consider information from formal sources & input from the participant. Several factors are considered, including: Information from the functional screen & assessment processes; Participant & 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 documentation for further details.

- Respite – rates are based on weighted average BLS wage survey data for related job categories, depending on participant care level and provider type.

- Personal Supports – rates mirror those of respite services.

- Specialized Youth Care – rates mirror those of respite services for 1:1 or small group care.

- Adult Day Services – rates mirror those of respite services.

Rates Based on Other Wisconsin Medicaid Services: Services in this rate method category share close similarities with other services offered in the Wisconsin Medicaid State Plan, and as a result their CLTS reimbursement rates are set to be equal with the rates paid for State Plan services.

- In-Home Unpaid Caregiver Training – the rate reflects the per unit amounts paid in another locally-administered Medicaid program to providers of an equal certification level rendering services to an analogous participant population.

- Transportation, per Trip

Outlier Rate Requests

If a CLTS participant requires an exception to a service's statewide maximum rate to meet their unique needs, locally-contracted waiver agencies may submit an outlier request to increase a service rate when either or both of the following criteria are present:

Individual Care Need: The complexity or intensity of the individual's care needs (acuity) exceeds what is common among waiver participants. This could include 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, or has ongoing involvement with multiple systems (e.g. juvenile justice, substance abuse treatment, hospitals/institutions, etc.).

Service/Provider Availability: Access to a needed service is limited, no caregiver is located within a reasonable distance of the participant, or no caregiver within a reasonable distance will accept the service's maximum rate.

Outlier requests are available for all services subject to the statewide rate schedule, and waiver agencies submit outlier requests to DHS for review & final approval. DHS has not established outlier rate maximums but has published an Outlier Rate Guidelines document on the DHS website to help waiver agencies determine whether an outlier request is warranted. Up to 5% of total CLTS participants are anticipated to meet the outlier criteria.

Market rates are used when certain goods or services under a service category are purchased at the price set by the market. Market rate services include: Assistive Technology; Children's Foster Care; Communication Assistance for Community Inclusion; Conferences and Education for Unpaid Caregivers; Counseling & Therapeutic Services-therapeutic equipment & supplies; Daily Living Skills Training – Classes; Discovery and Career Planning – Goods; Empowerment and Self-Determination Supports; Health and Wellness – classes and memberships; Home Modifications;

Housing Support Services; Mentoring—ancillary costs associated with the service; Personal Emergency Response System; Personal Supports—caregiver living expenses, chore services; Relocation Services; Safety Planning and Prevention – Items; Specialized Medical Equipment and Therapeutic Supplies; Respite camps; Transportation—ancillary costs (parking fees, tolls, etc.); Vehicle Modifications; Virtual Equipment and Supports—technology or equipment purchases; Specialized Youth Care – Care in community-based entities.

- 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:

DHS contracts with a fiscal agent 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 service authorization to both the service provider and the fiscal agent. The fiscal agent 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 fiscal agent. The fiscal agent 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 fiscal agent pays providers by check or EFT. 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 fiscal agent. The federal portion of the expense 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 these services are paid for through a financial management provider. The financial management provider submits claims to the Department's fiscal agent on the providers' behalf as the billing provider, receives payment for those claims, and 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 fiscal agent 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 service authorizations for all waiver services to the fiscal agent. The fiscal agent is contractually required to ensure that all payments, adjustments, and other financial transactions made through the fiscal agent 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.

Additionally, DHS conducts a fiscal reconciliation process, which is used to ensure that the locally-contracted Waiver Agencies are properly funded. DHS' fiscal reconciliation process occurs annually, and waiver agencies are responsible for verifying that their operating costs, administrative costs, and revenues received from support and service coordination are fully reported and that DHS' 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 participant's approved Individualized Service Plan (ISP), and the provider actually delivered the service to the participant.

The fiscal agent only pays claims for individuals enrolled in the waiver program. On a daily basis, the fiscal agent receives a file of enrolled waiver participants, which includes the participant's program start date and end date (when applicable) and the applicable responsible waiver agency. The fiscal agent will reject service authorizations and claims for any person not included on the enrollment list.

DHS has established multilayered quality assurance processes to ensure billed services have been rendered to the participant.

- The DHS-contracted fiscal agent 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 participant's needs have been fully met.*
- Annual surveys are also conducted with participants and families to ensure services have been appropriately delivered.*

The contracted fiscal agent has developed a service recovery protocol when waiver service payment errors have been identified. Payment errors may be identified by the following entities:

- 1. DHS*
- 2. Contracted fiscal agent*
- 3. Locally-contracted waiver agencies*
- 4. Providers*

When DHS identifies inappropriate service payments, recoupments are processed through the fiscal agent's claim correction or voided claim processes when possible. Recoupments processed through these fiscal agent claim adjustments are recovered directly from the service provider, including locally-contracted waiver agency providers.

DHS also has a process to correct inappropriate payments directly from locally-contracted waiver agencies through DHS's Bureau of Fiscal Services (BFS). DHS ensures that adjustments for inappropriate payments are reflected in the federal Medicaid reporting.

If the provider does not return an overpayment amount voluntarily, the fiscal agent will recover it directly from the provider's future claims.

When the fiscal agent claims department identifies or is notified by DHS, a waiver agency, or a provider about a payment error, and the service provider has not returned excess funds via the claims engine:

1) The fiscal agent's collections department issues a notice to the provider requesting return of the overpayment, if applicable:

- a) Day 30 – initial letter*
- b) Day 60 – second notice*
- c) Day 90 – final notice*

2) The fiscal agent turns collection duties to Wisconsin's Department of Revenue (DOR) for any collections received from the provider.

The state-established rate methodology is validated using several approaches. The fiscal agent validates all authorizations and claims payments are 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

- 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:

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 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 waiver allowable services that promote a participants transition from an ineligible setting.. Locally-contracted waiver agencies receive payment for delivered waiver services through the fiscal agent 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

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 section 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 section 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 section 1915(b)/section 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 section 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 section 1115/section 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 section 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 text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 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 section 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 transfers. 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 participant'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 participant, 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 participant-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 participant'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

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	11746.12	19783.65	31529.77	460369.14	76326.38	536695.52	505165.75
2	12094.29	20438.45	32532.74	475331.14	78806.99	554138.13	521605.39
3	12458.84	21096.36	33555.20	490779.40	81368.22	572147.62	538592.42
4	12826.65	21759.70	34586.35	506729.73	84012.68	590742.41	556156.06
5	13222.55	22431.47	35654.02	523198.45	86743.10	609941.55	574287.53

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:	Level of Care:	Level of Care:
		Hospital	Nursing Facility	ICF/IID
Year 1	36958	13097	2043	21818
Year 2	40918	14500	2262	24156

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:	Level of Care:	Level of Care:
		Hospital	Nursing Facility	ICF/IID
Year 3	44878	15903	2481	26494
Year 4	48838	17307	2699	28832
Year 5	52798	18710	2918	31170

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.

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 trends 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 CY 2024 waiver service costs, as this is the most complete reporting year available.

The mix of estimated service utilization is expected to remain consistent over the course of the waiver period. For example, if 20% of waiver participants are estimated to utilize a particular service in Waiver Year 1, 20% of participants are estimated to utilize that same service in Waiver Year 5, though in absolute terms the number of participants receiving the service is projected to be higher in Waiver Year 5.

Costs are trended forward using the Consumer Price Index for Medical Care as of Q4 2025. A trend of 3.28% is applied to service costs from December 2024 through December 2031.

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 CY 2024 service costs paid by the State Medicaid plan for waiver participants. State plan service costs in Factor D' are pulled from the same CY 2024 Medicaid fee-for-service paid claims data in the State's MMIS. Cumulative Factor D' costs are then divided by the number of individual waiver participant service months to generate an average monthly Factor D' cost per participant month.

Average monthly factor D' costs are trended forward using the Consumer Price Index for Medical Care. A trend of 3.28% is applied from December 2024 through December 2031. The inflation-trended average monthly factor D' costs are then multiplied by the number of waiver participant months used in the average length of stay estimates to arrive at factor D' estimates for each waiver year.

- 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 CY 2024 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 claims and HMO paid encounter data in the State's MMIS.

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. Since the institutional population has a lower ALOS than typical 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 waiver ALOS, which increases Factor G for the waiver population relative to the institutional population and creates a corresponding Factor G per diem estimation.

Factor G per diem estimates are trended forward using the Consumer Price Index for Medical Care. A trend of 3.28% is applied from December 2024 through December 2031. The inflation-trended factor G per diem costs are then multiplied by the number of enrollment days used in the average length of stay estimates to arrive at Factor G estimates for each waiver year.

- 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 CY 2024 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 claims data in the State's MMIS. Costs are trended forward using the Consumer Price Index for Medical Care.

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. Since the institutional population has a lower ALOS than typical 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 waiver ALOS, which increases Factor G' for the waiver population relative to the institutional population and creates a corresponding Factor G' per diem estimation.

Factor G' per diem estimates are trended forward using the Consumer Price Index for Medical Care. A trend of 3.28% is applied to from December 2024 through December 2031. The inflation-trended Factor G' per diem costs are then multiplied by the number of enrollment days used in the average length of stay estimates to arrive at Factor G' estimates for each waiver year.

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	
Adult Day Services	
Community/Competitive Integrated Employment - Individual	
Discovery and Career Planning	
Respite	
Support and Service Coordination	
Financial Management Services	
Participant and Family-Direction Broker Services	
Adult Family Home	
Assistive Technology	
Children's Foster Care	
Communication Assistance for Community Inclusion	
Community Integration Services	
Community/Competitive Integrated Employment - Small Group	
Conferences and Education for Unpaid Caregivers	
Counseling and Therapeutic Services	
Daily Living Skills Training	
Empowerment and Self-Determination Supports	
Grief and Bereavement Counseling	
Health and Wellness	
Home Modifications	
Housing Support Services	
In-Home Unpaid Caregiver Training	
Mentoring	
Personal Emergency Response System (PERS)	
Personal Supports	
Relocation Services	
Safety Planning and Prevention	
Specialized Medical and Therapeutic Supplies	
Specialized Youth Care	
Transportation	
Vehicle Modifications	
Virtual Equipment and Supports	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							9587.16
Day Services - Hours		Hours	24	13.50	29.59	9587.16	
Community/Competitive Integrated Employment - Individual Total:							72425.55
Community/Competitive Integrated Employment - Individual		Hours	18	5.44	739.64	72425.55	
Discovery and Career Planning Total:							476652.02
Discovery and Career Planning - Hours		Hours	145	37.21	81.54	439944.99	
Discovery and Career Planning - Days		Days	29	4.97	254.68	36707.03	
Respite Total:							166047287.22
Respite - Hours		Hours	16988	356.95	17.80	107936825.48	
Respite - Days		Days	8915	16.69	390.55	58110461.74	
Support and Service Coordination Total:							116611931.69
Support and Service Coordination		Hours	32467	24.46	146.84	116611931.69	
Financial Management Services Total:							9044255.48
Financial Management Services		Months	12935	7.10	98.48	9044255.48	
Participant and Family-Direction Broker Services Total:							1312.88
Participant and Family Direction Broker Services - Hours		Hours	12	1.50	35.36	636.48	
Participant and Family Direction Broker Services - Days		Days	16	2.50	16.91	676.40	
Adult Family Home Total:							15488.44
Adult Family Home		Days	16	2.75	352.01	15488.44	
Assistive Technology Total:							1022509.60
<p>GRAND TOTAL: 434112936.24</p> <p>Total: Services included in capitation:</p> <p>Total: Services not included in capitation: 434112936.24</p> <p>Total Estimated Unduplicated Participants: 36958</p> <p>Factor D (Divide total by number of participants): 11746.12</p> <p>Services included in capitation:</p> <p>Services not included in capitation: 11746.12</p> <p>Average Length of Stay on the Waiver: 299</p>							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology		Each	1163	1.40	628.00	1022509.60	
Children's Foster Care Total:							8312020.24
Children's Foster Care - Days		Days	244	93.02	161.98	3676440.62	
Children's Foster Care - Months		Months	535	18.36	471.93	4635579.62	
Communication Assistance for Community Inclusion Total:							118235.22
Communication Assistance for Community Inclusion - Each		Each	59	0.81	583.30	27875.91	
Communication Assistance for Community Inclusion - Hours		Hours	184	1.44	341.03	90359.31	
Community Integration Services Total:							659986.96
Community Integration Services - Hours		Hours	243	98.37	27.61	659986.96	
Community/Competitive Integrated Employment - Small Group Total:							39951.65
Community/Competitive Integrated Employment - Small Group		Hours	13	5.54	554.73	39951.65	
Conferences and Education for Unpaid Caregivers Total:							77127.60
Conferences and Education for Unpaid Caregivers - Each		Each	438	1.48	118.98	77127.60	
Counseling and Therapeutic Services Total:							29877864.10
Counseling and Therapeutic Services - Each		Each	11961	4.81	90.56	5210135.05	
Counseling and Therapeutic Services - Days		Days	5824	21.88	193.58	24667729.05	
Daily Living Skills Training Total:							20564515.70
Daily Living Skills Training		Hours	3872	132.91	39.96	20564515.70	
Empowerment and Self-Determination Supports Total:							3665912.74

GRAND TOTAL: 434112936.24

Total: Services included in capitation:

Total: Services not included in capitation: 434112936.24

Total Estimated Unduplicated Participants: 36958

Factor D (Divide total by number of participants): 11746.12

Services included in capitation:

Services not included in capitation: 11746.12

Average Length of Stay on the Waiver: 299

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Empowerment and Self Determination Supports - Days		Days	1707	6.87	139.43	1635108.16	
Empowerment and Self Determination Supports - Hours		Hours	732	56.32	49.26	2030804.58	
Grief and Bereavement Counseling Total:							59400.00
Grief and Bereavement Counseling		Days	10	9.00	660.00	59400.00	
Health and Wellness Total:							13959118.37
Health and Wellness - Days		Days	11588	5.27	212.99	13007035.19	
Health and Wellness - Hours		Hours	238	278.77	14.35	952083.18	
Home Modifications Total:							16387823.24
Home Modifications		Each	1324	1.22	10145.50	16387823.24	
Housing Support Services Total:							139931.34
Housing Support Services		Hours	27	51.41	100.81	139931.34	
In-Home Unpaid Caregiver Training Total:							6135809.22
In-Home Unpaid Caregiver Training - Hours		Hours	3654	86.29	19.46	6135809.22	
Mentoring Total:							635205.89
Mentoring - Hours		Hours	243	82.32	31.20	624117.31	
Mentoring - Each		Each	46	155.52	1.55	11088.58	
Personal Emergency Response System (PERS) Total:							2243331.37
Personal Emergency Response System (PERS) - Months		Months	3473	5.63	93.48	1827813.51	
Personal Emergency Response System (PERS) - Each		Each	1886	0.93	236.90	415517.86	
Personal Supports Total:							23597541.65
Personal Supports - Days		Days	216	306.94	35.17	2331737.24	
Personal Supports - Hours		Hours	1795	402.42	29.44	21265804.42	

GRAND TOTAL: 434112936.24

Total: Services included in capitation:

Total: Services not included in capitation: 434112936.24

Total Estimated Unduplicated Participants: 36958

Factor D (Divide total by number of participants): 11746.12

Services included in capitation:

Services not included in capitation: 11746.12

Average Length of Stay on the Waiver: 299

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Relocation Services Total:							18259.17
Relocation Services	<input type="checkbox"/>	Each	14	1.36	958.99	18259.17	
Safety Planning and Prevention Total:							772279.96
Safety Planning and Prevention - Hours	<input type="checkbox"/>	Hours	325	25.38	20.74	171073.89	
Safety Planning and Prevention - Days	<input type="checkbox"/>	Days	2055	3.11	94.07	601206.07	
Specialized Medical and Therapeutic Supplies Total:							3938015.25
Specialized Medical and Therapeutic Supplies	<input type="checkbox"/>	Each	6565	7.50	79.98	3938015.25	
Specialized Youth Care Total:							2456473.85
Specialized Youth Care - Hours	<input type="checkbox"/>	Hours	484	215.24	23.58	2456473.85	
Transportation Total:							4467948.02
Transportation - Trips	<input type="checkbox"/>	Trips	967	67.52	39.12	2554216.78	
Transportation - Each	<input type="checkbox"/>	Each	102	3.84	49.66	19450.83	
Transportation - Miles	<input type="checkbox"/>	Miles	3221	773.82	0.76	1894280.41	
Vehicle Modifications Total:							2651810.76
Vehicle Modifications	<input type="checkbox"/>	Each	207	1.00	12810.68	2651810.76	
Virtual Equipment and Supports Total:							32923.91
Virtual Equipment and Supports - Months	<input type="checkbox"/>	Months	17	5.88	121.16	12111.15	
Virtual Equipment and Supports - Each	<input type="checkbox"/>	Each	41	1.49	340.69	20812.75	
GRAND TOTAL: 434112936.24 Total: Services included in capitation: Total: Services not included in capitation: 434112936.24 Total Estimated Unduplicated Participants: 36958 Factor D (Divide total by number of participants): 11746.12 Services included in capitation: Services not included in capitation: 11746.12 Average Length of Stay on the Waiver: <input type="text" value="299"/>							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							10927.17
Day Services - Hours		Hours	26	12.46	33.73	10927.17	
Community/Competitive Integrated Employment - Individual Total:							82629.68
Community/Competitive Integrated Employment - Individual		Hours	20	4.90	843.16	82629.68	
Discovery and Career Planning Total:							543323.27
Discovery and Career Planning - Hours		Hours	161	33.52	92.93	501517.19	
Discovery and Career Planning - Days		Days	32	4.50	290.32	41806.08	
Respite Total:							189310636.62
Respite - Hours		Hours	18808	505.01	12.96	123097035.92	
Respite - Days		Days	9870	15.15	442.81	66213600.70	
Support and Service Coordination Total:							132965644.81
Support and Service Coordination		Hours	35945	24.42	151.48	132965644.81	
Financial Management Services Total:							10303282.12
Financial Management Services		Months	14321	6.43	111.89	10303282.12	
Participant and Family-Direction Broker Services Total:							1493.00
Participant and Family Direction Broker Services - Hours		Hours	13	1.38	40.31	723.16	
Participant and Family Direction Broker Services - Days		Days	17	2.35	19.27	769.84	
Adult Family Home Total:							17668.36
Adult Family Home		Days	17	2.59	401.28	17668.36	
Assistive Technology							1171024.23

GRAND TOTAL: 494874063.69

Total: Services included in capitation:

Total: Services not included in capitation: 494874063.69

Total Estimated Unduplicated Participants: 40918

Factor D (Divide total by number of participants): 12094.29

Services included in capitation:

Services not included in capitation: 12094.29

Average Length of Stay on the Waiver: 301

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Assistive Technology		Each	1288	1.27	715.89	1171024.23	
Children's Foster Care Total:							9472351.41
Children's Foster Care - Days		Days	271	83.82	184.50	4190958.09	
Children's Foster Care - Months		Months	592	16.59	537.75	5281393.32	
Communication Assistance for Community Inclusion Total:							135082.77
Communication Assistance for Community Inclusion - Each		Each	65	0.74	664.94	31983.61	
Communication Assistance for Community Inclusion - Hours		Hours	204	1.30	388.76	103099.15	
Community Integration Services Total:							752436.85
Community Integration Services - Hours		Hours	269	88.94	31.45	752436.85	
Community/Competitive Integrated Employment - Small Group Total:							45505.35
Community/Competitive Integrated Employment - Small Group		Hours	14	5.14	632.37	45505.35	
Conferences and Education for Unpaid Caregivers Total:							88145.94
Conferences and Education for Unpaid Caregivers - Each		Each	485	1.34	135.63	88145.94	
Counseling and Therapeutic Services Total:							34057649.46
Counseling and Therapeutic Services - Each		Each	13242	4.35	103.02	5934230.15	
Counseling and Therapeutic Services - Days		Days	6447	19.86	219.65	28123419.30	
Daily Living Skills Training Total:							23443606.97
Daily Living Skills Training		Hours	4287	128.49	42.56	23443606.97	
Empowerment and Self-Determination Supports Total:							4179647.87

GRAND TOTAL: 494874063.69

Total: Services included in capitation:

Total: Services not included in capitation: 494874063.69

Total Estimated Unduplicated Participants: 40918

Factor D (Divide total by number of participants): 12094.29

Services included in capitation:

Services not included in capitation: 12094.29

Average Length of Stay on the Waiver: 301

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Empowerment and Self Determination Supports - Days		Days	1890	6.21	158.88	1864758.67	
Empowerment and Self Determination Supports - Hours		Hours	810	50.97	56.07	2314889.20	
Grief and Bereavement Counseling Total:							95397.30
Grief and Bereavement Counseling		Days	12	7.50	1059.97	95397.30	
Health and Wellness Total:							15911538.31
Health and Wellness - Days		Days	12830	4.77	242.26	14826093.97	
Health and Wellness - Hours		Hours	263	252.89	16.32	1085444.34	
Home Modifications Total:							18650283.41
Home Modifications		Each	1466	1.10	11565.35	18650283.41	
Housing Support Services Total:							159520.45
Housing Support Services		Hours	30	46.27	114.92	159520.45	
In-Home Unpaid Caregiver Training Total:							6993648.05
In-Home Unpaid Caregiver Training - Hours		Hours	4045	78.84	21.93	6993648.05	
Mentoring Total:							723663.77
Mentoring - Hours		Hours	269	74.58	35.44	710997.99	
Mentoring - Each		Each	51	140.31	1.77	12665.78	
Personal Emergency Response System (PERS) Total:							2557767.21
Personal Emergency Response System (PERS) - Months		Months	3845	5.09	106.49	2084121.11	
Personal Emergency Response System (PERS) - Each		Each	2088	0.84	270.05	473646.10	
Personal Supports Total:							26892890.08
Personal Supports - Days		Days	239	278.07	40.00	2658349.20	
Personal Supports - Hours		Hours	1987	398.58	30.60	24234540.88	

GRAND TOTAL: 494874063.69

Total: Services included in capitation:

Total: Services not included in capitation: 494874063.69

Total Estimated Unduplicated Participants: 40918

Factor D (Divide total by number of participants): 12094.29

Services included in capitation:

Services not included in capitation: 12094.29

Average Length of Stay on the Waiver: 301

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Relocation Services Total:							20814.53
Relocation Services	<input type="checkbox"/>	Each	16	1.19	1093.20	20814.53	
Safety Planning and Prevention Total:							880403.92
Safety Planning and Prevention - Hours	<input type="checkbox"/>	Hours	360	22.91	23.64	194973.26	
Safety Planning and Prevention - Days	<input type="checkbox"/>	Days	2275	2.81	107.22	685430.66	
Specialized Medical and Therapeutic Supplies Total:							4491318.02
Specialized Medical and Therapeutic Supplies	<input type="checkbox"/>	Each	7268	6.79	91.01	4491318.02	
Specialized Youth Care Total:							2800414.06
Specialized Youth Care - Hours	<input type="checkbox"/>	Hours	535	195.46	26.78	2800414.06	
Transportation Total:							5067991.91
Transportation - Trips	<input type="checkbox"/>	Trips	1071	61.11	44.48	2911163.07	
Transportation - Each	<input type="checkbox"/>	Each	113	3.47	56.61	22197.35	
Transportation - Miles	<input type="checkbox"/>	Miles	3566	757.73	0.79	2134631.49	
Vehicle Modifications Total:							3009785.47
Vehicle Modifications	<input type="checkbox"/>	Each	229	0.90	14603.52	3009785.47	
Virtual Equipment and Supports Total:							37571.34
Virtual Equipment and Supports - Months	<input type="checkbox"/>	Months	19	5.26	138.12	13803.71	
Virtual Equipment and Supports - Each	<input type="checkbox"/>	Each	45	1.36	388.36	23767.63	
GRAND TOTAL: 494874063.69 Total: Services included in capitation: Total: Services not included in capitation: 494874063.69 Total Estimated Unduplicated Participants: 40918 Factor D (Divide total by number of participants): 12094.29 Services included in capitation: Services not included in capitation: 12094.29 Average Length of Stay on the Waiver: <input type="text" value="301"/>							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							12341.73
Day Services - Hours		Hours	29	11.17	38.10	12341.73	
Community/Competitive Integrated Employment - Individual Total:							93240.94
Community/Competitive Integrated Employment - Individual		Hours	22	4.45	952.41	93240.94	
Discovery and Career Planning Total:							613555.12
Discovery and Career Planning - Hours		Hours	176	30.66	104.96	566380.95	
Discovery and Career Planning - Days		Days	35	4.11	327.94	47174.17	
Respite Total:							214060319.48
Respite - Hours		Hours	20629	721.21	9.36	139256592.60	
Respite - Days		Days	10825	13.89	497.50	74803726.88	
Support and Service Coordination Total:							150168539.14
Support and Service Coordination		Hours	39424	24.60	154.84	150168539.14	
Financial Management Services Total:							11633490.74
Financial Management Services		Months	15706	5.88	125.97	11633490.74	
Participant and Family-Direction Broker Services Total:							1695.03
Participant and Family Direction Broker Services - Hours		Hours	14	1.29	45.53	822.27	
Participant and Family Direction Broker Services - Days		Days	19	2.11	21.77	872.76	
Adult Family Home Total:							19980.58
Adult Family Home		Days	19	2.32	453.28	19980.58	
Assistive Technology							1314015.82

<p>GRAND TOTAL: 559127826.18</p> <p>Total: Services included in capitation:</p> <p>Total: Services not included in capitation: 559127826.18</p> <p>Total Estimated Unduplicated Participants: 44878</p> <p>Factor D (Divide total by number of participants): 12458.84</p> <p>Services included in capitation:</p> <p>Services not included in capitation: 12458.84</p> <p>Average Length of Stay on the Waiver: 303</p>							
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Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Assistive Technology		Each	1413	1.15	808.65	1314015.82	
Children's Foster Care Total:							10700345.86
Children's Foster Care - Days		Days	297	76.55	208.23	4734181.93	
Children's Foster Care - Months		Months	649	15.14	607.19	5966163.93	
Communication Assistance for Community Inclusion Total:							152333.95
Communication Assistance for Community Inclusion - Each		Each	71	0.68	751.10	36263.11	
Communication Assistance for Community Inclusion - Hours		Hours	224	1.18	439.13	116070.84	
Community Integration Services Total:							849918.07
Community Integration Services - Hours		Hours	295	81.18	35.49	849918.07	
Community/Competitive Integrated Employment - Small Group Total:							51430.32
Community/Competitive Integrated Employment - Small Group		Hours	16	4.50	714.31	51430.32	
Conferences and Education for Unpaid Caregivers Total:							99432.93
Conferences and Education for Unpaid Caregivers - Each		Each	532	1.22	153.20	99432.93	
Counseling and Therapeutic Services Total:							38461161.10
Counseling and Therapeutic Services - Each		Each	14524	3.97	116.12	6695511.71	
Counseling and Therapeutic Services - Days		Days	7071	18.19	246.97	31765649.39	
Daily Living Skills Training Total:							26484103.40
Daily Living Skills Training		Hours	4702	125.39	44.92	26484103.40	
Empowerment and Self-Determination Supports Total:							4719624.10

GRAND TOTAL: 559127826.18

Total: Services included in capitation:

Total: Services not included in capitation: 559127826.18

Total Estimated Unduplicated Participants: 44878

Factor D (Divide total by number of participants): 12458.84

Services included in capitation:

Services not included in capitation: 12458.84

Average Length of Stay on the Waiver: 303

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Empowerment and Self Determination Supports - Days		Days	2073	5.66	179.39	2104815.16	
Empowerment and Self Determination Supports - Hours		Hours	889	46.51	63.24	2614808.94	
Grief and Bereavement Counseling Total:							107710.91
Grief and Bereavement Counseling		Days	13	6.92	1197.32	107710.91	
Health and Wellness Total:							17977547.81
Health and Wellness - Days		Days	14071	4.36	273.05	16751497.36	
Health and Wellness - Hours		Hours	289	230.69	18.39	1226050.45	
Home Modifications Total:							21006879.84
Home Modifications		Each	1608	1.00	13063.98	21006879.84	
Housing Support Services Total:							180173.68
Housing Support Services		Hours	33	42.06	129.81	180173.68	
In-Home Unpaid Caregiver Training Total:							7901875.49
In-Home Unpaid Caregiver Training - Hours		Hours	4437	72.69	24.50	7901875.48	
Mentoring Total:							817466.32
Mentoring - Hours		Hours	295	68.20	39.92	803150.48	
Mentoring - Each		Each	56	127.82	2.00	14315.84	
Personal Emergency Response System (PERS) Total:							2889816.01
Personal Emergency Response System (PERS) - Months		Months	4217	4.64	120.20	2351938.98	
Personal Emergency Response System (PERS) - Each		Each	2290	0.77	305.04	537877.03	
Personal Supports Total:							30406361.06
Personal Supports - Days		Days	262	254.27	45.07	3002506.61	
Personal Supports - Hours		Hours	2179	398.49	31.56	27403854.45	

GRAND TOTAL: 559127826.18

Total: Services included in capitation:

Total: Services not included in capitation: 559127826.18

Total Estimated Unduplicated Participants: 44878

Factor D (Divide total by number of participants): 12458.84

Services included in capitation:

Services not included in capitation: 12458.84

Average Length of Stay on the Waiver: 303

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Relocation Services Total:							23511.54
Relocation Services	<input type="checkbox"/>	Each	17	1.12	1234.85	23511.54	
Safety Planning and Prevention Total:							993742.43
Safety Planning and Prevention - Hours	<input type="checkbox"/>	Hours	395	20.89	26.70	220316.38	
Safety Planning and Prevention - Days	<input type="checkbox"/>	Days	2495	2.56	121.09	773426.05	
Specialized Medical and Therapeutic Supplies Total:							5071500.92
Specialized Medical and Therapeutic Supplies	<input type="checkbox"/>	Each	7971	6.20	102.62	5071500.92	
Specialized Youth Care Total:							3162665.95
Specialized Youth Care - Hours	<input type="checkbox"/>	Hours	587	178.82	30.13	3162665.95	
Transportation Total:							5715624.61
Transportation - Trips	<input type="checkbox"/>	Trips	1175	55.83	50.13	3288540.53	
Transportation - Each	<input type="checkbox"/>	Each	124	3.16	63.95	25058.17	
Transportation - Miles	<input type="checkbox"/>	Miles	3911	748.99	0.82	2402025.91	
Vehicle Modifications Total:							3395171.73
Vehicle Modifications	<input type="checkbox"/>	Each	251	0.82	16495.83	3395171.73	
Virtual Equipment and Supports Total:							42249.56
Virtual Equipment and Supports - Months	<input type="checkbox"/>	Months	21	4.76	156.01	15594.76	
Virtual Equipment and Supports - Each	<input type="checkbox"/>	Each	49	1.24	438.69	26654.80	
GRAND TOTAL: 559127826.18 Total: Services included in capitation: Total: Services not included in capitation: 559127826.18 Total Estimated Unduplicated Participants: 44878 Factor D (Divide total by number of participants): 12458.84 Services included in capitation: Services not included in capitation: 12458.84 Average Length of Stay on the Waiver: <input type="text" value="303"/>							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							13835.90
Day Services - Hours		Hours	31	10.45	42.71	13835.90	
Community/Competitive Integrated Employment - Individual Total:							104548.20
Community/Competitive Integrated Employment - Individual		Hours	24	4.08	1067.69	104548.20	
Discovery and Career Planning Total:							687863.27
Discovery and Career Planning - Hours		Hours	192	28.11	117.64	634917.20	
Discovery and Career Planning - Days		Days	38	3.79	367.63	52946.07	
Respite Total:							239517314.18
Respite - Hours		Hours	22449	1038.10	6.68	155672770.09	
Respite - Days		Days	11781	12.83	554.71	83844544.08	
Support and Service Coordination Total:							168369803.13
Support and Service Coordination		Hours	42903	24.99	157.04	168369803.13	
Financial Management Services Total:							13038888.58
Financial Management Services		Months	17092	5.42	140.75	13038888.58	
Participant and Family-Direction Broker Services Total:							1896.54
Participant and Family Direction Broker Services - Hours		Hours	16	1.13	51.05	922.98	
Participant and Family Direction Broker Services - Days		Days	21	1.90	24.40	973.56	
Adult Family Home Total:							22408.97
Adult Family Home		Days	21	2.10	508.14	22408.97	
Assistive Technology							1476936.81

GRAND TOTAL: 626428064.03

Total: Services included in capitation:

Total: Services not included in capitation: 626428064.03

Total Estimated Unduplicated Participants: 48838

Factor D (Divide total by number of participants): 12826.65

Services included in capitation:

Services not included in capitation: 12826.65

Average Length of Stay on the Waiver: 305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Assistive Technology		Each	1537	1.06	906.53	1476936.81	
Children's Foster Care Total:							11998906.07
Children's Foster Care - Days		Days	323	70.45	233.24	5307457.83	
Children's Foster Care - Months		Months	706	13.93	680.40	6691448.23	
Communication Assistance for Community Inclusion Total:							171649.05
Communication Assistance for Community Inclusion - Each		Each	78	0.62	842.01	40719.60	
Communication Assistance for Community Inclusion - Hours		Hours	244	1.09	492.29	130929.45	
Community Integration Services Total:							952770.53
Community Integration Services - Hours		Hours	321	74.67	39.75	952770.53	
Community/Competitive Integrated Employment - Small Group Total:							57719.50
Community/Competitive Integrated Employment - Small Group		Hours	17	4.24	800.77	57719.50	
Conferences and Education for Unpaid Caregivers Total:							111376.44
Conferences and Education for Unpaid Caregivers - Each		Each	579	1.12	171.75	111376.44	
Counseling and Therapeutic Services Total:							43119487.03
Counseling and Therapeutic Services - Each		Each	15805	3.66	129.91	7514812.83	
Counseling and Therapeutic Services - Days		Days	7695	16.79	275.58	35604674.20	
Daily Living Skills Training Total:							29709062.21
Daily Living Skills Training		Hours	5116	123.45	47.04	29709062.21	
Empowerment and Self-Determination Supports Total:							5293938.12

GRAND TOTAL: 626428064.03

Total: Services included in capitation:

Total: Services not included in capitation: 626428064.03

Total Estimated Unduplicated Participants: 48838

Factor D (Divide total by number of participants): 12826.65

Services included in capitation:

Services not included in capitation: 12826.65

Average Length of Stay on the Waiver: 305

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Empowerment and Self Determination Supports - Days		Days	2256	5.21	201.02	2362740.84	
Empowerment and Self Determination Supports - Hours		Hours	967	42.82	70.79	2931197.28	
Grief and Bereavement Counseling Total:							120828.44
Grief and Bereavement Counseling		Days	14	6.43	1342.24	120828.44	
Health and Wellness Total:							20175853.07
Health and Wellness - Days		Days	15313	4.02	305.42	18801123.77	
Health and Wellness - Hours		Hours	314	212.84	20.57	1374729.30	
Home Modifications Total:							23578820.30
Home Modifications		Each	1750	0.92	14645.23	23578820.30	
Housing Support Services Total:							202018.92
Housing Support Services		Hours	36	38.56	145.53	202018.92	
In-Home Unpaid Caregiver Training Total:							8857089.11
In-Home Unpaid Caregiver Training - Hours		Hours	4828	67.57	27.15	8857089.11	
Mentoring Total:							916786.55
Mentoring - Hours		Hours	321	62.86	44.64	900748.60	
Mentoring - Each		Each	60	119.33	2.24	16037.95	
Personal Emergency Response System (PERS) Total:							3244342.90
Personal Emergency Response System (PERS) - Months		Months	4590	4.27	134.65	2639045.74	
Personal Emergency Response System (PERS) - Each		Each	2493	0.71	341.97	605297.16	
Personal Supports Total:							34058991.22
Personal Supports - Days		Days	285	234.32	50.41	3366440.29	
Personal Supports - Hours		Hours	2372	401.35	32.24	30692550.93	

GRAND TOTAL: 626428064.03

Total: Services included in capitation:

Total: Services not included in capitation: 626428064.03

Total Estimated Unduplicated Participants: 48838

Factor D (Divide total by number of participants): 12826.65

Services included in capitation:

Services not included in capitation: 12826.65

Average Length of Stay on the Waiver: 305

Waiver Service/Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Relocation Services Total:							26302.08
Relocation Services	<input type="checkbox"/>	Each	19	1.00	1384.32	26302.08	
Safety Planning and Prevention Total:							1116567.27
Safety Planning and Prevention - Hours	<input type="checkbox"/>	Hours	430	19.19	29.92	246890.86	
Safety Planning and Prevention - Days	<input type="checkbox"/>	Days	2715	2.36	135.73	869676.40	
Specialized Medical and Therapeutic Supplies Total:							5688513.27
Specialized Medical and Therapeutic Supplies	<input type="checkbox"/>	Each	8675	5.71	114.84	5688513.27	
Specialized Youth Care Total:							3545522.49
Specialized Youth Care - Hours	<input type="checkbox"/>	Hours	639	164.89	33.65	3545522.49	
Transportation Total:							6414174.11
Transportation - Trips	<input type="checkbox"/>	Trips	1278	51.46	56.06	3686835.23	
Transportation - Each	<input type="checkbox"/>	Each	135	2.90	71.69	28066.64	
Transportation - Miles	<input type="checkbox"/>	Miles	4256	746.15	0.85	2699272.24	
Vehicle Modifications Total:							3786333.23
Vehicle Modifications	<input type="checkbox"/>	Each	273	0.75	18492.47	3786333.23	
Virtual Equipment and Supports Total:							47516.52
Virtual Equipment and Supports - Months	<input type="checkbox"/>	Months	22	4.55	174.90	17507.49	
Virtual Equipment and Supports - Each	<input type="checkbox"/>	Each	54	1.13	491.79	30009.03	
GRAND TOTAL: 626428064.03 Total: Services included in capitation: Total: Services not included in capitation: 626428064.03 Total Estimated Unduplicated Participants: 48838 Factor D (Divide total by number of participants): 12826.65 Services included in capitation: Services not included in capitation: 12826.65 Average Length of Stay on the Waiver: <input type="text" value="305"/>							

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 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	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Services Total:							15413.63
Day Services - Hours		Hours	34	9.53	47.57	15413.63	
Community/Competitive Integrated Employment - Individual Total:							116573.23
Community/Competitive Integrated Employment - Individual		Hours	26	3.77	1189.28	116573.23	
Discovery and Career Planning Total:							766196.49
Discovery and Career Planning - Hours		Hours	207	26.08	131.01	707265.35	
Discovery and Career Planning - Days		Days	41	3.51	409.50	58931.14	
Respite Total:							267212571.17
Respite - Hours		Hours	24269	1504.13	4.76	173757759.42	
Respite - Days		Days	12736	11.94	614.56	93454811.75	
Support and Service Coordination Total:							187541239.56
Support and Service Coordination		Hours	46381	25.54	158.32	187541239.56	
Financial Management Services Total:							14522553.12
Financial Management Services		Months	18478	5.03	156.25	14522553.12	
Participant and Family-Direction Broker Services Total:							2112.90
Participant and Family Direction Broker Services - Hours		Hours	17	1.06	56.86	1024.62	
Participant and Family Direction Broker Services - Days		Days	22	1.82	27.18	1088.29	
Adult Family Home Total:							24904.44
Adult Family Home		Days	22	2.00	566.01	24904.44	
Assistive Technology							1644672.99

GRAND TOTAL: 698124356.63

Total: Services included in capitation:

Total: Services not included in capitation: 698124356.63

Total Estimated Unduplicated Participants: 52798

Factor D (Divide total by number of participants): 13222.55

Services included in capitation:

Services not included in capitation: 13222.55

Average Length of Stay on the Waiver: 306

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Assistive Technology		Each	1662	0.98	1009.77	1644672.99	
Children's Foster Care Total:							13360262.37
Children's Foster Care - Days		Days	349	65.25	259.58	5911220.66	
Children's Foster Care - Months		Months	764	12.87	757.58	7449041.71	
Communication Assistance for Community Inclusion Total:							190564.86
Communication Assistance for Community Inclusion - Each		Each	84	0.57	937.90	44906.65	
Communication Assistance for Community Inclusion - Hours		Hours	263	1.01	548.35	145658.21	
Community Integration Services Total:							1061233.99
Community Integration Services - Hours		Hours	347	69.13	44.24	1061233.99	
Community/Competitive Integrated Employment - Small Group Total:							64230.04
Community/Competitive Integrated Employment - Small Group		Hours	19	3.79	891.96	64230.04	
Conferences and Education for Unpaid Caregivers Total:							124543.95
Conferences and Education for Unpaid Caregivers - Each		Each	626	1.04	191.30	124543.95	
Counseling and Therapeutic Services Total:							48017538.91
Counseling and Therapeutic Services - Each		Each	17087	3.39	144.40	8364359.89	
Counseling and Therapeutic Services - Days		Days	8319	15.60	305.55	39653179.02	
Daily Living Skills Training Total:							33069822.45
Daily Living Skills Training		Hours	5531	122.12	48.96	33069822.45	
Empowerment and Self-Determination Supports Total:							5896760.77

GRAND TOTAL: 698124356.63

Total: Services included in capitation:

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Average Length of Stay on the Waiver: 306

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Empowerment and Self Determination Supports - Days		Days	2439	4.82	223.81	2631105.88	
Empowerment and Self Determination Supports - Hours		Hours	1046	39.65	78.74	3265654.89	
Grief and Bereavement Counseling Total:							134559.00
Grief and Bereavement Counseling		Days	15	6.00	1495.10	134559.00	
Health and Wellness Total:							22435080.38
Health and Wellness - Days		Days	16555	3.72	339.44	20904276.62	
Health and Wellness - Hours		Hours	340	197.04	22.85	1530803.76	
Home Modifications Total:							26234727.42
Home Modifications		Each	1892	0.85	16313.10	26234727.42	
Housing Support Services Total:							224996.42
Housing Support Services		Hours	39	35.59	162.10	224996.42	
In-Home Unpaid Caregiver Training Total:							9865360.88
In-Home Unpaid Caregiver Training - Hours		Hours	5219	63.22	29.90	9865360.88	
Mentoring Total:							1020780.34
Mentoring - Hours		Hours	347	58.32	49.56	1002947.70	
Mentoring - Each		Each	65	110.18	2.49	17832.63	
Personal Emergency Response System (PERS) Total:							3604892.10
Personal Emergency Response System (PERS) - Months		Month	4962	3.95	149.88	2937633.01	
Personal Emergency Response System (PERS) - Each		Each	2695	0.65	380.91	667259.09	
Personal Supports Total:							37943541.90
Personal Supports - Days		Days	308	217.34	56.01	3749349.73	
Personal Supports - Hours		Hours	2564	407.09	32.76	34194192.18	

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Average Length of Stay on the Waiver: 306

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Relocation Services Total:							29143.23
Relocation Services		Each	21	0.90	1541.97	29143.23	
Safety Planning and Prevention Total:							1242511.51
Safety Planning and Prevention - Hours		Hours	465	17.75	33.32	275014.95	
Safety Planning and Prevention - Days		Days	2936	2.18	151.16	967496.56	
Specialized Medical and Therapeutic Supplies Total:							6334156.28
Specialized Medical and Therapeutic Supplies		Each	9378	5.29	127.68	6334156.28	
Specialized Youth Care Total:							3949244.94
Specialized Youth Care - Hours		Hours	691	153.06	37.34	3949244.94	
Transportation Total:							7167725.30
Transportation - Trips		Trips	1382	47.70	62.30	4106903.22	
Transportation - Each		Each	146	2.68	79.86	31247.62	
Transportation - Miles		Miles	4601	748.25	0.88	3029574.46	
Vehicle Modifications Total:							4253584.05
Vehicle Modifications		Each	295	0.70	20598.47	4253584.06	
Virtual Equipment and Supports Total:							52858.00
Virtual Equipment and Supports - Months		Months	24	4.17	194.82	19497.59	
Virtual Equipment and Supports - Each		Each	58	1.05	547.79	33360.41	

GRAND TOTAL: 698124356.63

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