

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the 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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information

- A. The State of Wisconsin requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.
- B. **Program Title:**  
Family Care Waiver Renewal 2015
- C. **Waiver Number:** WI.0367  
**Original Base Waiver Number:** WI.0367.
- D. **Amendment Number:**
- E. **Proposed Effective Date:** (mm/dd/yy)  
07/01/18
- Approved Effective Date of Waiver being Amended:** 01/01/15

### 2. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:

This amendment: broadens the care management service definition to include Indian Health Care Providers (IHCPs) pursuant to section 5006 of ARRA; establishes a reimbursement rate for IHCPs as a cost-based methodology; and documents/defines safeguards for conflict free care management provided by IHCPs. Enrollment projections are updated to reflect current enrollment levels and transition projections for Dane, Adams, and tribal members.

### 3. Nature of the Amendment

- A. **Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input checked="" type="checkbox"/> Waiver Application	Purpose; Waiver Des
<input checked="" type="checkbox"/> Appendix A – Waiver Administration and Operation	A.2.a.;A.5
<input checked="" type="checkbox"/> Appendix B – Participant Access and Eligibility	B.3.a.; B.7.a.,b.; B.8.
<input checked="" type="checkbox"/> Appendix C – Participant Services	C1 - care management
<input checked="" type="checkbox"/> Appendix D – Participant Centered Service Planning and Delivery	D.1.b.; D.1.f.; D.2.b.
<input checked="" type="checkbox"/> Appendix E – Participant Direction of Services	E.1.n.
<input type="checkbox"/> Appendix F – Participant Rights	
<input type="checkbox"/> Appendix G – Participant Safeguards	
<input type="checkbox"/> Appendix H	
<input checked="" type="checkbox"/> Appendix I – Financial Accountability	I.2.a.,b.,d; I.1 Financ
<input checked="" type="checkbox"/> Appendix J – Cost-Neutrality Demonstration	J.1, J.2.a.-d.

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
- Modify Medicaid eligibility**
- Add/delete services**
- Revise service specifications**
- Revise provider qualifications**
- Increase/decrease number of participants**
- Revise cost neutrality demonstration**
- Add participant-direction of services**
- Other**

Specify:

This amendment also establishes a reimbursement rate for IHCPs as a cost-based methodology and documents/defines safeguards for conflict free care management provided by IHCPs.

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

### 1. Request Information (1 of 3)

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

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

**Family Care Waiver Renewal 2015**

**C. Type of Request:** amendment

**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.0367

**Draft ID:** WI.018.03.05

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended:** 01/01/15

**Approved Effective Date of Waiver being Amended:** 01/01/15

### 1. Request Information (2 of 3)

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**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:

**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:  
Not applicable.

**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:  
Not applicable.

### 1. Request Information (3 of 3)

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

WI.07 is a previously approved 1915(b) waiver.

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

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

**§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

A SPA approved by CMS and effective 1/1/2008 amended Wisconsin's Medicaid state plan to extend the highly successful Medicaid/Medicaid Family Care Partnership program, which was originally authorized under s. 1115 waiver authority, and provides integrated primary and acute care and long-term care to individuals with long-term support needs. The SPAs allow certain categories of Medicaid beneficiaries to voluntarily enroll in managed care entities without being out of compliance with provisions of section 1902 of the Social Security Act on statewideness, freedom of choice or comparability.

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

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

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

Specify the program:

**H. Dual 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.

Family Care is a comprehensive and flexible managed long term care program, which strives to foster people's independence and quality of life, while recognizing the need for individualized support. Family Care gives elders and adults with physical or intellectual/developmental disabilities the choice to receive long term care in their own homes and integrated community settings.

The goals of managed long term care are:

CHOICE – Give people better choices about the services and supports available to meet their needs

ACCESS – Improve people's access to services

QUALITY – Improve overall quality of the long term care system by focusing on achieving people's health and social outcomes

COST-EFFECTIVENESS – Create a cost-effective long term care system for the future

Managed long term care is a risk-based capitated program that strives to incorporate the consumer-centered values of Wisconsin's home and community-based programs and services in a managed care service delivery system. The target groups are elders, adults with physical disabilities and adults with developmental disabilities who have long term care needs. The State Medicaid Agency (SMA) contracts directly with prepaid inpatient health plans (PIHPs) to deliver a comprehensive long term care benefit that includes all services available in Wisconsin's fee-for-service HCB waivers plus the long term care Medicaid State Plan services, i.e., nursing facility, home health, personal care, durable medical equipment, disposable medical supplies, therapies and outpatient mental health and AODA services.

The design of the system is intended to provide incentives for the PIHPs to deliver the most effective and efficient set of services tailored to each individual member's unique needs, circumstances and preferences. The most recent independent evaluation of Family Care showed that when measured against a fee-for-service comparison group, the PIHPs have significantly reduced costs and accomplished that by preserving members' health and functioning.

The SMA monitors the contracts with PIHPs and uses an external quality review organization (EQRO) to help implement a multi-level

quality management system within the PIHPs and for managed long term care on a statewide level. Monitoring activities include: on-site annual quality reviews with each PIHP, annual care management reviews which include review of a sample of member individualized service plans, review of quarterly narrative reports submitted by the PIHP, ongoing review of grievances and appeals, review of critical incidents and other adverse events for members, and ongoing review of utilization data for each PIHP. In particular, under the direction of the SMA, the EQRO undertakes discovery activities in accordance with the SMA's quality strategy, while the SMA executes remediation and quality improvement efforts.

Family Care has succeeded in eliminating wait lists for home and community-based long term care services and supports for Medicaid eligible persons in the 57 counties where it currently (2014) operates. Family Care will expand to an additional seven counties (total 64 out of 72 counties) beginning in 2015 and, by the end of the next waiver period, will have eliminated all wait lists there as well. 2015 Wisconsin Act 55 authorized expansion of Family Care statewide. The purpose of this current amendment (2017) is to include the following counties: Adams, Dane, Florence, Forest, Oneida, Taylor and Vilas. Family Care will then be statewide. Family Care has achieved lower per person costs than the fee-for-service HCBS waiver programs it replaces. Furthermore, in 13 counties, including the two largest, Milwaukee and Dane, eligible persons may choose the Family Care Partnership Program. Partnership is a §1932a/1915c managed care model that provides one-stop, fully integrated health and long term care services, combining the Family Care long term care benefit with primary and acute health care services including all Medicaid and Medicare services. For dual eligibles, Medicare services are provided through a Medicare Advantage Fully Integrated Dual Eligible (FIDE) Special Needs Plan.

While the new HCBS rules will require some changes in services –primarily in employment and day services-these rules will only accelerate the pace of implementation of established policy directions in the Family Care Program. In other respects, since the values and design of Family Care are consistent with the final rule's emphasis on member choice and control, community integration and full participation, Family Care is already far along in complying with the new setting requirements.

The SMA believes that its practice and policy with respect to paraprofessional direct home care services provided under this waiver are aligned with the federal Fair Labor Standards Act (FLSA). It bases this judgment on the delineation of responsibilities for hiring, directing and controlling such workers specified in Appendix E for members who self-direct their home care services as common law employers. Applying written interpretative materials disseminated by the Department of Labor, such workers would be solely the employee of the member or member's appointed representative and not joint employees of the member and the PIHP or the SMA under the FLSA. As such, the waiver aligns with the FLSA. The SMA does note, however, that since under the FLSA a judgment on employer status ultimately is dependent on the unique facts of each situation, to the extent those facts may in individual cases vary from the responsibilities specified in Appendix E the result with respect to compliance might conceivably vary as well.

UNDER THIS WAIVER AMENDMENT EFFECTIVE 7/1/18, PIHPs ARE NOT AT RISK FOR SERVICES RENDERED TO INDIAN MEMBERS THAT RECEIVE CARE MANAGEMENT FROM AN INDIAN HEALTH CARE PROVIDER (IHCP).

### **3. Components of the Waiver Request**

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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

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- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

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

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

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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:
- As specified in Appendix C, adequate standards for all types of providers that provide services under this waiver;
  - 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,
  - Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in Appendix C.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in Appendix I.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in Appendix B.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in Appendix B, the individual (or, legal representative, if applicable) is:
- 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

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:  
A broad spectrum of stakeholders participated in the initial design of the Family Care program, including consumers, advocates, providers and their associations, legislators, county government and representatives of all State agencies involved in providing services to individuals with long term care needs.

In 2008, the Wisconsin Council on Long Term Care was convened by the Department of Health Services Secretary and was operated through 2012. Its mission was to advise the Department of Health Services (the SMA) on the statewide implementation of Family Care for elderly people and adults with disabilities. The Council had broad stakeholder representation and reserved time on each agenda to hear from the public on issues and concerns about the long term care system in Wisconsin.

In 2012, this council was replaced by the Wisconsin Long Term Care Advisory Council, which provides ongoing guidance to the SMA related to policies and operations of Wisconsin's long term care programs and statewide expansion of the Family Care program. The Council is comprised of individuals from multiple organizations and disciplines related to long term care, as well as consumer representatives. The Council consists of: The Laureate Group, Wisconsin Assisted Living Association, Board on Aging and Long Term Care, ContinuUs, Community Care of Central Wisconsin, ADRC of Brown County, Oneida Tribe, Alzheimer's Association of Southeastern Wisconsin, Disability Rights Wisconsin, Greater Wisconsin Agency on Aging Resources, Milwaukee County Department of Family Care, Milwaukee County Department of Health and Human Services, Eau Claire School District, Wisconsin Health Care Association, ADRC of the North, ADRC of Winnebago County, Wisconsin County Human Services Association (WCHSA), Brain Injury Alliance of Wisconsin, Independence First, WI Coalition of Independent Living Centers, LeadingAge Wisconsin, Richland County Aging and Disability Board, Milwaukee County Department of Aging, Board for People with Developmental Disabilities, Milwaukee County Commission on Aging, Advanced Employment, and consumer and member representatives. Council members serve for 3 years, on staggered terms. The Council reserves time on each agenda to hear from the public on issues and concerns about the long term care system in Wisconsin. This group of stakeholders continues to provide feedback to the SMA on a regular basis.

On July 30, 2014 the SMA hosted a special teleconference session to brief key stakeholders on the proposed changes to the Family Care Medicaid Home and Community-Based Services (HCBS) waiver and Managed Care waiver renewal applications and to share information related to the five-year transition plan to ensure compliance with the new federal HCBS waiver rule. This briefing also contained information on the public input process. Participants invited to this special teleconference session included: the Wisconsin Long Term Care Advisory Council, MCO Leadership, Tribes, residential provider associations, IRIS Advisory Committee, Governor's Council for People with Physical Disabilities, Independent Living Council, Childrens Long Term Support Council, Survival Coalition, RFW, MetaStar, and the Wisconsin County Human Services Association (WCHSA).

In addition, the SMA has a formal process for informing tribal leadership of all changes to the Medicaid state plan, including any new waiver proposals and any changes or renewals of existing waivers under 1915(b) and 1915(c). Formal tribal consultation meetings are held semiannually to brief tribal leaders on a range of activities and initiatives at the SMA.

At the mid-year tribal consultation meeting on May 14, 2014, the SMA provided the tribal leadership with information on the process for renewal of the 1915(b) and (c) Family Care waivers. In addition to the tribal consultation requirements for the public notice, the SMA meets periodically with tribal health directors, aging directors and with a group known as the Tribal Long Term Care Services Study Group. All of the meetings provide an opportunity for the SMA to brief Tribes and to get input on waiver proposals.

Tribes are notified and have the same opportunity as other stakeholders to comment on the waiver drafts posted for public comment.

Major newspapers in Wisconsin contained public notices that the Family Care waiver renewal applications and five-year transition plan to ensure compliance with the new federal HCBS waiver rule were available on the SMA's website for a 30-day public input period.

The draft Family Care waiver renewal applications and transition plan were posted for a 30-day public input period.

For public and tribal input into this amendment, effective 7/1/18, see the "optional" section.

- 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)

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

**Last Name:**

Poole

**First Name:**

Diane

**Title:**

Chief of Policy and Federal Relations

**Agency:**

DHS/Division of Medicaid Services/Bureau of Adult Long Term Care Services

**Address:**

1 W. Wilson Street, Room 527

**Address 2:**

P.O. Box 7851

**City:**

Madison

**State:**

Wisconsin

**Zip:**

53707-7851

**Phone:**

(608) 267-4896 Ext:   TTY

**Fax:**

(608) 266-5629

**E-mail:**

Diane.Poole@dhs.wisconsin.gov

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

**Last Name:**

**First Name:**

**Title:**

**Agency:**

**Address:**

**Address 2:**



City:   
 State: **Wisconsin**  
 Zip:   
 Phone:  Ext:   TTY  
 Fax:   
 E-mail:

## 8. Authorizing Signature

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This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

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**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:

Major activities include a preliminary assessment of all C waiver services, provider self-assessments with PIHP and SMA validation, provider remediation & member transitions.

Timeframes were established with the following priorities: minimize avoidable member transitions; maximize the time for providers to come into compliance; provide enough time for PIHPs and the SMA to carry out on-site provider assessments; and provide enough time for any necessary member transitions so they can be done in a planned member-centered manner.

In the preliminary assessment of compliance with setting requirements, all C waiver services are categorized to identify whether they meet setting requirements, does not meet requirements, or needs further assessment. This phase is discussed in attachment #2 describing the current implementation status. The settings the SMA contends are in compliance with the requirements are included in appendix C-5.

The SMA will develop, with stakeholder input, a provider self-assessment tool to compile baseline information on individual provider's compliance with settings requirements. The DHS designee will distribute & collect results of the survey. PIHPs will validate results via site visits on a stratified sample of provider self-assessments. The SMA will then conduct site visits on a stratified sample of PIHP validated surveys. Final results will be summarized & distributed to providers, PIHPs & stakeholders.

The plan allows sufficient time for provider remediation. Non-compliant providers wishing to come into compliance will submit a compliance plan to the PIHP for approval. These providers will have approx 17 months to implement their plan & come into compliance. PIHPs will do an on-site evaluation to assess whether the provider is in compliance. The SMA will conduct on-site reviews of a sample of PIHP compliance determinations.

The plan also allows sufficient time for member transitions. The PIHPs & SMA will know which providers do not wish to comply with setting requirements by 8/9/16 at which point, they will begin transition planning with members who are impacted. By 9/14/18, the PIHPs and SMA will know which providers will remain noncompliant and will immediately begin transition planning with any remaining members impacted. Pursuant to the DHS-MCO contract, members will receive at least a 30 day notice of the need to transition to a new service provider.

The initial draft plan was available on the DHS website for 30 days. It was modified per CMS request and resubmitted to CMS on 12/10/14 & 12/12/14. The modified plan is summarized below:

**1. Public Notice & Input: (7/30/14 - 9/2/14)**

Stakeholder Meeting – State will hold stakeholder meeting on C waiver renewal/transition plan; indicate where they can be found on State's website; and the 30 day public input process.

Website Posting - State will post renewal application and transition plan on website for 30 days for public comment.

Newspaper Notice - State will post notice of C waiver renewal and transition plan in major newspapers. Notice will indicate where C waiver renewal application and transition plan can be found on website and the 30 day public input process.

Public Comment - State will accept comments during 30 day public input period. Comments must be submitted by 9/2/14.

**2. C Waiver Renewal and Transition Plan (9/3/14 – 10/2/14)**

State Analysis of Public Comment: State will analyze public comments and revise application and transition plan based on that analysis.

Revised Transition Plan Posting - (10/1/14) State will post revised transition plan on website for public information.

Submission to CMS for Approval – (10/2/14) State will submit the C Waiver Renewal Application and HCBS Transition Plan to CMS.

### 3. Preliminary Assessment

State will conduct a state-directed preliminary assessment of existing HCB services for compliance with HCBS characteristics (Yes, No, or Needs Provider Self-Assessment Verified by MCO/State). State will consider any services provided in the waiver participant's own or family home as home and community-based. For residential settings, preliminary assessment will be based upon a cross walk of the State's existing certification and regulatory requirements vs. CMS regulations and guidance. For day and vocational settings, preliminary assessment will be based upon the language of the HCBS settings regulations and a cross walk of the State's existing regulatory requirements.

Distribute Preliminary Residential Assessment to Stakeholders for input (1/1/15 – 2/27/15)

Review of Stakeholder Input of Preliminary Residential Assessment (3/2/15- 3/31/15)

State will review stakeholder input and make adjustments as necessary.

### 4. Provider Self-Assessment/MCO & State Validation

Development – Preliminary Provider Self-Assessment Tools: State will develop a residential provider self-assessment tool to compile baseline information on individual HCBS settings compliance (8/11/14 – 11/12/14); State will develop a day and vocational provider self-assessment tool to compile baseline information on individual HCBS settings compliance (1/05/15- 1/30/15).

Distribute Preliminary Provider Self-Assessment Tools to Stakeholders: State will share preliminary residential self-assessment tool with stakeholders for input (11/26/14 – 12/26/14); State will share preliminary day and vocational self-assessment tool with stakeholders for input (1/5/15 – 1/30/15).

Review of Stakeholder Input of Preliminary Provider Self-Assessment Tools: State will review stakeholder input on residential self-assessment tool and make adjustments as necessary (1/1/15 – 1/30/15); State will review stakeholder input on day and vocational self-assessment tool and make adjustments as necessary (03/10/15 – 03/10/15)

Implementation - Provider Self-Assessments: State will implement the residential provider self-assessment tool to compile baseline information on individual HCBS settings compliance (2/9/15 – 5/11/15). State will implement the day and vocational self-assessment tool to compile baseline information on individual HCBS settings compliance (4/6/15 – 6/8/15). The DHS designee is responsible for distributing and collecting the tools.

MCO Quality Control - Provider Self-Assessments (5/25/15 -11/25/15) MCO will conduct a review on a representative sample of settings to evaluate validity of provider self-assessments. The MCO will use a stratified representative sample so that all settings types are included. MCO will report results to the State. This review will include on-site visits.

State Quality Control - Provider Self-Assessments (12/9/15 – 4/11/16) State will conduct a review on a representative sample of MCOs' quality control to evaluate validity of provider on-site surveys/self-assessments. The state will use a stratified representative sample so that all settings types are included. This review will include on-site visits.

Analysis of Provider Self-Assessments (4/25/16 – 5/25/16) Analyze the results of the on-site survey assessment (after verification) to identify specific issues and challenges that will need to be addressed through the 5-year transition period.

Distribute Analysis of Provider Self-Assessments to Providers, MCOs and Stakeholders (6/8/16)

### 5. Provider Remediation

Non-Compliant Providers Who Wish to Come Into Compliance Will Submit a Compliance Plan to MCO for Approval (6/9/16 – 8/9/16) Plan must identify action steps and dates to come into compliance for all items identified as non-compliant on the Provider-Self Assessment Analysis. Compliance Plan may not extend beyond 6/9/17.

MCO Quality Control - MCOs Evaluate Whether Non-Compliant Providers Are Now Compliant (6/10/17 – 12/31/17). MCOs will conduct on-site visits of all non-compliant providers using the Provider Self-Assessment Analysis to determine if non-compliant providers are now in compliance.

State Quality Control – Evaluation of Non-Compliant Providers (9/1/17 – 12/31/17) State will conduct on-site visits using a representative sample of MCOs' quality control to evaluate validity of remediation compliance assessments. This review will include on-site visits.

### 6. Member Transitions

Member Transitions to HCB Compliant Settings (9/9/16 – 9/30/18)

If necessary, the state will work with MCOs to ensure that members are transitioned to providers meeting HCBS setting requirements. Members will be given, at minimum, a 30 day notice pursuant to the DHS-MCO contract (however, the state anticipates being able to identify non-compliant providers early in the process and starting the relocation process as appropriate) and a choice of alternative providers through a person centered process. Transition of the members will be comprehensively tracked to successful placement and continuity of service.

MCOs and the State will know which non-compliant providers are not willing or are unable to come into compliance as of

8/9/16. Transitions for individuals in these settings will begin immediately and will be completed within one calendar year (8/9/17). Willing providers will be given the opportunity to bring their settings into compliance. Throughout the process, as soon as it is identified that a setting will be unable to timely come into compliance, members will begin to be transitioned immediately. Individuals in non-compliant settings as of 12/31/17 will be transitioned to compliant settings by 9/30/18. It is expected that individuals will be transitioned not later than 9/30/18 to compliant settings.

#### 7. Participant Survey

Participant Survey – Analysis (1/1/16 – 6/1/16) State will analyze requirements for annual MCO member survey for potential inclusion of questions regarding HCBS settings.

Participant Survey – Development & Implementation (6/2/16 – 1/1/17) State will modify and implement participant survey requirements dependent on analysis.

Participant Survey – Quality Control (1/1/17 – 3/17/19) State will monitor participant survey results to flag member experience that is not consistent with assuring control over choices and community access. State will conduct necessary follow-up with MCOs. Activity will occur annually.

#### 8. Regulations

Wisconsin Administrative Code & Statutes – analysis (10/12/14 – 12/1/14) State will analyze programmatic rules for compliance with HCBS final regulations.

State will not revise licensing regulations as they are applicable to non-waiver individuals. HCBS setting compliance will need to be at the program (contract) level.

Family Care regulations have been found to be compliant or silent on the settings requirements. No revisions are necessary and federal requirements will be reflected in the DHS-MCO contract.

#### 9. Contract

DHS-MCO Contract Revisions – Analysis (10/12/14 – 12/1/14) State will analyze current contract for compliance with new HCBS waiver regulations.

DHS-MCO Contract - Development & Implementation (1/1/15) State will amend contract to comply with new HCBS waiver regulations. The 2015 DHS-MCO Contract will incorporate new HCBS waiver regulations. MCOs that cannot immediately comply effective 1/1/15 are required to submit a compliance plan outlining steps to achieve compliance by 12/31/15.

The 2019 DHS-MCO Contract will prohibit providers/sites that have an institutional or isolating quality effective 3/17/19 (contract effective 1/1/19)

#### 10. Member Handbooks

Member Handbooks – Analysis (1/1/16 – 6/1/16) State will analyze member handbook for compliance with new HCBS waiver regulations. Member Handbooks – Development & Implementation (6/2/16 – 3/17/19) State will amend member handbook to comply with new HCBS waiver regulations. Activity will occur annually.

The State will submit an amendment to the waiver, if necessary, due to any changes to comply with the HCBS settings rule.

Due to limited space, see Optional section.

#### **Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

This is the SMA's first 1915 (c) waiver renewal required to submit a settings transition plan. Therefore, the SMA has not yet submitted a statewide HCB transition plan; the latter will follow within 120 days of this renewal submission as required by federal regulations. Since

the statewide plan has not yet been submitted, our response to this item is limited to the current status of the Family Care transition plan that is part of this waiver renewal.

For a summary of the Family Care transition plan see attachment #1 (above). The State also submitted a PDF of the Family Care Transition plan to CMS on 10/02/14. It was modified per CMS request and resubmitted to CMS on December 10, 2014. It was again modified per CMS request and resubmitted to CMS on December 12, 2014. At this point in time, the SMA is nearing completion of the preliminary assessment phase of the plan. The goal of this phase is to produce an initial assessment of compliance with setting requirements for all Family Care HCB waiver settings. To accomplish this, each setting is being evaluated as meeting the setting requirements, not meeting setting requirements, or needs further assessment. The settings the SMA contends are in compliance with the settings requirements are included and discussed in appendix C-5.

To assess residential settings, the SMA is creating a crosswalk between State licensure/certification requirements and the federal setting requirements. To assess day and vocational settings, preliminary assessment will be based upon the language of the HCBS settings regulations and a cross walk of the State's existing regulatory requirements. These crosswalks will provide the SMA with critical information on any areas of non-compliance in order to determine how to proceed in the next phase.

The SMA's draft preliminary assessments will be completed by the end of 2014. The preliminary assessment for residential settings will be released to stakeholders and finalized based on their input by the end of the first quarter of 2015.

The results of this preliminary assessment of will then provide the basis for the next phase of transition, involving provider self-assessment of compliance with setting requirements followed by MCO and State verification of those self-assessments.

The state assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in Wisconsin's approved Statewide Transition Plan. The state will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

### **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

Public and Tribal Input Process for this Amendment (effective 7/1/18):

At the DATE XXXX meeting, the SMA provided tribal leadership with information on the process for amending the 1915(b) and (c) Family Care waivers and the process for providing tribal input. In addition, the SMA has been meeting with the Tribal Long Term Care Services Study Group regarding options for tribal case management since XXXX. Tribes were also given formal written notice of the amendments and input process on XX/XX/XXXX.

Major newspapers and the Administrative Register in Wisconsin contained public notice that the Family Care waiver amendments were available on the SMA's website for a 30-day public input period.

Public comments received and SMA response for this Amendment (effective 7/1/18):

The SMA received XXXX public comments. They are summarized below:

Comment: XXXX

DHS Response: XXXXX

NOTE: Tribal comments and the SMA responses are attached separately to the waiver submission due to space limitations in the portal.

### **Appendix A: Waiver Administration and Operation**

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**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:

**Division of Medicaid Services, Long Term Care Benefits and Programs**

(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.

(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:

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

- 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.:*

Managed Care Organizations (MCOs)/PIHPs – 1) conduct level of care evaluation activities using the State’s automated long term care functional screen; 2) develop individual service plans; 3) perform prior authorization of waiver services; 4) conduct utilization management functions; 5) recruit and contract with providers; 6) execute the Medicaid provider agreement; and 7) develop and implement local QA/QI plans. Managed Care Organizations may be private or public entities.

External quality review organization (EQRO) – 1) review participant service plans to ensure waiver requirements are met; 2) assist SMA staff in conducting training and technical assistance concerning waiver requirements; 3) assist SMA staff in QA/QI monitoring of local PIHPs; 4) evaluate PIHP performance improvement projects and assist with training and technical assistance for PIHP staff responsible for performance improvement projects; 5) validate PIHP performance measures; 6) assess compliance with federal requirements related to enrollee rights, access to services, structure and operations, measurement and improvement, and grievance systems; 7) perform an Information Systems Capability Assessment of PIHPs; 8) provide technical assistance to both the SMA and the PIHPs with regard to quality management activities and responsibilities, such as assisting in the development of indicators of member health and well-being; 9) administer or validate consumer or provider surveys of quality of care, including collaborating with the SMA in developing and testing new quality-discovery methods.

In addition, the EQRO receives and logs complaints made directly to the SMA, through the operation of the Family Care hotline and receipt of notices of appeals made to State administrative hearings officers. They gather information about the complaints, mediate, and refer complainants to advocacy representatives or SMA staff.

Family Care Ombudsman Program: 1) provides information and education on consumer rights; 2) investigates complaints; 3) attempts resolution of complaints through informal strategies (negotiation and mediation, support of consumer self-advocacy and work with internal advocates); 4) assists members in filing complaints and appeals; 5) assists members in filing for administrative hearings; 6) provides individual case advocacy in administrative hearings and legal representation for administrative and judicial proceedings; and 7) identifies patterns of member issues and ADRC or MCO non-compliance issues

Ageing and Disability Resource Centers (ADRCs) are public entities that 1) provide information and assistance; 2) provide preadmission pre-enrollment counseling; 3) conduct level of care evaluation activities using the SMA's automated long term care functional screen; 4) coordinate other program eligibility activities on behalf of the SMA, and 5) carry out prevention activities.

- 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

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- 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:*

- 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

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- 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:

DHS Division of Medicaid Services, Long Term Care Benefits and Programs

## Appendix A: Waiver Administration and Operation

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- 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:

Methods used by the SMA to assess the performance vary by each type of agency and are described below.

PIHPs - The primary agencies performing waiver operational and administrative entities are Prepaid In-patient Health Plans (PIHPs). The SMA closely monitors the performance of the PIHPs through various means.

1. The SMA has an extensive PIHP contract that identifies federal and state requirements including requirements that address each

of the 1915(c) waiver assurances. The contract contains requirements regarding: 1) PIHP administration of the level of care tool; 2) care planning requirements including, but not limited to, assessment, the member-centered plan, the service authorization process, the training plan, the self-directed supports options and the member rights requirements (including appeals and grievances), 3) provider management requirements, including verification of provider licensure and/or certification, assurance that providers are not barred from providing Medicaid services, and background check requirements, 4) monitoring of member health and safety including report and investigation of member incidents and compliance with restrictive measures policies; and 5) financial accountability. The contract maintains the administrative authority and responsibility of the SMA over the Family Care program. The contract provides the vehicle for implementing many system improvements. SMA oversight teams and content experts monitor compliance with the contract through review of policies and procedures, review of regular reports, and investigation of complaints. The contract is reviewed and updated annually.

2. The SMA is required by Wisconsin State statute to certify PIHPs annually. State statute forbids the SMA from contracting with a PIHP that has not been certified and requires the SMA to recertify PIHPs annually. During the initial and annual certification process, a number of compliance areas are reviewed. In 2014, the following areas were reviewed by SMA oversight teams before certification was granted: Provider network and capacity, marketing plan and materials, member handbook, contract template, 24 Hour on call, comprehensive member assessments, member centered plan policy and procedure and template, service authorization policy, care management training plan, safety and risk policy, restrictive measures policy, prevention and wellness policy, self-directed supports policy, notice of action procedures, quality management plan and activities, functional screen quality, cost share, claims adjudication/provider appeals, financial reporting, incurred but not reported (IBNR), investment policy, managing capitation and enrollment discrepancies, and encounter reporting and claims system. A site readiness visit, using an SMA designed review tool, is completed by the SMA oversight team prior to issuance of initial certification. Certification criteria are reviewed and modified, where appropriate, on an annual basis.

3. The SMA has an oversight team for each PIHP that is supervised by a SMA manager and consists of a contract coordinator, representatives of the fiscal team and one or more member care quality specialists. SMA content experts support oversight team members across PIHPs as needed. This team monitors ongoing operations of the PIHP through review of regular reports. Member incident reports are reviewed and responded to on an ongoing basis as they are submitted. This team also reviews other report information, including grievances and appeals and member incident reports that are received and reviewed continually, encounter data reports, financial report, EQRO annual report, the PIHP's audited year-end financial report and other reports that are required by contract. This team can initiate immediate remedial action and impose corrective action plans to address any issues discovered. The team monitors the plans and then documents that remediation has occurred. SMA oversight teams hold regular meetings with PIHP managers to discuss a range of issues including care management and provider issues and program changes, expectations, and clarifications to the PIHP. SMA oversight teams communicate issues to SMA leadership.

The SMA oversight teams provide technical assistance and monitoring of PIHP activities; provide support and recommendations for resolving issues including relocations of members from institutions and care for members with complex behaviors; respond to and investigate complaints about care plans, services, poor quality, abuse, and discrimination; track member issues in the SMA's tracking system and close entries when the issues are resolved. When significant changes are needed, the SMA managers, working with the oversight teams, require PIHPs to create and implement remediation plans to make needed changes and the SMA oversight teams verify and document compliance with those plans. SMA Oversight team review of PIHP performance is ongoing. The SMA oversight teams review regular reports and follow up on those reports as needed.

4. The SMA contracts with an External Quality Review Organization (EQRO) to conduct independent quality reviews of PIHP processes and outcomes including the service plan and qualified provider quality assurances. EQRO activities occur annually unless specified below.

a. The EQRO conducts a comprehensive on-site Annual Quality Review (AQR) at each PIHP to validate PIHP compliance with federal Medicaid managed care regulations and contract components including waiver requirements. As part of this process, the EQRO completes a care management file review focusing on how individual members' needs are being met. In 2014, the EQRO reviewed 14 standards regarding member assessments and care plans to ascertain if they are comprehensive, timely, and responsive to member changes.

b. The EQRO conducts an Information Systems Capability Assessment at least once every three years, and more frequently if needed, such as when a PIHP replaces a claims-processing system. The EQRO may also review data integrity of encounter reporting by PIHPs as directed by the SMA.

c. The EQRO conducts performance measure validation annually and as needed and conducts focused studies as directed by the SMA.

d. Recommendations for improvement may be identified as a result of EQRO review activities. If recommendations for improvement are identified, the SMA oversight team reviews those recommendations, identifies priorities, and monitors PIHP progress.

e. When issues that require mandatory remediation are identified, the SMA will require a remediation plan. The PIHP provides status information to the SMA oversight team, while the SMA oversight team gives the feedback to the PIHP on this progress.



f. The SMA reviews quality trends identified by the EQRO with internal managers and staff, with PIHPs and with the EQRO itself. Trends requiring action are prioritized by the SMA.

5. SMA managers meet regularly with PIHP leadership; these meetings are used to identify and prioritize issues including systems-improvement opportunities.

6. The SMA has a hotline (currently staffed by the EQRO under contract to the SMA) through which Family Care members can report their concerns, including requesting a review by the SMA. Hotline staff also investigate all appeals made to the State Division of Hearings and Appeals.

7. The SMA's Office of Inspector General (OIG) monitors and audits providers that participate in the Medicaid program and responds to and investigates complaints of fraud and abuse. If complaints of this nature would arise regarding a PIHP, the OIG would respond.

8. Other performance issues may also be reported by agencies that provide independent ombudsman services for Family Care members, advisory groups and other consumer advocacy organizations.

ADRCs - Primary functions of the Aging and Disability Resource Centers (ADRCs) in administering this waiver, include: dissemination of information regarding the waiver to potential enrollees; reviewing options counseling materials annually; assisting individuals in waiver enrollment; monitoring enrollment processes on an ongoing basis; reviewing grievances and appeals quarterly; and conducting level of care evaluation activities.

ADRCs operate under a contract with the SMA. They submit regular reports to the SMA regarding information and assistance functions and monthly expenditures. ADRCs also submit quarterly narrative reports. On-site reviews are conducted annually by oversight staff from the Office of Resource Center Development in the SMA.

In addition, SMA staff conduct quality reviews of level of care evaluations conducted using the automated Long-Term Care Functional Screen on an ongoing basis and provide feedback and remediation to ADRC and PIHP screening staff. All certified screeners are required to participate in a biennial continuing skills testing process.

EQRO - The External Quality Review Organization is selected through a competitive process conducted every five years, but operates under a biennial contract that is renewed at the discretion of the SMA. The EQRO must meet federal requirements for an EQRO under 42 CFR 438.354. SMA oversight of the EQRO includes standard contract oversight, as well as programmatic oversight, to ensure that reviews are conducted consistent with priorities established by the SMA. SMA staff review sampling criteria, determine review criteria to be used by the EQRO, review and provide input into criteria for identifying trends, review all reports produced by the EQRO, meet regularly with the EQRO and review contract requirements on at least an annual basis. The performance of the EQRO is measured by: 1) the level and quality of assistance and support provided to SMA staff in quality monitoring activities; 2) the quality of regular monitoring reports and an annual EQRO report; 3) performance of optional EQRO activities; and 4) compliance with the EQRO contract.

## Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program		

Function	Medicaid Agency	Contracted Entity
	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## 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:**

All PIHPs providing Family Care have achieved certification to contract with the SMA to offer the Family Care benefit. Numerator: The number and percent of PIHPs that achieve certification to contract with the SMA to offer the Family Care benefit. Denominator: The number of PIHPs that contract with the SMA to offer the Family Care benefit.

**Data Source** (Select one):

**Financial records (including expenditures)**

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

	Specify: <input type="text"/>	
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**Data Source** (Select one):

**Financial audits**

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

**Data Source** (Select one):

**Presentation of policies or procedures**

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

	<input style="width: 90%;" type="text"/>
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**Data Source** (Select one):

**Reports to State Medicaid Agency on delegated Administrative functions**

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

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**PIHP provider directories**

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

	<input style="width: 90%;" 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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

The SMA reviews the findings of each PIHP’s annual quality review and orders corrective action for any finding determined to require remediation. Numerator: Percentage of PIHPs needing corrective action for which the SMA requires corrective actions. Denominator: Percentage of all PIHPs that have findings determined to require remediation.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**EQRO reports**

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>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%; height: 20px;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	

**Data Source (Select one):**

**Provider performance monitoring**

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

**Performance Measure:**

PIHPs implement corrective actions as required by the SMA. Numerator: Number of corrective actions implemented within timeframe determined by SMA. Denominator: Number of corrective actions required by SMA.

Data Source (Select one):

**Provider performance monitoring**

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> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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. In addition, provide information on the methods used by the State to document these items.

In general, SMA oversight teams direct the correction of individual problems. The SMA oversight team assigned to each PIHP discovers problems and issues through: reports from the EQRO related to individual member concerns; Family Care Ombudsman program reports; review of grievances and appeals; review of member incident reports; review of requests for use of isolation, seclusion and restrictive measures; discovery of problems or issues when giving a PIHP policy clarification, complaints to the SMA and from other sources. The team also interacts with PIHP staff on a regular basis and may identify concerns through such communication and direct observation. As needed, the SMA oversight team directs remediation of individual member concerns, as well as isolated operational concerns. The SMA oversight team also uses information gathered through direct interaction with the PIHP and from many available sources to identify and direct remediation of systemic problems or issues within the PIHP. SMA oversight teams have the ability to respond quickly to any issue that affects member health or safety identified through routine discovery activities, but also respond quickly to other issues as

they are identified.

Each SMA oversight team documents issues and concerns and any resolution or remediation in a tracking system maintained by the SMA. An issue cannot be cleared in the tracking system without approval of the SMA supervisor of the oversight team. The SMA has also developed policies and procedures for the EQRO and SMA oversight teams to report concerns that rise to a level where they require the immediate attention of the SMA.

**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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 Administrative Authority that are currently non-operational.

- No
- Yes

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

**Appendix B: Participant Access and Eligibility**

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input checked="" type="checkbox"/> Aged or Disabled, or Both - General					
	<input checked="" type="checkbox"/>	Aged	65		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Disabled (Physical)	18	64	
	<input checked="" type="checkbox"/>	Disabled (Other)	18	64	
<input type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input checked="" type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>



Target Group	Included	Target SubGroup	Minimum Age		Maximum Age	
					Maximum Age Limit	No Maximum Age Limit
	<input checked="" type="checkbox"/>	Developmental Disability	18			<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/>	Intellectual Disability	18			<input checked="" type="checkbox"/>
<input type="checkbox"/> Mental Illness						
	<input type="checkbox"/>	Mental Illness				
	<input type="checkbox"/>	Serious Emotional Disturbance				

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

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:

Individuals who have physical disabilities who reach the age of 65 while participating in this waiver are considered to be part of the Aged target group. No other change occurs for the member.

## 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	52532
Year 2	55072
Year 3	57216
Year 4	61954
Year 5	64266

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

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

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

Table: B-3-b

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

**Appendix B: Participant Access and Eligibility**

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

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

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

**Appendix B: Participant Access and Eligibility**

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

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

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

- e. **Allocation of Waiver Capacity.**

*Select one:*

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

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

County service areas covered under this Waiver for more than 3 years are at full entitlement for all eligible individuals.

When Family Care expands into new counties, the Aging and Disability Resource Centers are responsible for managing waiver capacity by managing the wait list for enrollment during the initial three year transition period. One thirty-sixth of the number of people waiting at the time Family Care starts in a service area are allowed to enroll in each of the first 36 months. After 36 months, all eligible individuals must be enrolled without waiting. At that point, there is no longer a role for Aging and Disability Resource Centers in managing waiver capacity.

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

All persons who have a nursing home level of care who enroll in the CMS-approved companion s. 1915 (b) waiver or s. 1932(a) SPA are entitled to entrance into this waiver.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

a.

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

- §1634 State
- SSI Criteria State
- 209(b) State

- 2. Miller Trust State.**

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

- No
- Yes

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

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

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

*Select one:*

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

Specify percentage:

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

- Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
- Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
- Medically needy in 209(b) States (42 CFR §435.330)
- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)

Specify:

- Other caretaker relatives specified in 42 CFR 435.110
- Pregnant women specified in 42 CFR 435.116
- Children specified in 42 CFR 435.118
- All other mandatory and optional groups under the state plan are included.

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*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*

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- 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 spenddown 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 are aged or 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 Family Care PIHPs 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.

## 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 five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.*

- Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses spousal post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

- Use spousal post-eligibility rules under §1924 of the Act.**  
*(Complete Item B-5-b (SSI State) and Item B-5-d)*
- Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**  
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*
- Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**  
*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

- The following standard included under the State plan**

*Select one:*

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

*(select one):*

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

- A percentage of the FBR, which is less than 300%**

Specify the percentage:

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

Specify dollar amount:

- A percentage of the Federal poverty level**

Specify percentage:

- Other standard included under the State Plan**

*Specify:*

- The following dollar amount**

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

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

*Specify:*

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

In FFS waivers, Medicaid pays the actual cost of the s.1915 (c) services a member receives. In a managed care program, Medicaid pays the portion of the capitation rate that is paid to the PIHP for s.1915 (c) services. Therefore, in a managed care program it is appropriate to apply cost sharing (PETI) to the portion of the capitation rate that is paid to the PIHP for s.1915 (c) services since that is what Medicaid pays for an individual regardless of the cost of services they receive. Wisconsin has developed a method to ensure that cost sharing (PETI) applies only to the cost of home and community-based s.1915 (c) waiver services in the capitation payment that a PIHP receives. The cost of other Medicaid services in the capitation rate are carved out when calculating the costs to which an individual's cost share (PETI) is applied. The method used is to determine the statewide historical average cost of s.1915 (c) waiver services (annually trended for inflation). This amount also represents the person's maximum cost share (PETI) after all applicable exclusions or deductions from countable income.

- Other**

*Specify:*

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

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

*Specify:*

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

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

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

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

*Specify:*

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

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

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

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

*Specify:*

- Other**

*Specify:*

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

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

Select one:

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

*Specify:*

**Appendix B: Participant Access and Eligibility**

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

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

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

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



## Appendix B: Participant Access and Eligibility

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

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

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

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

##### 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, 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 in-come 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. In a managed care program, Medicaid pays the portion of the capitation rate that is paid to the PIHP for s.1915 (c) services. Therefore, in a managed care program it is appropriate to apply cost sharing (PETI) to the portion of the capitation rate that is paid to the PIHP for s.1915 (c) services since that is what Medicaid pays for an individual regardless of the cost of services they receive. Wisconsin has developed a method to ensure that cost sharing (PETI) applies only to the cost of home and community-based s.1915 (c) waiver services in the capitation payment that a PIHP receives. The cost of other Medicaid services in the capitation rate are carved out when calculating the costs to which an individual's cost share (PETI) is applied. The method used is to determine the statewide historical average cost of s.1915 (c) waiver services (annually trended for inflation). This amount also represents the person's maximum cost share (PETI) after all applicable exclusions or deductions from countable income.

- 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:

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

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

Select one:

- Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- The State does not establish reasonable limits.**
- The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## Appendix B: Participant Access and Eligibility

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

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

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

**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

## 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:*

**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:*

Level of care assessments for new enrollees are conducted by Aging and Disability Resource Centers using the State Medicaid Agency's automated long term care functional screen. This is a tool that calculates level of care based on objective information collected and entered by a qualified and trained screener. The tool includes automated edits that cross check for screener error or manipulation. The State Medicaid Agency conducts extensive quality assurance monitoring of the use of the functional screen. Reevaluations of level of care are performed by PIHPs.

- 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:

Initial evaluation of level of care is performed by registered nurses licensed in Wisconsin, social workers certified in Wisconsin or persons with a four year bachelor's degree in the social services area and specialized knowledge of managed long term care target populations. Individuals permitted to perform level of care evaluation are certified as screeners after passing an online course and tests of their knowledge of instructions and criteria for level of care determination. The State Medicaid Agency also requires each screener to pass a periodic test of continuing knowledge and skills. Electronic records of the results of these tests are maintained by the State Medicaid Agency.

Records of each screener's educational and experience credentials are created and maintained by the ADRCs and PIHPs. In addition, the State Medicaid Agency collects information regarding education and experience at the time each potential screener applies to take the online screener instructions training course and tests.

**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 criteria for Nursing Facility level of care are the same as the criteria for Medicaid reimbursement of nursing facility care in Wisconsin. The specific nursing home levels of care are intensive skilled nursing, skilled nursing facility and intermediate care facility 1 and 2. The level of care criteria for the ICF/IID level of care is the same as the criteria for Medicaid reimbursement for ICF/IID facility care in Wisconsin. The level of care tool used is the Wisconsin long term care functional screen (LTCFS).

**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.

The long term care functional screen (LTCFS) is an automated tool developed by the State Medicaid Agency to determine the appropriate nursing facility level of care for waiver applicants. The functional screen was developed with State Medicaid Agency registered nurses who evaluate Physician Plans of Care to determine Medicaid eligibility for nursing home residents. It has been evaluated by the State Medicaid Agency and determined to be valid, reliable and to result in comparable level of care.

- 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:

Information used in level of care assessments for new enrollees is gathered by certified screeners at Aging and Disability Resource Centers during a face-to-face meeting with the applicant using the State Medicaid Agency's automated long term care functional screen. When assessment information is entered into the secure, online functional screen tool, the tool returns a level of care for the individual. Information for annual reevaluations of level of care is gathered during face-to-face meetings between a certified screener at the PIHP and the enrolled program member.

The same tool is used to reevaluate level of care.

- 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:*

Every 365 days.

- 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*):

Annual reevaluation of level of care is a component part of case management. Each PIHP uses an internal tracking system to ensure that a certified screener uses the LTCFS tool to reevaluate level of care at least every 365 days.

The level of care result of the annual functional screen is sent automatically from the functional screen computer system (FSIA) to the Medicaid eligibility system (CARES). The economic support worker who recertifies Medicaid eligibility annually cannot do so unless there is a current (within the last 365 days) level of care result.

- 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:

All functional screens are maintained electronically by the SMA central office in its automated long term care functional screen computer system (FSIA). Each PIHP has electronic access to all active and historical level of care evaluations for each member that it currently has enrolled.

## 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:**

All applicants enrolled in a PIHP have a valid Family Care level of care based on an evaluation using the Long Term Care Functional Screen. Numerator: New enrollees during waiver year who do not have a completed Long Term Care Functional Screen that indicates a valid Family Care level of care. Denominator: All new enrollees during waiver year.

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

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

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

- 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:**

**PIHPs remediate level of care evaluation errors within 90 days of notification of error by SMA. Numerator: Number of level of care evaluation errors remediated by PIHP within 90 days of notification by SMA. Denominator: Number of level of care evaluation errors identified by SMA.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**SMA Administrative Data**

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

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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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. Typical reasons for errors in level of care evaluation include misinterpretation of the written level of care instructions that are provided by the SMA to the evaluator and human error in keying selections in the online level of care application (FSIA).

The SMA uses a combination of LOC data generated by the online level of care application (FSIA) and evidence gathered during direct audit of the evaluator’s level of care records to identify errors. Under contracts between the SMA and level of care evaluators, evaluators are required to remediate all errors identified by the SMA during quality assurance audits. The SMA verifies that 100% remediation has occurred prior to providing the reviewer with written approval of remediation.

**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. In addition, provide information on the methods used by the State to document these items.  
When the SMA discovers a delayed level of care determination, the SMA directs the PIHP to conduct an immediate reevaluation of level of care. Completion of the reevaluation is verified by the SMA. For each questionable or incorrect screen, the SMA screen-quality staff contacts the ADRC or PIHP to ascertain the correct facts and to direct correction of the screen. Correction is verified via observation of the corrected screen in the level of care system (FSIA). The SMA maintains a record of individual level of care remediation.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party(check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>

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

## Appendix B: Participant Access and Eligibility

### B-7: Freedom of Choice

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

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

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

The Aging and Disability Resource Center (ADRC) offers a functional screen to each individual who may have a need for long term care services. For Indians, the Tribal Aging and Disability Resource Specialist (TADRS) offers the functional screen when the tribe has opted to provide this service to its members, the TADRS is certified to provide the screen, and the tribal member opts to have this service provided by the TADRS rather than the ADRC.

The functional screen process must include a face-to-face interview with the individual and/or his/her legal representative. The screener must inform the individual or her/his legal representative of available long term care options, including nursing facility services and home and community-based waiver services, and determine whether the potential enrollee wants to apply for managed long term care.

The ADRC or TADRS under the conditions described above, is responsible to inform the potential enrollee and/or her/his legal representative about the available service and enrollment options, including managed long term care (Family Care or Family Care Partnership), institutional services, fee-for-service Medicaid card and self-directed supports waiver (IRIS) services. If the individual is an Indian, the ADRC or TADRS informs the potential enrollee and/or her/his legal representative of 1) the option to choose between an Indian Health Care Provider (IHCP)(if available) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either the IHCP (if available) or PIHP network providers. The ADRC or TADRS also provides information about other options available to individuals, including the SSI Managed Care Program where available.

If the individual chooses Family Care, the preferred enrollment date is identified. This information is documented on an enrollment form signed by the enrollee or her/his legal representative. Copies of the signed enrollment form are provided to the enrollee and the PIHP, by the ADRC or TADRS, which is responsible for facilitating the enrollment process.

A copy of the enrollment form is maintained by the ADRC or TADRS. The form documents that the individual has been informed prior to enrollment of the options to 1) use fee-for-service Medicaid State Plan services including institutional or community-based



services, or 2) use self-directed supports waiver services, or 3) enroll in the PIHP to receive those options or home and community-based waiver services.

In addition, once enrolled in managed long term care, the plan of care used by each PIHP includes a statement that informs the individual of the options for nursing facility services, self-directed supports waiver services, home and community-based waiver services, IHCP services available to Indians, and the availability of options counseling regarding these services at the ADRC or TADRS. An individual can request nursing facility services as part of individualized member-centered care planning process in the PIHP, or may disenroll at any time and seek admission and Medicaid reimbursement for nursing facility care or seek self-directed supports waiver services.

- 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.

Copies of Medicaid developed and owned enrollment forms are maintained by the Aging and Disability Resource Center(ADRC), or Tribal Aging and Disability Resource Specialist (TADRS). The ADRC which is responsible for conducting level of care assessment evaluations and for facilitating the eligibility determination and enrollment processes. For Indians, a TADRS is responsible for conducting level of care assessment evaluations and for facilitating the eligibility determination and enrollment processes when the tribe has opted to provide these service to its members, the TADRS is certified to provide the level of care assessment, and when the individual choses to seek these services from the TADRS rather than the ADRC. Copies of individualized member-centered care plans are maintained by the PIHP.

## 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):

Aging and Disability Resource Centers and Tribal Aging and Disability Resource Specialists (TADRS) are required to have enrollment and other materials related to managed long term care, including an SMA-developed brochure and the PIHP member handbook, available in the prevalent foreign languages spoken in Wisconsin – Hmong, Russian and Spanish, and are required to obtain interpreters or telephonic interpretation services when needed by an applicant.

PIHPs are required to provide written information to members in the prevalent languages (5% of the population in the PIHP’s service area), and are required to obtain interpreters or telephonic interpretation services when needed by members to participate fully in care planning and to benefit fully from the receipt of services. PIHPs shall use professional interpreters when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as an interpreter is inappropriate.

## 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 Care Services
Statutory Service	Care Management
Statutory Service	Daily Living Skills Training
Statutory Service	Day Habilitation Services
Statutory Service	Prevocational Services
Statutory Service	Respite
Statutory Service	Supported Employment - Individual Employment Support
Supports for Participant Direction	Consumer Directed Supports (Self-Directed Supports) Broker
Supports for Participant Direction	Financial Management Services
Other Service	Adaptive aids
Other Service	Adult residential care - 1-2 bed adult family homes
Other Service	Adult Residential Care - 3-4 Bed Adult Family Homes
Other Service	Adult Residential Care - Community-Based Residential Facilities (CBRF)
Other Service	Adult Residential Care - Residential Care Apartment Complexes (RCAC)
Other Service	Assistive Technology/Communication aids
Other Service	Consultative Clinical and Therapeutic Services for Caregivers
Other Service	Consumer Education and Training
Other Service	Counseling and Therapeutic Resources

Service Type	Service
Other Service	Environmental Accessibility Adaptations (Home Modifications)
Other Service	Home Delivered Meals
Other Service	Housing Counseling
Other Service	Personal Emergency Response Systems (PERS)
Other Service	Relocation services
Other Service	Self-Directed Personal Care
Other Service	Skilled Nursing Services RN/LPN
Other Service	Specialized Medical Equipment and Supplies
Other Service	Supported Employment - Small Group Employment Support
Other Service	Supportive Home Care
Other Service	Training Services for Unpaid Caregivers
Other Service	Transportation (Specialized Transportation) - Community Transportation
Other Service	Transportation (Specialized Transportation) - Other Transportation
Other Service	Vocational Futures Planning and Support

## 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:**

**Service:**

**Alternate Service Title (if any):**

Adult Day Care Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Adult day care services are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision and/or protection. Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site. Transportation between the member's place of residence and the adult day care center may be provided as a component part of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care services. Meals provided as part of adult day care may not constitute a "full nutritional regimen" (3 meals per day).

**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 or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult day center services/treatment

### Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Adult Day Care Services**

**Provider Category:**

Agency

**Provider Type:**

Adult day center services/treatment

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Stats. Chapter 49.45

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

### 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):**

Care Management

**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:

**Service Definition (Scope):**

Care management services (sometimes called support and service coordination) are provided by an interdisciplinary care management team (IDT). The member is the center of the IDT. The IDT consists of, at minimum, a registered nurse and a social services coordinator, and may also include other professionals as appropriate to the needs of the member, as well as family or other informal supports requested by the member. The IDT initiates and oversees the initial comprehensive assessment of needs and reassessment process, the results of which are used in developing the individual’s member-centered plan of care. The IDT identifies the member’s preferred outcomes and the services needed to achieve those outcomes and monitors the member’s health and welfare, the delivery of services, and progress in achieving identified outcomes. The IDT also carries out activities that help members and their families to identify other service needs and gain access to medical, social, rehabilitation, vocational, educational and other services identified.

Care management is always provided by individuals employed by the managed care organization or by a sub-contract agency of the managed care organization. In addition, care management can be provided to Indian members by an Indian Health Care Provider (IHCP) under Provision 5006(d) of the American Recovery and Reinvestment Act of 2009. With the exception of IHCPs, providers of home and community based services, or those who have an interest in or are employed by a provider of home and community based services, cannot provide care management or develop the member centered plan. When the only willing and qualified entity to provide care management and/or develop member centered plans in a geographic area also provides home and community based services, the SMA may consider granting a waiver of this prohibition following specific, prior approval from CMS. Care management services are provided by the case manager with the member and other participants of the interdisciplinary team and include:

- A comprehensive assessment of the member’s strengths, abilities, functional limitations, lifestyle, personal circumstances, values, preferences and choices.
- Development of an individualized plan of care.
- Authorization for the purchase of paid services identified in the plan of care.
- Monitoring of the delivery of and quality of the paid services identified in the plan of care.
- Monitoring of the member’s circumstances and ongoing health and well-being.
- Maintenance of a member record and all documentation associated with the delivery of services and any required waiver procedures.

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

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	PIHP or contracted Registered Nurse
Agency	PIHP Social Services Coordinator
Agency	Indian Health Care Provider
Agency	PIHP or contracted Social Worker

**Appendix C: Participant Services**


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

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**Service Type: Statutory Service**  
**Service Name: Care Management**

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**Provider Category:**Agency **Provider Type:**

PIHP or contracted Registered Nurse

**Provider Qualifications****License (specify):**

PIHP RN - Wis. Stats. Chapter 441 (exception is nurses working for IHS/638 facilities do not need to be licensed in the state in which they are working BUT they do need to be licensed in a state.)

**Certificate (specify):**


**Other Standard (specify):**


**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

### Appendix C: Participant Services

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

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**Service Type: Statutory Service**  
**Service Name: Care Management**

---

**Provider Category:**Agency **Provider Type:**

PIHP Social Services Coordinator

**Provider Qualifications****License (specify):**


**Certificate (specify):**

Four year bachelor's degree in social services area (e.g. social work, rehabilitation, psychology, etc.) and knowledge of the conditions of LTC target populations.

**Other Standard (specify):**


**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

### Appendix C: Participant Services

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

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**Service Type: Statutory Service**  
**Service Name: Care Management**

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**Provider Category:**Agency **Provider Type:**

Indian Health Care Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Indian Health Care Provider as defined by the American Recovery and Reinvestment Act of 2009

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency (SMA)

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Care Management**

**Provider Category:**

**Provider Type:**

PIHP or contracted Social Worker

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Stats. Chapter 457

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**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:**

**Service:**

**Alternate Service Title (if any):**

Daily Living Skills Training

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

08 Home-Based Services  08010 home-based habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Daily living skills training is the provision of education and skill development to teach members the skills involved in performing activities of daily living, including skills intended to increase the member's independence and participation in community life; May include teaching money management, home care maintenance, food preparation, mobility training, self-care skills and the skills necessary for accessing and using community resources. Daily living skills training may involve training the member or the natural support person to assist the member.

**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 or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Daily living skills training agency
Individual	Daily living skills trainer

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Daily Living Skills Training**

**Provider Category:**

Agency

**Provider Type:**

Daily living skills training agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing this service, day habilitation, supportive home care, personal care, home health

care, skilled nursing, supported employment or similar services.

If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Daily Living Skills Training**

**Provider Category:**

Individual ▾

**Provider Type:**

Daily living skills trainer

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The PHIP shall assure that the provider has the ability and qualifications to provide this service, including a minimum of two years of experience working with the target population in providing this service, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PHIP and member must ensure that the individual provider receives member-specific training sufficient to enable the individual to competently provide the daily living skills training services to the member consistent with the care plan. If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## 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:**

Habilitation ▾

**Alternate Service Title (if any):**

Day Habilitation Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**



04 Day Services 04020 day habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Day habilitation services are the provision of regularly scheduled activities in a non-residential setting, separate from the member’s private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and full community citizenship. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice.

Day habilitation services focus on enabling the member to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the member’s person-centered services and support plan, such as physical, occupational, or speech therapy. For members with degenerative conditions, day habilitation activities may include training and supports to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Day habilitation services may also be used to provide retirement activities. As some members get older they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities.

Day habilitation may be furnished in a variety of settings in the community except for the member’s residence. Day habilitation services are not limited to fixed-site facilities but may take place in stores, restaurants, libraries, parks, recreational facilities, community centers or any other place in the community.

Transportation may be provided between a member’s place of residence and the site of day habilitation activities or between habilitation activities sites (in cases where the member receives habilitation services in more than one place) as a component part of day habilitation activities. Meals provided as part of these services shall not constitute a “full nutritional regimen” (3 meals per day). Personal care/assistance may be a component part of day habilitation services as necessary to meet the need of members, but may not comprise the entirety of the service. Members who receive day habilitation services may also receive educational, supported employment and prevocational services. Day habilitation may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).

**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 or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult day center services/treatment

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**  
**Service Name: Day Habilitation Services**

**Provider Category:**

Agency

**Provider Type:**

Adult day center services/treatment

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Admin. Code DHS 61.41 and DHS 61.75

**Other Standard (specify):**

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including 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.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## 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):**

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04010 prevocational services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Prevocational services are designed to create a path to integrated community based employment 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. Prevocational services involve the provision of

learning and work experiences where a member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time as determined by the member and his/her care planning team in the ongoing member-centered planning process. Services are expected to specifically involve strategies that enhance a member's employability in integrated, community settings.

Prevocational services should enable each member to attain the highest possible wage and work which is in the most integrated setting and matched to the member's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Prevocational services may be delivered in a variety of locations in the community and are not limited to fixed-site facilities. Some examples of community sites may be the library, job center, banks, or any business.

Prevocational services, regardless of how and where they are delivered, are expected to help people make reasonable and continued progress toward participation in at least part-time, integrated employment. Prevocational services are not considered outcomes in and of themselves. Competitive employment and supported employment are considered successful outcomes of prevocational services.

Prevocational services may be provided to supplement, but may not duplicate services provided as part of an approved Individualized Plan for Employment (IPE) funded under the Rehabilitation Act of 1973, as amended, or under an approved Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA).

The contracted provider of pre-vocational services must complete a six month progress report and service plan document for the IDT. The purpose is to ensure and document that prevocational services are assisting the member in progressing toward a goal of at least part-time, integrated employment. Timely completion of this document is required for the IDT to consider reauthorization of prevocational services.

Participation in prevocational services is not a pre-requisite for individual or small group supported employment services provided under the waiver. Members who receive prevocational services may also receive educational, supported employment and/or day services. A member's care plan may include two or more types of non-residential services. However, different types of non-residential services may not be billed for the same period of time.

Members participating in prevocational services shall be compensated in accordance with applicable Federal and State laws and regulations, if those laws require compensation. The optimal outcome of the provision of prevocational services is permanent integrated employment at or above the minimum wage in the community.

Transportation may be provided between the member's place of residence and the site of the prevocational services or between prevocational service sites (in cases where the member receives prevocational services in more than one place) either as a component part of prevocational services or under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met. If the transportation is provided by the prevocational services provider, the cost of this transportation is included in the rate paid to the provider.

Personal care provided to a member during the receipt of prevocational services may be included in the reimbursement paid to the prevocational services provider, or may be covered and reimbursed under another waiver service so long as there is no duplication of payment.

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

Prevocational services may be provided to supplement, but may not duplicate services provided under supported employment or vocational futures planning and support services provided under the waiver.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

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

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

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Prevocational Services

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service**

**Service Type: Statutory Service**  
**Service Name: Prevocational Services**

**Provider Category:**

Agency

**Provider Type:**

Prevocational Services

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The PHIP shall assure the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable experience for a qualified entity, including a minimum of two years of experience working with the target population providing employment-related services that have a goal of integrated employment in the community at minimum wage or above.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**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:**

09012 respite, in-home

**Category 2:**

09 Caregiver Support

**Sub-Category 2:**

09011 respite, out-of-home

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Respite care services are services provided for a member on a short-term basis to ease the member’s family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in an institution such as a certified Medicaid setting (hospital, nursing home) or other licensed facility. Respite care may also be provided in a residential facility such as a certified or licensed adult family home, licensed community-based residential facility, certified residential care apartment complex, in the member’s own home or the home of a respite care provider.

**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 or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supportive home care agency
Individual	Individual respite provider
Agency	1-2 bed adult family home, residential care apartment complex (RCAC)
Agency	Personal care agency
Agency	Hospital, nursing home, community-based residential facility, 3-4 bed adult family home.

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Supportive home care agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**  
Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Respite**

**Provider Category:**

Individual ▾

**Provider Type:**

Individual respite provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Respite**

**Provider Category:**

Agency ▾

**Provider Type:**

1-2 bed adult family home, residential care apartment complex (RCAC)

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Certified 1-2 bed adult family home - WI Medicaid Waiver Standards and Wis. Admin. Code DHS 82 for Barrett Homes; residential care apartment complex (RCAC)- Wis. Admin. Code DHS 89

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**  
**Service Name: Respite**

**Provider Category:**Agency **Provider Type:**

Personal care agency

**Provider Qualifications****License (specify):****Certificate (specify):**

Wis. Admin. Code DHS 105.17

**Other Standard (specify):**

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite****Provider Category:**Agency **Provider Type:**

Hospital, nursing home, community-based residential facility, 3-4 bed adult family home.

**Provider Qualifications****License (specify):**

References are to Wisconsin Administrative Code chapters:

Hospital - DHS 124

Nursing home - DHS 132 and 134

Community-based residential facility - DHS 83

3-4 bed adult family home - DHS 88

**Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**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):**

Supported Employment - Individual Employment Support

**HCBS Taxonomy:****Category 1:**

03 Supported Employment ▼

**Sub-Category 1:**

03021 ongoing supported employment, individual ▼

**Category 2:**

03 Supported Employment ▼

**Sub-Category 2:**

03010 job development ▼

**Category 3:**

▼

**Sub-Category 3:**

▼

**Category 4:**

▼

**Sub-Category 4:**

▼

**Service Definition (Scope):**

Supported employment-Individual employment support services are the on-going supports provided to members who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive, customized, or self-employment in an integrated work setting in the general workforce. A member receiving this service shall be 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. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

Individual employment support services are individualized and may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, job supports, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. Also included are other workplace support services not specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Individual employment supports may include support to maintain self-employment, including home-based self-employment. Individual employment supports may also include services and supports that assist the member in achieving self-employment; however, Medicaid funds may not be used to defray the expenses associated with starting or operating a business. Assistance for self-employment may include: (a) aid to the member in identifying potential business opportunities; (b) assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the member to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched.

Individual employment support does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business. Individual employment support services may be provided by a co-worker or other job site personnel provided that the services are not part of the normal duties of the co-worker, supervisor, or other personnel and these individuals meet the qualifications established below for individual providers of this service. Employers may be reimbursed for supported employment services provided by co-workers.

Supported employment services do not include vocational services provided in facility based work settings or other types of vocational services furnished in specialized facilities that are not part of general community work places. Supported employment services may not include volunteer work.

Members receiving individual employment supports may also receive educational, pre-vocational, and/or day services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded under the section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

Coverage does not include incentive payments, subsidies or unrelated vocational training expenses such as the following:

1. Incentive payment made to an employer to encourage or subsidize the employer's participation in supported employment; or



2. Wages or other payments that are passed through to users of supported employment services.

Payment for individual employment support services may be based on different methods including but not limited to co-worker support models, payments for work milestones, such as length of time on the job, or number of hours the member works.

The cost of transportation for a member 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 specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider, or may be reimbursed under the waiver service supportive home care or self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

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

When personal care/assistance or transportation or both are a component of this service, payment may not be made for such assistance or transport under another waiver service for the same period of time.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Supported Employment - Individual Employment Support**

**Provider Category:**

Agency

**Provider Type:**

Supported employment agency

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

The PIHP shall assure that the provider has 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) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Supported Employment - Individual Employment Support**

**Provider Category:**

Individual ▾

**Provider Type:**

On the job support person

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Holding the Certified Employment Support Professional accreditation.
- Meeting the ASPE Quality Indicators for Supported Employment Personnel.
- Comparable experience for a qualified individual, including a minimum of two years of experience working with the target population providing supported employment. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PHIP and member shall ensure that the individual provider has the member –specific competencies to effectively provide the service.

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## 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:**

Other Supports for Participant Direction ▾

**Alternate Service Title (if any):**

Consumer Directed Supports (Self-Directed Supports) Broker

**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:**

▼

**Service Definition (Scope):**

A support broker is an individual who assists a member in planning, securing and directing self-directed supports. The services of a support broker are paid for from the member’s self-directed supports budget authority. Support brokers are subject to criminal background checks and must be independent of any other waiver service provider. A support broker shall be knowledgeable of the local service delivery system and local community-integrated services and resources available to the member. A support broker shall also be knowledgeable of the typical kinds of needs of persons in the member’s target group. The member and interdisciplinary team staff are responsible to assure that a support broker selected by the member has the appropriate knowledge. (See Appendix E for more information.)

**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 or through the Medicaid State Plan.

Excludes the cost of any direct services authorized and obtained by a consumer through an SDS plan, which is paid for and reported under the appropriate service definition.

Excludes the cost of fiscal agent services, which is paid for and reported as financial management services.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Support broker agency
Individual	Individual support broker

**Appendix C: Participant Services**

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

**Service Type: Supports for Participant Direction**

**Service Name: Consumer Directed Supports (Self-Directed Supports) Broker**

**Provider Category:**

Agency ▼

**Provider Type:**

Support broker agency

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Knowledge of the unique needs/preferences of the participant and the service system

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Supports for Participant Direction****Service Name: Consumer Directed Supports (Self-Directed Supports) Broker****Provider Category:**Individual **Provider Type:**

Individual support broker

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Knowledge of the unique needs/preferences of the participant and the service system

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**Supports for Participant Direction 

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

**Support for Participant Direction:**Financial Management Services **Alternate Service Title (if any):****HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction ▼

**Sub-Category 1:**

12010 financial management services in support of self-directi

**Category 2:**

▼

**Sub-Category 2:**

▼

**Category 3:**

▼

**Sub-Category 3:**

▼

**Category 4:**

▼

**Sub-Category 4:**

▼

**Service Definition (Scope):**

Financial management services are services to assist members and their families to manage service dollars or manage their personal finances to prevent institutionalization. This service includes a person or agency paying service providers after the member, guardian or other authorized representative authorizes payment to be made for services included in the member’s approved self-directed supports plan. Financial management services providers, sometimes referred to as fiscal intermediaries or fiscal agents, are organizations or individuals that write checks to pay bills for personnel costs, tax withholding, worker’s compensation, health insurance and other taxes and benefits appropriate for the specific provider consistent with the individual’s self-directed supports plan and budget for services. Financial management services are purchased directly by the MCO and made available to the member/family to insure that appropriate compensation is paid to providers of services. Also includes the provision of assistance to members who are unable to manage their own personal funds to assist them to manage their personal resources. This service includes assistance to the participant to effectively budget the participant’s personal funds to ensure sufficient resources are available for housing, board and other essential costs. This service includes paying bills authorized by the participant or their guardian, keeping an account of disbursements and assisting the member to ensure that sufficient funds are available for needs.

**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.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Financial management agency
Individual	Financial management assistant

**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:**

Financial management agency

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

PIHP contract standards for fiscal intermediaries and co-employment agencies. A PIHP must have standards in place that ensure at minimum that a financial management services provider: 1) is an agency, unit of an agency or individual that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include self-directed supports; 2) has training and experience in accounting or bookkeeping; and 3) has a system in place that recognizes the authorization of payment by the participant or legal representative, that promptly issues payment as authorized and that documents budget authority and summarizes payments in a manner that can be readily understood by the participant or legal representative.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**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:**

Financial management assistant

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

PIHP contract standards for fiscal intermediaries and co-employment agencies. A managed care organization must have standards in place that ensure at minimum that a financial management services provider: 1) is an agency, unit of an agency or individual that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include self-directed supports; 2) has training and experience in accounting or bookkeeping; and 3) has a system in place that recognizes the authorization of payment by the participant or legal representative, that promptly issues payment as authorized and that documents budget authority and summarizes payments in a manner that can be readily understood by the participant or legal representative.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services****C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Adaptive aids

**HCBS Taxonomy:**

**Category 1:**

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:**

**Service Definition (Scope):**

Adaptive aids are controls or appliances that enable members to increase their abilities to perform activities of daily living or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services and material benefits that enable members to access, participate and function in their community. These include the purchase of vehicle modifications (such as van lifts, hand controls, equipment modifications etc. that allow the vehicle to be used by the member to access the community), or those costs associated with the maintenance of these items. The service may also include the initial purchase of a service dog and routine veterinary costs for a service dog.

**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 or through the Medicaid State Plan.

Excludes food and non-routine veterinary care for service dogs based on DHS guidelines.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adaptive aids vendors

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Adaptive aids

**Provider Category:**

Agency

**Provider Type:**

Adaptive aids vendors

**Provider Qualifications****License (specify):**

**Certificate (specify):**

Medicaid certified provider

**Other Standard (specify):**

UL or FCC standards for electronic devices. Reputable provider with experience providing and training service dogs.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

**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:**

Adult residential care - 1-2 bed adult family homes

**HCBS Taxonomy:****Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Adult family homes of 1-2 beds are places in which the operator provides care, treatment, support, or services above the level of room and board to up to two adults. Services typically include supportive home care, personal care and supervision. Services may also include transportation and recreational/social activities, behavior and social supports, daily living skills training and transportation if provided by the operator or designee of the operator. Includes homes which are the primary domicile of the operator or homes which are controlled and operated by a third party that hires staff to provide support and services.

Adult family home services also include coordination with other services received by the participant and providers, including health care services, vocational or day services. Services may also include the provision of other waiver services as specified in the individual contract between the PIHP and residential provider.

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



Waiver funds are not used to pay for the cost of room and board.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Adult family home sponsor

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Adult residential care - 1-2 bed adult family homes

**Provider Category:**

Individual ▾

**Provider Type:**

Adult family home sponsor

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

WI Medicaid Waiver Standards for Certified 1-2 Bed AFH and Wis. Admin. Code DHS 82 for Barrett Homes.

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## 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 Residential Care - 3-4 Bed Adult Family Homes

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services ▼

**Sub-Category 1:**

02011 group living, residential habilitation ▼

**Category 2:**

02 Round-the-Clock Services ▼

**Sub-Category 2:**

02013 group living, other ▼

**Category 3:**

02 Round-the-Clock Services ▼

**Sub-Category 3:**

02021 shared living, residential habilitation ▼

**Category 4:**

02 Round-the-Clock Services ▼

**Sub-Category 4:**

02023 shared living, other ▼

**Service Definition (Scope):**

Adult family homes of 3-4 beds are licensed under DHS 88 of the Wisconsin Administrative code and are places where 3-4 adults who are not related to the licensee reside, receive care, treatment or services above the level of room and board, and may include up to seven hours per week of nursing care per resident. Services typically include supportive home care, personal care and supervision. Other services provided may include behavior and social supports, daily living skills training and transportation performed by the operator or designee of the operator. This service type also includes homes of 3-4 beds, specified under s. 50.01 (1)(a) of the Wisconsin Statutes, which are licensed as a foster home under s. 48.62 of the Wisconsin Statutes and certified by a certifying agency as defined under DHS 82 of the Wisconsin Administrative Code. The latter are owner-occupied homes for persons with intellectual disabilities who are aging out of foster care. This category of homes permits such persons to remain in the same home, promoting continuity of care.

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

Waiver funds are not used to pay for the cost of room and board.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed adult family home

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adult Residential Care - 3-4 Bed Adult Family Homes**

**Provider Category:**

Agency ▼

**Provider Type:**

Licensed adult family home

**Provider Qualifications**

**License (specify):**

Wis. Admin. Code DHS 88

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**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 Residential Care - Community-Based Residential Facilities (CBRF)

**HCBS Taxonomy:****Category 1:**02 Round-the-Clock Services **Sub-Category 1:**02011 group living, residential habilitation **Category 2:**02 Round-the-Clock Services **Sub-Category 2:**02013 group living, other **Category 3:**02 Round-the-Clock Services **Sub-Category 3:**02012 group living, mental health services **Category 4:****Sub-Category 4:****Service Definition (Scope):**

A community-based residential facility (CBRF) is a place where 5 or more adults, and in cases of persons with an intellectual disability up to 8 adults, who are not related to the operator or administrator reside and receive care, treatment, support, supervision and training. Services may include supportive home care, personal care, supervision, behavior and social supports, daily living skills training, transportation and up to three hours per week of nursing care per resident.

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

Waiver funds are not used to pay for the cost of room and board.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed CBRF

**Appendix C: Participant Services**

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

**Service Type:** Other Service

**Service Name:** Adult Residential Care - Community-Based Residential Facilities (CBRF)

**Provider Category:**

Agency

**Provider Type:**

Licensed CBRF

**Provider Qualifications**

**License (specify):**

Wis. Admin. Code DHS 83

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**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 Residential Care - Residential Care Apartment Complexes (RCAC)

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02033 in-home round-the-clock services, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

▼

▼

**Service Definition** *(Scope):*

Residential care apartment complexes (RCAC) are services provided in a homelike, community-based setting where 5 or more adults reside in their own living units that are separate and distinct from each other. Persons who reside in the facility also receive the following services: supportive services (e.g., laundry, house cleaning), personal assistance (e.g., personal care), nursing services (e.g., wound care, medication management), and assistance in the event of an emergency (e.g., PERS and response).

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

Waiver funds are not used to pay for the cost of room and board.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified RCAC

## Appendix C: Participant Services

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

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**Service Type:** Other Service

**Service Name:** Adult Residential Care - Residential Care Apartment Complexes (RCAC)

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**Provider Category:**

Agency ▼

**Provider Type:**

Certified RCAC

**Provider Qualifications**

**License** *(specify):*

▲  
▼

**Certificate** *(specify):*

Wis. Admin. Code DHS 89

**Other Standard** *(specify):*

▲  
▼

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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### 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/Communication aids

**HCBS Taxonomy:****Category 1:**

14 Equipment, Technology, and Modifications ▼

**Sub-Category 1:**

14031 equipment and technology ▼

**Category 2:**

17 Other Services ▼

**Sub-Category 2:**

17020 interpreter ▼

**Category 3:**

▼

**Sub-Category 3:**

▼

**Category 4:**

▼

**Sub-Category 4:**

▼

**Service Definition (Scope):**

Assistive technology means an item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain or improve functional capabilities of members at home, work and in the community. Assistive technology service means a service that directly assists a member in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:

- (A) the evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the member in the customary environment of the member;
- (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for members;
- (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 with assistive technology devices, such as therapies, intervention, or services, associated with other services in the service plan;
- (E) training or technical assistance for the member, or where appropriate, the family members, guardians, advocates or authorized representatives of the member; and
- (F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of members.

Assistive Technology includes communication aids that are devices or services needed to assist members with hearing, speech, communication or vision impairments. These items or services assist the individual to effectively communicate with service providers, family, friends and the general public; decrease reliance on paid staff; increase personal safety; enhance independence; and improve social and emotional well-being.

Communication aids include any device that addresses these objectives such as augmentative and alternative communication systems, hearing or speech amplification devices, aids and assistive devices, interpreters, and cognitive retraining aids and the repair and/or servicing of such systems. Communication aids also include electronic technology such as tablets or mobile devices and related software that assist with communication, when the use provides assistance to a person who needs such assistance due to her/her disabilities. Applications for mobile devices or other technology also are covered under this service, when the use is primarily medical in nature or provides assistance to a person who needs such assistance due to her/her disabilities. This list is intended to be illustrative and is not exhaustive.

**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 or through the Medicaid State Plan.

Excludes interpreter services that are otherwise available, including for communication with the managed care organization, its contractors or other health care professionals, which are required to provide interpreter services as part of their rate.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual interpreters
Agency	Communications aids vendors

### Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Assistive Technology/Communication aids

Provider Category:

Individual ▾

Provider Type:

Individual interpreters

Provider Qualifications

License (specify):

Certificate (specify):

State or national registry

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

### Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Assistive Technology/Communication aids

Provider Category:

Agency ▾

Provider Type:

Communications aids vendors

Provider Qualifications

License (specify):

Certificate (specify):

Medicaid certified providers

Other Standard (specify):

UL or FCC standards for electronic devices

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of authorization/purchase

## 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:**

Consultative Clinical and Therapeutic Services for Caregivers

**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:**

10090 other mental health and behavioral services ▼

**Category 3:**

11 Other Health and Therapeutic Services ▼

**Sub-Category 3:**

11030 medication assessment and/or management ▼

**Category 4:**

▼

**Sub-Category 4:**

▼

**Service Definition (Scope):**

The purpose of consultative services is to improve the ability of unpaid caregivers and paid direct support staff to carry out therapeutic interventions.

Clinical and therapeutic services assist unpaid caregivers and/or paid support staff in carrying out the member's treatment/support plans, are not covered by the Medicaid State Plan and are necessary to improve the member's independence and inclusion in their community.

The service includes assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans, and monitoring of the member and the caregiver/staff in the implementation of the plans.

This service includes the provision of training for caregivers/staff that are or will be serving members with complex needs (beyond routine care). For example, when an individual with complex needs is relocating from one of the State Centers for the Intellectually Disabled, this service could be used to train caregivers/staff on the behavioral support plans necessary for community integration.

This service may also include consultation with service providers and potential providers to identify providers that can meet the unique needs of the member and to identify additional supports necessary for caregivers to perform therapeutic interventions.

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

Excludes training in member self-advocacy or caregiver advocacy on behalf of a member, which are covered under consumer education and training.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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



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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Counseling agencies
Individual	Individual counselors

### Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Consultative Clinical and Therapeutic Services for Caregivers

Provider Category:

Agency

Provider Type:

Counseling agencies

Provider Qualifications

License (specify):

Certificate (specify):

Wis. Admin. Code DHS 61.35

Other Standard (specify):

Employing or contracting with professionals with current state licensure or certification in their field of practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At the time of authorization/purchase.

### Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Consultative Clinical and Therapeutic Services for Caregivers

Provider Category:

Individual

Provider Type:

Individual counselors

Provider Qualifications

License (specify):

Professionals with current state licensure in their field of practice

Certificate (specify):

Professionals with current state certification in their field of practice

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of authorization/purchase

## 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:**

Consumer Education and 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:**

▼

**Service Definition (Scope):**

Consumer education and training services are designed to help a person with a disability develop self-advocacy skills, support self-determination, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services; includes education and training for members, their caregivers and/or legal representatives that is directly related to building or acquiring such skills. Managed care organizations assure that information about educational and/or training opportunities is available to members and their caregivers and legal representatives. Covered expenses may include enrollment fees, books and other educational materials and transportation related to participation in training courses, conferences and other similar events.

**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 or through the Medicaid State Plan.

Excludes educationally related services available under Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq) or other relevant funding sources.

Excludes education/training costs exceeding \$2500 per participant annually.

Excludes payment for hotel and meal expenses while members or their legal representatives attend allowable training/education events.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative

Legal Guardian

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
Agency	Education and training agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Consumer Education and Training**

**Provider Category:**

Agency

**Provider Type:**

Education and training agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Competent and qualified providers of consumer education and training that have expertise in problem solving, self-advocacy skills development, self-determination, community integration, financial management and decision-making.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

**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 Resources

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11040 nutrition consultation

**Category 2:**

11 Other Health and Therapeutic Services

**Sub-Category 2:**

11020 health assessment

**Category 3:**

**Sub-Category 3:**

11 Other Health and Therapeutic Services    11030 medication assessment and/or management

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Counseling and therapeutic services is the provision of professional, treatment-oriented services to address a member’s identified needs for personal, social, physical, medical, behavioral, emotional, cognitive, mental or substance abuse disorders.

Counseling and therapeutic services may include assistance in adjusting to aging and/or disabilities including understanding capabilities and limitations. Services may also include assistance with interpersonal relationships, recreational therapies, music therapy, art therapy, nutritional counseling, medical counseling, weight counseling and grief counseling.

Counseling and therapeutic services must meet clearly defined outcomes, be proven effective for the member’s condition or outcome and be cost effective. Any alternative therapies and treatments must meet DHS requirements.

**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 or through the Medicaid State Plan.

Excludes inpatient services, services provided by a physician, and services covered by the Medicare program (except for payment of any Medicare cost share).

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Counseling agencies
Individual	Individual counselors

**Appendix C: Participant Services**

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

**Service Type:** Other Service

**Service Name:** Counseling and Therapeutic Resources

**Provider Category:**

Agency

**Provider Type:**

Counseling agencies

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Admin.Code DHS 61.35

**Other Standard (specify):**

Employing or contracting with professionals with current state licensure or certification in their field of practice

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Counseling and Therapeutic Resources

**Provider Category:**

Individual

**Provider Type:**

Individual counselors

**Provider Qualifications**

**License (specify):**

Professionals with current state licensure in their field of practice

**Certificate (specify):**

Professionals with current state certification in their field of practice

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

**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:**

Environmental Accessibility Adaptations (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:**

**Service Definition (Scope):**

Home modifications are the provision of services and items to assess the need for, arrange for and provide modifications and or improvements to a member's living quarters in order to provide accessibility or increase safety. Modifications may provide for safe access to and within the home, reduce the risk of injury, facilitate independence and self-reliance, allow the individual

to perform more ADLs or IADLs with less assistance and decrease reliance on paid staff. Home modifications may include materials and services such as ramps; stair lifts, wheelchair lifts or other mechanical devices to lift persons with impaired mobility from one vertical level to another; kitchen/bathroom modifications; specialized accessibility/safety adaptations; voice-activated, light-activated, motion-activated and electronic devices that increase the member's self-reliance and capacity to function independently. Home modifications may include modifications that add to the square footage of the residence if the modifications are to assure the health, safety or independence of the person and prevents institutionalization and the modification is the most cost effective means of meeting the accessibility or safety need compared to other more expensive options.

**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 or through the Medicaid State Plan.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual carpenters
Agency	Contractor

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations (Home Modifications)**

**Provider Category:**

Individual ▾

**Provider Type:**

Individual carpenters

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

In accordance with local and/or state housing and building codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At the time of authorization/purchase.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations (Home Modifications)**

**Provider Category:**

Agency ▾

**Provider Type:**

Contractor

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

In accordance with local and/or state housing and building codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase.

**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:**

Home Delivered Meals

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition** *(Scope):*

Home delivered meals are meals provided to recipients who are unable to prepare or obtain nourishing meals without assistance, including those who may be unable to manage a special diet recommended by their physician. Home-delivered meal costs may include the costs associated with the purchase and planning of food, nutrition services, supplies, equipment, labor and transportation to deliver one or two meals a day.

Home delivered meals may not constitute a "full nutritional regimen" (3 meals per day).

This service does not include payment for meals at federally subsidized nutrition sites.

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

Home delivered meals may not constitute a "full nutritional regimen" (3 meals per day).

This service does not include payment for meals at federally subsidized nutrition sites.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Restaurants
Agency	Hospitals or nursing homes
Agency	Aging network agencies

### Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Home Delivered Meals

**Provider Category:**

Agency

**Provider Type:**

Restaurants

**Provider Qualifications**

**License** *(specify):*

Wis. Admin. Code DHS 196

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

### Appendix C: Participant Services

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

**Service Type:** Other Service  
**Service Name:** Home Delivered Meals

**Provider Category:**

Agency

**Provider Type:**

Hospitals or nursing homes

**Provider Qualifications**

**License** *(specify):*

Wis. Admin. Code DHS 124, DHS 132 and DHS 134

**Certificate** *(specify):*

**Other Standard** *(specify):*



**Verification of Provider Qualifications**  
**Entity Responsible for Verification:**  
 PIHP  
**Frequency of Verification:**  
 Annually

**Appendix C: Participant Services**

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

**Service Type: Other Service**  
**Service Name: Home Delivered Meals**

**Provider Category:**

Agency

**Provider Type:**

Aging network agencies

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Stats. Chapter 46.82 (3)

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**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 Counseling

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17030 housing consultation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Housing counseling is a service which provides assistance to a recipient when acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of the housing counseling is to promote consumer choice and control of housing and access to housing that is affordable and promotes community inclusion. Housing counseling includes exploring both home ownership and rental options, and both individual and shared housing situations, including situations where the individual lives with his or her family. Services include counseling and assistance in identifying housing options, identifying financial resources and determining affordability, identifying preferences of location and type of housing, identifying accessibility and modification needs, locating available housing, identifying and assisting in access to financing, explaining the rights and responsibilities of a tenant with disabilities, including how to ask for reasonable accommodations and modifications and how to file a complaint, and planning for ongoing management and maintenance. Housing counseling is not a one-time service and may be accessed by a member at any time. A qualified provider must be an agency or unit of an agency that provides housing counseling to people who need assistance with housing as a regular part of its mission or activities. Counseling must be provided by staff with specialized training and experience in housing issues.

**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 or through the Medicaid State Plan.

Waiver funds may not be used to purchase this service if it is otherwise provided free to the general public.

This service may not be provided by an agency that also provides residential support services or support/service coordination to the member.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Housing counseling agency

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Housing Counseling

**Provider Category:**

**Provider Type:**

Housing counseling agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Providers must have expertise in housing issues relevant to the participant and may not be a provider of residential support services to the participant.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

**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 Systems (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:**

**Service Definition (Scope):**

Personal emergency response system (PERS) is a service that provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate response and assistance in the event of a physical, emotional or environmental emergency. This service may include devices and services necessary for operation of PERS when otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as 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 or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	PERS Vendors

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Personal Emergency Response Systems (PERS)

**Provider Category:**

Individual ▼

**Provider Type:**

PERS Vendors

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

UL Standards for electronic devices or FCC regulations for telephonic devices

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

### 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:**

**Service Definition (Scope):**

Relocation services are services and essential items needed to establish a community living arrangement for persons who are relocating from an institution or who are moving from a family home to establish an independent living arrangement. This service includes person-specific services, supports or goods that will be put in place in preparation for the member's relocation to a safe, accessible, affordable community living arrangement. Services or items covered by this service may not be

purchased more than 180 days prior to the date the participant relocates to the new community living arrangement. Relocation services may include the purchase of necessary furniture, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings and kitchen appliances not otherwise included in a rental arrangement if applicable. Relocations services may include the payment of a security deposit, utility connection costs and telephone installation charges. This service includes payment for moving the member’s 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:**

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Relocation services exclude home modifications necessary to address safety and accessibility in the person’s living arrangement, which may be provided as the waiver service home modifications. Excludes housekeeping services provided after occupancy which are considered the waiver service supportive home care.

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.)

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual movers/individual landlords
Agency	Moving companies, public utilities, real estate agencies, vendors of home furnishings

**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 contractors

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

**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 companies

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

**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:**

Self-Directed Personal Care

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Self-directed personal care services are activities to assist a member with activities of daily living, instrumental activities of daily living and housekeeping services directly related to the care of the person to maintain the member in his or her place of

residence and to assist the member to access the community. Services may include the following:

1. Assistance with activities of daily living (ADLs): bathing; getting in and out of bed; oral, hair and skin care excluding skilled wound care; help with toileting; simple transfers; assistance with mobility and ambulation; assistance with eating; and assistance with dressing and undressing.
2. Assistance with instrumental activities of daily living (IADLs): managing medications and treatments normally self-administered, care of eyeglasses and hearing aids, meal preparation and serving, bill paying and other aspects of money management, using the telephone or other forms of communication, arranging and using transportation, and physical assistance to function at a job site.
3. Housekeeping services related to the care of the person: cleaning in essential areas of the home used when assisting with ADLs and IADLs, laundry of the member's clothes and bedding and changing of bedding, and shopping for the member's food.
4. Accompanying and assisting the member to access the community for medical care, employment, recreation, shopping and other purposes, as long as the provision of assistance with ADLs and IADLs is required during such trips.
5. Medically-oriented tasks delegated by a registered nurse pursuant to an agreement between the member and the interdisciplinary care team staff.

Services are provided by either an individual or agency selected by the member, pursuant to a physician's order (a state law requirement) and following a member-centered plan developed jointly by the member and interdisciplinary care team (IDT) staff including a registered nurse. The plan shall specify delegated nursing tasks, if any. The member may use as a provider any individual who passes a background check including a legally responsible relative who qualifies under Appendix C-2 d & e of this waiver, or an agency or individual that is not barred from participating in the Medicaid or Medicare program. The member-centered plan, including self-directed personal care and all other services received, is reviewed by the member and care team staff at least every six months or more often as needed. Visits by the consulting RN, who may be a member of the IDT or other nurse consultant, to the member's residence will occur at least once a year unless the member and RN agree on a more frequent visits or the RN determines that delegated nursing tasks need to be reviewed more often. The member and care team staff will determine any training needed by selected providers and how it will be obtained. The member shall be the common law employer of individual providers; if the member selects an agency, the member shall be a managing, co-employer of the worker and the agency shall hire any worker referred by the member who passes the background check and is, or can become competent in required tasks. Services may be provided both in the member's residence and outside the residence in other community settings.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days where there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment, or if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

#### Medically- Related

- Hospitalization
- Nursing home or ICF-I/ID admission
- Receipt of medical or rehabilitative care entailing at least an overnight absence
- Participation in a therapeutic rehabilitative program as defined in DHS 101.03(175)

There shall be no yearly limit on the number of medically-related episodes for which retainer payments may be made.

#### Non-Medically Related

- Planned vacation entailing at least an overnight absence and unaccompanied by the worker
- Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence
- Obtaining education, employment, or job, habilitative or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence
- Recreational activities unaccompanied by the worker entailing at least an overnight absence

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

PIHPs shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

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

Members must have budget authority over an allocation of waiver funding through the Self-Directed Services option to receive personal care through this service and must function themselves or through a representative as either the common law employer of an individual worker or the managing, co-employer of an agency-provided worker. Members without budget authority who are authorized by the MCO to receive personal care services would receive them through the State Plan personal care benefit instead.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Member-employed individual worker
Agency	Agency-employed, member-directed workers

### Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Self-Directed Personal Care

Provider Category:

Individual

Provider Type:

Member-employed individual worker

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

### Appendix C: Participant Services

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

Service Type: Other Service  
 Service Name: Self-Directed Personal Care

Provider Category:

Agency

Provider Type:

Agency-employed, member-directed workers

Provider Qualifications

License (specify):

Certificate (specify):

Wis. Admin. Code DHS 105.17

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP



**Frequency of Verification:**

Annually

**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:**

Skilled Nursing Services RN/LPN

**HCBS Taxonomy:****Category 1:**

05 Nursing ▼

**Sub-Category 1:**

05020 skilled nursing ▼

**Category 2:**

05 Nursing ▼

**Sub-Category 2:**

05010 private duty nursing ▼

**Category 3:**

▼

**Sub-Category 3:**

▼

**Category 4:**

▼

**Sub-Category 4:**

▼

**Service Definition (Scope):**

Skilled nursing is the “professional nursing” as defined in Wisconsin’s Nurse Practice Act. Wis. Stats, Chapter 441. Nursing services are those medically necessary, skilled nursing services that may only be provided safely and effectively by an advanced practice nurse, a registered nurse, or a licensed practical nurse working under the supervision of a registered nurse. The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act, consistent with the Member Centered Plan, authorized by the PIHP and are not otherwise available to the member under the Medicaid state plan or for members enrolled in Medicare, services available through the federal Medicare program. However, the lack of coverage under the State plan benefit or through Medicare does not preclude coverage of skilled nursing as a waiver service if services are within the scope of the Wisconsin Nurse Practice Act.

Under the Wisconsin Nurse Practice Act, professional nursing includes any of the following:

Professional skilled nursing means the observation or care of the ill, injured, or infirm, or for the maintenance of health or prevention of illness that requires substantial nursing skill, knowledge, or training, or application of nursing principles based on biological, physical, and social sciences. Professional skilled nursing includes any of the following:

- (a) The observation and recording of symptoms and reactions;
- (b) The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, podiatrist licensed under Wis. Stats. ch. 448, dentist licensed under Wis. Stats. ch. 447, or optometrist licensed under Wis. Stats. ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry, or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state.
- (c) The execution of general nursing procedures and techniques.
- (d) The supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants in accordance with Wis. Stats 441.

Nursing services may include periodic assessment of the member’s medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services

provided by non-professional care providers. Services may also include regular, ongoing monitoring of a member’s fragile or complex medical condition as well as the monitoring of a member with a history of non-adherence with medication or other medical treatment needs.

Delegation of nursing tasks to less skilled personnel shall be in accordance with Wis. Stats. Ch. 441 and Wis. Admin. Code Ch. N.6. and the Guidelines for Registered Nurse Delegation to Unlicensed Assistive personnel (Wisconsin Nurses Association).

These services are provided when nursing services identified as needed in a plan of care and furnished under the approved State plan limits are exhausted or when the nursing services are not covered under the Medicaid State Plan. For members enrolled in Medicare, excludes services available through the Medicare program except for payment of Medicare cost share. **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 or through the Medicaid State Plan.

For members enrolled in Medicare, excludes services available through the Medicare program except for payment of Medicare cost share.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual RN or LPN
Agency	Agency-directed registered nurse/LPN

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Skilled Nursing Services RN/LPN

**Provider Category:**

Individual ▾

**Provider Type:**

Individual RN or LPN

**Provider Qualifications**

**License** (specify):

Wis. Stats. Chapter 441

**Certificate** (specify):

**Other Standard** (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Skilled Nursing Services RN/LPN

**Provider Category:**

Agency

**Provider Type:**

Agency-directed registered nurse/LPN

**Provider Qualifications**

**License (specify):**

Wis. Stats. Chapter 441

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**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 Equipment and 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:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Specialized medical equipment, items, devices and supplies are those items necessary to maintain the participant's health, manage a medical or physical condition, improve functioning or enhance independence. Items or devices provided must be of

direct medical or remedial benefit to the participant. Allowable items, devices or supplies may include: incontinence supplies; wound dressings; IV or life support equipment; orthotics; enteral nutrition products and associated supplies and equipment not covered under the Medicaid state plan but needed for the member to obtain adequate nutrition; 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; and prescribed Vitamin D, a prescribed multivitamin and prescribed calcium supplements. (The Department of Health Services may add other prescribed vitamins or nutritional supplements in the future based on clear and convincing evidence substantiating their safety and effectiveness in maintaining health or treating or managing a medical condition.) Additionally, allowable items may include books and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, humidifiers and water treatment systems may be allowable when needed to support a participant’s health and safety outcomes.

**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 or through the Medicaid State Plan.

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 has been denied.

Excludes items considered as and regulated by the federal Food and Drug Administration (FDA) as nutritional supplements unless specifically covered under this definition or under the Medicaid state plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Authorized DME Vendors or Licensed Pharmacy
Agency	Other merchants

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Specialized Medical Equipment and Supplies

**Provider Category:**

Agency

**Provider Type:**

Authorized DME Vendors or Licensed Pharmacy

**Provider Qualifications**

**License** (specify):

Wis. Admin Code DHS 105.40 or Wis. Stats. Chapter 450

**Certificate** (specify):

**Other Standard** (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

**Appendix C: Participant Services**

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

**Service Type:** Other Service  
**Service Name:** Specialized Medical Equipment and Supplies

**Provider Category:**

Agency

**Provider Type:**

Other merchants

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Reputable merchant

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PHIP

**Frequency of Verification:**

At time of authorization/purchase

### 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:**

Supported Employment - Small Group Employment Support

**HCBS Taxonomy:**

**Category 1:**

03 Supported Employment

**Sub-Category 1:**

03022 ongoing supported employment, group

**Category 2:**

03 Supported Employment

**Sub-Category 2:**

03010 job development

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

**Service Definition (Scope):**

Supported employment - Small group employment support services are services and training activities provided in a regular business, industry or community setting for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small group employment support must be provided in a manner that promotes integration into the workplace and

integration between members and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experiences leading to further career development and individual integrated community-based employment for which a member 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.

Small group employment support services may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. Also included are other workplace support services not specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Small group employment support does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business. Small group employment support services may be provided 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 supported employment services provided by co-workers.

Supported employment services do not include vocational services provided in facility based work settings or other types of vocational services furnished in specialized facilities that are not part of general community work places. Supported employment services may not include volunteer work.

Members receiving small group employment support 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.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded under the section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

Coverage does not include incentive payments, subsidies or unrelated vocational training expenses such as the following:

1. Incentive payment made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Wages or other payments that are passed through to users of supported employment services.

The cost of transportation for a member to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider, or may be covered and reimbursed under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider, or may be reimbursed under the waiver service supportive home care or self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

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

When personal care/assistance or transportation or both are a component of supported employment services, payment may not be made for such assistance or transport under another waiver service for the same period of time.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Employment Agency

Provider Category	Provider Type Title
Individual	On the job support person

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Employment - Small Group Employment Support**

**Provider Category:**

Agency

**Provider Type:**

Supported Employment Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The PIHP shall assure that the provider has 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) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Employment - Small Group Employment Support**

**Provider Category:**

Individual

**Provider Type:**

On the job support person

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Holding the Certified Employment Support Professional accreditation.

- Meeting the ASPE Quality Indicators for Supported Employment Personnel.
- Comparable experience for a qualified individual, including a minimum of two years of experience working with the target population providing supported employment. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PHIP and member shall ensure that the individual provider has the member –specific competencies to effectively provide the service.

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## 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:**

Supportive Home Care

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services ▼

**Sub-Category 1:**

08030 personal care ▼

**Category 2:**

08 Home-Based Services ▼

**Sub-Category 2:**

08040 companion ▼

**Category 3:**

08 Home-Based Services ▼

**Sub-Category 3:**

08050 homemaker ▼

**Category 4:**

08 Home-Based Services ▼

**Sub-Category 4:**

08060 chore ▼

**Service Definition (Scope):**

Supportive home care is the provision of services to directly assist people with daily living activities and personal needs and to assure adequate functioning and safety in their home and community. Services include:

1. Hands-on assistance with activities of daily living such as dressing/undressing, bathing, feeding, managing medications and treatments that are normally self-administered, toileting, assistance with ambulation (including the use of a walker, cane, etc.), carrying out professional therapeutic treatment plans, grooming such as care of hair, teeth or dentures. This may also include preparation and cleaning of areas used during provision of personal assistance such as the bathroom and kitchen.
2. Direct assistance with instrumental activities of daily living, as well as observation or cueing of the member to safely and appropriately complete activities of daily living and instrumental activities of daily living. Providing supervision necessary for member safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, arranging and using transportation and personal assistance at a job site and in non-employment related community activities.



3. Routine housekeeping and cleaning activities performed for a member consisting of tasks that take place on a daily, weekly or other regular basis. These may include: washing dishes, laundry, dusting, vacuuming, meal preparation, shopping and similar activities that do not involve hands-on care of the member.

4. Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event for reasons of health and safety or the need to assure the member's continued community living. These may include: outdoor activities such as yard work and snow removal; indoor activities such as window washing; cleaning of attics and basements; cleaning of carpets, rugs and drapery; refrigerator/freezer defrosting; the necessary cleaning of vehicles, wheelchairs and other adaptive equipment and home modifications such as ramps. This also may include assistance with packing/unpacking and household cleaning/organizing when a member moves.

An unrelated live-in caregiver may provide any or all of the types of supportive home care services. Services by a related live-in caregiver are subject to the requirements in Appendix C-2-e. Payment of a live-in caregiver may be reduced by the value of room and board in accordance with any applicable wage and hour laws.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days where there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment, or if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

**Medically- Related**

- Hospitalization
  - Nursing home or ICF-I/ID admission
  - Receipt of medical or rehabilitative care entailing at least an overnight absence
  - Participation in a therapeutic rehabilitative program as defined in DHS 101.03(175)
- There shall be no yearly limit on the number of medically-related episodes for which retainer payments may be made.

**Non-Medically Related**

- Planned vacation entailing at least an overnight absence and unaccompanied by the worker
  - Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence
  - Obtaining education, employment, or job, habilitative or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence
  - Recreational activities unaccompanied by the worker entailing at least an overnight absence
- Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

PIHPs shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

**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 or through the Medicaid State Plan.

Excludes training provided to a member intended to improve the member's ability to independently perform routine daily living tasks, which may be provided as daily living skills training.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Agency-directed workers
Individual	Individual workers

## Appendix C: Participant Services

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

**Service Type: Other Service**  
**Service Name: Supportive Home Care**

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**Provider Category:**

**Provider Type:**

Agency-directed workers

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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**Service Type: Other Service**  
**Service Name: Supportive Home Care**

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**Provider Category:**

**Provider Type:**

Individual workers

**Provider Qualifications****License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PHIP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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### 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:**

Training Services 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:**

▼

**Service Definition (Scope):**

This service is the provision of training services for individuals who provide uncompensated care, training, companionship, supervision, or other supports to members.

Training includes instruction about treatment regimens and other services included in the member’s care plan, use of equipment specified in the service plan, and guidance as necessary to safely maintain the member in the community. Training must be aimed at assisting the unpaid caregiver in meeting the needs of the member. All training for individuals who provide unpaid support to the member must be included in the member’s care plan.

Training furnished to individuals who provide uncompensated care and support to the member must be directly related to their role in supporting the member in areas specified in the care plan.

This service includes, but is not limited to, on-line or in-person training, conferences, or resource materials on the specific disabilities, illnesses, conditions that affect the member for whom they care. The purpose of the training is for the caregiver to learn more about member’s condition, what to expect, and how to provide the best care for someone with that specific condition. For example, training could be provided on effectively caring for a member with dementia.

Training includes the costs of registration and training fees associated with formal instruction in areas relevant to the needs identified in the member’s care plan.

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

This service may not be provided in order to train paid caregivers.

This service excludes payment for lodging and meal expenses incurred while attending a training event or conference.

This service does not cover teaching self-advocacy which is covered under consumer education and training services.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Training/Service Agency
Individual	Professional Services

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Training Services for Unpaid Caregivers**

**Provider Category:**

Agency ▼

**Provider Type:**

Training/Service Agency

**Provider Qualifications**

**License (specify):**

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

**Certificate (specify):**

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

**Other Standard (specify):**

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Training Services for Unpaid Caregivers**

**Provider Category:**

Individual ▼

**Provider Type:**

Professional Services

**Provider Qualifications**

**License (specify):**

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

**Certificate (specify):**

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

**Other Standard (specify):**

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**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 (Specialized Transportation) - Community 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:**

▼

**Service Definition (Scope):**

Community transportation is the provision of transportation services or items that enable a member to gain access to waiver and other community services, activities and resources, as specified in the member's care plan. This service may consist of items such as tickets, fare cards, or other fare media or services where the common carrier, specialized medical vehicle or other provider directly conveys a member and her or his attendant, if any, to destinations. Whenever possible, family, neighbors, friends or community agencies who can provide this service without charge will be utilized.

**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 or through the Medicaid State Plan.

Excludes transportation to receive non-emergency medical services which are covered under the Medicaid State plan transportation benefit, or in the case of a self-directing member with budget authority to purchase such services, under the Other Transportation service.

Excludes emergency (ambulance) medical transportation covered under the Medicaid State plan service.

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

- Participant-directed as specified in Appendix E  
 Provider managed

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

- Legally Responsible Person  
 Relative  
 Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Taxi or common carrier
Agency	Public mass transit

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Transportation (Specialized Transportation) - Community Transportation

**Provider Category:**

Agency ▼

**Provider Type:**

Taxi or common carrier

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Stat. Chapter 194

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Wisconsin Department of Transportation

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Transportation (Specialized Transportation) - Community Transportation

**Provider Category:**

Agency ▼

**Provider Type:**

Public mass transit

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Stat. Chapter 85.20

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Wisconsin Department of Transportation

**Frequency of Verification:**

Annually

## 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 (Specialized Transportation) - Other Transportation

**HCBS Taxonomy:**

<b>Category 1:</b>	<b>Sub-Category 1:</b>
<input type="text" value="17 Other Services"/>	<input type="text" value="17990 other"/>
<b>Category 2:</b>	<b>Sub-Category 2:</b>
<input type="text"/>	<input type="text"/>
<b>Category 3:</b>	<b>Sub-Category 3:</b>
<input type="text"/>	<input type="text"/>
<b>Category 4:</b>	<b>Sub-Category 4:</b>
<input type="text"/>	<input type="text"/>

**Service Definition (Scope):**

Other Transportation consists of transportation to receive non-emergency, Medicaid-covered medical services. This service may include items such as tickets, fare cards, or other fare media, reimbursement of mileage expenses, or payment for services where the provider directly conveys the member and her or his attendant, if any, by common carrier or specialized medical vehicle (SMV) as appropriate to and from receiving Medicaid-covered medical services.

Members eligible for this service must have decision-making authority over a budget for the purchase of such services. Such members are not limited to providers in the MCO’s network (although the credentials of specialized medical vehicle providers must be verified by the MCO), do not require MCO prior authorization to purchase any transportation service from a qualified provider to any Medicaid coverable medical service if the member’s budget is sufficient to pay the cost, and advanced scheduling of routine trips is not required if the member can obtain transport. Legally responsible relatives may be paid for providing this service if they meet the conditions under Appendix C-2 d & e of this waiver.

**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 or through the Medicaid State Plan.

Excludes ambulance transportation, which is available through the Medicaid State plan. Excludes non-emergency medical transportation when authorized by the MCO as a State plan service for members without budget authority. Excludes non-medical transportation which is provided under the sub-service of Community Transportation; however the same ride may be used to provide transport to medical appointments and community activities so long as there is not duplication of payment.

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Specialized Transportation Agency
Individual	Individuals (mileage reimbursed)

**Appendix C: Participant Services**

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

**Service Type: Other Service****Service Name: Transportation (Specialized Transportation) - Other Transportation**

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**Provider Category:**Agency **Provider Type:**

Specialized Transportation Agency

**Provider Qualifications****License (specify):****Certificate (specify):**

Wis. Stats. Chapter 85.21 and Wis. Admin. Code DHS 61.45

**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

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## Appendix C: Participant Services

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

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**Service Type: Other Service****Service Name: Transportation (Specialized Transportation) - Other Transportation**

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**Provider Category:**Individual **Provider Type:**

Individuals (mileage reimbursed)

**Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Valid driver's license, liability insurance.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

PIHP - may delegate to member or member's representative

**Frequency of Verification:**

At the time of authorization/purchase

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## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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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:**

Vocational Futures Planning and Support



**HCBS Taxonomy:****Category 1:**

03 Supported Employment ▼

**Sub-Category 1:**

03021 ongoing supported employment, individual ▼

**Category 2:**

03 Supported Employment ▼

**Sub-Category 2:**

03010 job development ▼

**Category 3:**

▼

**Sub-Category 3:**

▼

**Category 4:**

▼

**Sub-Category 4:**

▼

**Service Definition (Scope):**

Vocational futures planning and support (VFPS) is a person-centered, team based comprehensive employment planning and support service that provides assistance for members to obtain, maintain or advance in employment or self-employment/microenterprise. The agency providing VFPS services will ensure that the following service strategies are available as needed to the member:

- 1) Development of an employment plan based on an individualized determination of strengths, needs and interests of the individual with a disability, the barriers to work, including an assistive technology pre-screen or in-depth assessment, and identification of the assets a member brings to employment;
- 2) Work Incentive Benefits analysis and support;
- 3) Resource team coordination;
- 4) Career exploration and employment goal validation;
- 5) Job seeking support; and,
- 6) Job follow-up and long-term support.

VFPS must be provided by qualified professionals that include, for example, an employment specialist, a benefits specialist and an assistive technology consultant. When this service is provided the member record must contain activity reports, completed by the appropriate VFPS Team member(s), within thirty (30) days of completing a particular service strategy. When ongoing support is provided, monthly ongoing support reports must be completed by the provider of the on-going support.

**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 or through the Medicaid State Plan.

VFPS excludes services that could be provided as prevocational or as supported employment. Such services may be used to supplement, but may not duplicate any VFPS services provided under the waiver.

VFPS excludes services funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401(16 and 17)).

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

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

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Vocational futures planning

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Vocational Futures Planning and Support

**Provider Category:**

Agency

**Provider Type:**

Vocational futures planning

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

All team members shall have skills and knowledge typically acquired through completion of an advanced degree in human services, or an equivalent combination of education and experience, with ongoing training and technical assistance appropriate to their specific specialty.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

- As a waiver service defined in Appendix C-3.** Do not complete item C-1-c.
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** Complete item C-1-c.
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** Complete item C-1-c.
- As an administrative activity.** Complete item C-1-c.

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been

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

a) The requirement for the completion of caregiver and criminal background checks applies to all caregivers. A caregiver is a person who is, or is expected to be, an employee or contractor of an entity, who is or is expected to be under the control of an entity, as defined by the department by rule, and who has, or is expected to have, regular, direct contact with clients of the entity. A caregiver is also a person who has, or is seeking, a license, certification, registration, or certificate of approval issued or granted by the department to operate an entity. An entity is a facility, organization or service that is licensed or certified or registered with the department to provide direct care or treatment services to clients; or an agency that employs or contracts with an individual to provide personal care services. Regular contact includes scheduled, planned, expected or otherwise periodic contact. Direct means face-to-face physical proximity to a member that may afford the opportunity to commit abuse or neglect or to misappropriate property.

b) The caregiver background checks required include all of the following: 1) a criminal history search from the records of the Wisconsin Department of Justice (when the subject recently resided in a different state, the search must also include that state); 2) a search of the Caregiver Registry maintained by the Wisconsin Department of Health and Family Services; 3) a search of the status of credentials and licensing from the records of the applicable licensing/regulation entity, if applicable; 4) a search of the information maintained by the Department regarding any final determination or decision that the person has abused or neglected a child; and 5) a search of the information maintained by the Department regarding any denial to the person of a license, certification, certificate of approval or registration or of a continuation of a license, certification, certificate of approval or registration to operate an entity. Wisconsin statutes and administrative codes identify which criminal or caregiver offenses always preclude employment as a caregiver and which allow the potential caregiver to still be considered for employment.

c) Each PIHP is required by contract to ensure that all persons working as caregivers, including those employed by contract agencies, have had required background checks completed. These checks must be completed at the time of caregiver employment or contracting and at least every four years thereafter. During annual quality reviews and annual care management reviews, the SMA and EQRO reviews a sample of member records and contract agency records to determine whether required background checks have been completed.

**b. Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- No. The State does not conduct abuse registry screening.**
- Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a. The SMA, as required under Wisconsin Administrative Codes HFS 12 and HFS 13, maintains a registry of caregivers as an official record of persons found to have abused or neglected a client or misappropriated a client's property. PIHPs, as well as all other entities that are licensed or certified by or registered with the Department to provide direct care or treatment services to clients, are required to report to the SMA any allegation of abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity if the person is under the control of the entity.

b. Positions for which abuse registry screenings must be conducted include all caregivers. A caregiver is a person who is, or is expected to be, an employee or contractor of an entity, who is or is expected to be under the control of an entity, as defined by the department by rule, and who has, or is expected to have, regular, direct contact with clients of the entity. A caregiver is also a person who has, or is seeking, a license, certification, registration, or certificate of approval issued or granted by the department to operate an entity. An entity is a facility, organization or service that is licensed or certified or registered with the department to provide direct care or treatment services to clients; or an agency that employs or contracts with an individual to provide personal care services.

c. Each PIHP is required by contract to ensure that all persons working as caregivers, including those employed by contract agencies, have had required registry screenings completed. These screenings must be completed at the time of caregiver employment or contracting and at least every four years thereafter. The SMA and EQRO conduct random reviews of member records and contract agency records to determine whether required registry screenings have been completed.

## Appendix C: Participant Services

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

**c. Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Residential Care Apartment Complex (RCAC)	
Community-based residential facility (CBRF)	
Adult Residential Care - 1-2 Bed Adult Family Homes	
Adult family home - 3-4 beds	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

In the case of residential care apartment complexes and CBRFs there is no facility capacity limit for members who are frail elders or have physical disabilities. A community character is maintained in such situations by requiring private rooms or independent apartments within the facility. However, this waiver specifies that members with intellectual/developmental disabilities may not reside in any CBRF with a licensed capacity for more than eight persons.

Regardless of facility size, state licensure and certification rules enforced by the SMA’s Division of Quality Assurance require facilities to honor resident rights and act to promote integration and participation in the community. In addition, all residential facilities will be reviewed as part of the SMA’s transition plan to assure that all HCB service settings will be in compliance with the new federal setting requirements.

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Residential Care Apartment Complex (RCAC)

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations (Home Modifications)	<input type="checkbox"/>
Adult Residential Care - 3-4 Bed Adult Family Homes	<input type="checkbox"/>
Housing Counseling	<input type="checkbox"/>
Assistive Technology/Communication aids	<input type="checkbox"/>
Vocational Futures Planning and Support	<input type="checkbox"/>
Supported Employment - Individual Employment Support	<input type="checkbox"/>
Adult Residential Care - Community-Based Residential Facilities (CBRF)	<input type="checkbox"/>
Adult Day Care Services	<input type="checkbox"/>
Transportation (Specialized Transportation) - Community Transportation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Supported Employment - Small Group Employment Support	<input type="checkbox"/>
Care Management	<input type="checkbox"/>
Consultative Clinical and Therapeutic Services for Caregivers	<input type="checkbox"/>
Self-Directed Personal Care	<input type="checkbox"/>
Respite	<input type="checkbox"/>

Waiver Service	Provided in Facility
Counseling and Therapeutic Resources	<input type="checkbox"/>
Skilled Nursing Services RN/LPN	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Consumer Education and Training	<input type="checkbox"/>
Adult residential care - 1-2 bed adult family homes	<input type="checkbox"/>
Supportive Home Care	<input type="checkbox"/>
Transportation (Specialized Transportation) - Other Transportation	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Consumer Directed Supports (Self-Directed Supports) Broker	<input type="checkbox"/>
Training Services for Unpaid Caregivers	<input type="checkbox"/>
Financial Management Services	<input type="checkbox"/>
Personal Emergency Response Systems (PERS)	<input type="checkbox"/>
Daily Living Skills Training	<input type="checkbox"/>
Adaptive aids	<input type="checkbox"/>
Day Habilitation Services	<input type="checkbox"/>
Relocation services	<input type="checkbox"/>
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	<input checked="" type="checkbox"/>

**Facility Capacity Limit:**

No limit (See c.ii.)

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

**Appendix C: Participant Services****C-2: Facility Specifications****Facility Type:**

Community-based residential facility (CBRF)

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations (Home Modifications)	<input type="checkbox"/>
Adult Residential Care - 3-4 Bed Adult Family Homes	<input type="checkbox"/>
Housing Counseling	<input type="checkbox"/>
Assistive Technology/Communication aids	<input type="checkbox"/>
Vocational Futures Planning and Support	<input type="checkbox"/>
Supported Employment - Individual Employment Support	<input type="checkbox"/>
Adult Residential Care - Community-Based Residential Facilities (CBRF)	<input checked="" type="checkbox"/>
Adult Day Care Services	<input type="checkbox"/>
Transportation (Specialized Transportation) - Community Transportation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Supported Employment - Small Group Employment Support	<input type="checkbox"/>
Care Management	<input type="checkbox"/>
Consultative Clinical and Therapeutic Services for Caregivers	<input type="checkbox"/>
Self-Directed Personal Care	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Counseling and Therapeutic Resources	<input type="checkbox"/>
Skilled Nursing Services RN/LPN	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Consumer Education and Training	<input type="checkbox"/>
Adult residential care - 1-2 bed adult family homes	<input type="checkbox"/>
Supportive Home Care	<input type="checkbox"/>
Transportation (Specialized Transportation) - Other Transportation	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Consumer Directed Supports (Self-Directed Supports) Broker	<input type="checkbox"/>
Training Services for Unpaid Caregivers	<input type="checkbox"/>
Financial Management Services	<input type="checkbox"/>
Personal Emergency Response Systems (PERS)	<input type="checkbox"/>
Daily Living Skills Training	<input type="checkbox"/>
Adaptive aids	<input type="checkbox"/>
Day Habilitation Services	<input type="checkbox"/>
Relocation services	<input type="checkbox"/>
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	<input type="checkbox"/>

**Facility Capacity Limit:**

none

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (check each that applies):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Adult Residential Care - 1-2 Bed Adult Family Homes

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations (Home Modifications)	<input type="checkbox"/>
Adult Residential Care - 3-4 Bed Adult Family Homes	<input type="checkbox"/>
Housing Counseling	<input type="checkbox"/>
Assistive Technology/Communication aids	<input type="checkbox"/>
Vocational Futures Planning and Support	<input type="checkbox"/>
Supported Employment - Individual Employment Support	<input type="checkbox"/>
Adult Residential Care - Community-Based Residential Facilities (CBRF)	<input type="checkbox"/>
Adult Day Care Services	<input type="checkbox"/>
Transportation (Specialized Transportation) - Community Transportation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Supported Employment - Small Group Employment Support	<input type="checkbox"/>
Care Management	<input type="checkbox"/>
Consultative Clinical and Therapeutic Services for Caregivers	<input type="checkbox"/>
Self-Directed Personal Care	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Counseling and Therapeutic Resources	<input type="checkbox"/>
Skilled Nursing Services RN/LPN	<input type="checkbox"/>

Waiver Service	Provided in Facility
Home Delivered Meals	<input type="checkbox"/>
Consumer Education and Training	<input type="checkbox"/>
Adult residential care - 1-2 bed adult family homes	<input checked="" type="checkbox"/>
Supportive Home Care	<input type="checkbox"/>
Transportation (Specialized Transportation) - Other Transportation	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Consumer Directed Supports (Self-Directed Supports) Broker	<input type="checkbox"/>
Training Services for Unpaid Caregivers	<input type="checkbox"/>
Financial Management Services	<input type="checkbox"/>
Personal Emergency Response Systems (PERS)	<input type="checkbox"/>
Daily Living Skills Training	<input type="checkbox"/>
Adaptive aids	<input type="checkbox"/>
Day Habilitation Services	<input type="checkbox"/>
Relocation services	<input type="checkbox"/>
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	<input type="checkbox"/>

**Facility Capacity Limit:**

1 or 2 residents

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>
Physical environment	<input checked="" type="checkbox"/>
Sanitation	<input checked="" type="checkbox"/>
Safety	<input checked="" type="checkbox"/>
Staff : resident ratios	<input checked="" type="checkbox"/>
Staff training and qualifications	<input checked="" type="checkbox"/>
Staff supervision	<input checked="" type="checkbox"/>
Resident rights	<input checked="" type="checkbox"/>
Medication administration	<input checked="" type="checkbox"/>
Use of restrictive interventions	<input checked="" type="checkbox"/>
Incident reporting	<input checked="" type="checkbox"/>
Provision of or arrangement for necessary health services	<input checked="" type="checkbox"/>

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**



Adult family home - 3-4 beds

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Environmental Accessibility Adaptations (Home Modifications)	<input type="checkbox"/>
Adult Residential Care - 3-4 Bed Adult Family Homes	<input checked="" type="checkbox"/>
Housing Counseling	<input type="checkbox"/>
Assistive Technology/Communication aids	<input type="checkbox"/>
Vocational Futures Planning and Support	<input type="checkbox"/>
Supported Employment - Individual Employment Support	<input type="checkbox"/>
Adult Residential Care - Community-Based Residential Facilities (CBRF)	<input type="checkbox"/>
Adult Day Care Services	<input type="checkbox"/>
Transportation (Specialized Transportation) - Community Transportation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Supported Employment - Small Group Employment Support	<input type="checkbox"/>
Care Management	<input type="checkbox"/>
Consultative Clinical and Therapeutic Services for Caregivers	<input type="checkbox"/>
Self-Directed Personal Care	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Counseling and Therapeutic Resources	<input type="checkbox"/>
Skilled Nursing Services RN/LPN	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Consumer Education and Training	<input type="checkbox"/>
Adult residential care - 1-2 bed adult family homes	<input type="checkbox"/>
Supportive Home Care	<input type="checkbox"/>
Transportation (Specialized Transportation) - Other Transportation	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Consumer Directed Supports (Self-Directed Supports) Broker	<input type="checkbox"/>
Training Services for Unpaid Caregivers	<input type="checkbox"/>
Financial Management Services	<input type="checkbox"/>
Personal Emergency Response Systems (PERS)	<input type="checkbox"/>
Daily Living Skills Training	<input type="checkbox"/>
Adaptive aids	<input type="checkbox"/>
Day Habilitation Services	<input type="checkbox"/>
Relocation services	<input type="checkbox"/>
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	<input type="checkbox"/>

**Facility Capacity Limit:**

4 residents

**Scope of Facility Standards.** For this facility type, please specify whether the State's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	<input checked="" type="checkbox"/>

Standard	Topic Addressed
Physical environment	✓
Sanitation	✓
Safety	✓
Staff : resident ratios	✓
Staff training and qualifications	✓
Staff supervision	✓
Resident rights	✓
Medication administration	✓
Use of restrictive interventions	✓
Incident reporting	✓
Provision of or arrangement for necessary health services	✓

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

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

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

a. The parent (biological or adoptive) of a minor child, guardian of a minor child, or spouse of an adult waiver member may be paid to provide personal care, supportive home care, specialized transportation, certified 1-2 bed adult family home services or other direct care services that the member's interdisciplinary care management team identifies as necessary and are included in the member's individualized service plan, if: 1) the member's preference is for the family member to provide the service; 2) the family member meets the PIHP's provider qualifications and standards for the service to be provided and there is a properly executed provider agreement between the PIHP and the family member; 3) the family member will either provide an amount of service that exceeds normal family care giving responsibilities for a person in a similar family relationship who does not have a disability, or find it necessary to forego paid employment in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

b. The parent (biological or adoptive) of a minor child, guardian of a minor child, or spouse of an adult waiver member may be paid only for services that are above and beyond the usual familial responsibilities for a person of the waiver member's age. The member's interdisciplinary team in the PIHP is responsible to ensure that the purchase of service meets all of the following criteria intended to ensure that the provision of services by a legally responsible individual is in the best interest of the member: 1) the service to be provided meets identified needs and outcomes in the individual's individualized service plan and assures the health, safety and welfare of the individual; 2) purchase of services from the parent, guardian or spouse is cost-effective in comparison to purchase of services from another provider; and, 3) potential conflicts of interest for the provider are identified and monitored by the interdisciplinary team.

c. The interdisciplinary care management team in the PIHP is responsible to monitor and document that the services purchased

from the parent, guardian or spouse are actually delivered in accordance with the service plan. This may be accomplished through requiring signed timesheets and announced and unannounced visits or other strategies. The SMA and its contracted EQRO monitor PIHP oversight of all service providers including family caregivers.

- Self-directed**  
 **Agency-operated**

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- The State does not make payment to relatives/legal guardians for furnishing waiver services.**  
 **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

a. The parent (biological or adoptive) of a minor child, guardian of a minor child, or spouse of an adult waiver member may be paid to provide personal care, supportive home care, specialized transportation, certified 1-2 bed adult family home services or other direct care services that the member's interdisciplinary care management team identifies as necessary and are included in the member's individualized service plan, if: 1) the member's preference is for the family member to provide the service; 2) the family member meets the PIHP's provider qualifications and standards for the service to be provided and there is a properly executed provider agreement between the PIHP and the family member; 3) the family member will either provide an amount of service that exceeds normal family care giving responsibilities for a person in a similar family relationship who does not have a disability, or find it necessary to forego paid employment in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

b. The parent (biological or adoptive) of a minor child, guardian of a minor child, or spouse of an adult waiver member may be paid only for services that are above and beyond the usual familial responsibilities for a person of the waiver member's age. The member's interdisciplinary team in the PIHP is responsible to ensure that the purchase of service meets all of the following criteria intended to ensure that the provision of services by a legally responsible individual is in the best interest of the member: 1) the service to be provided meets identified needs and outcomes in the individual's individualized service plan and assures the health, safety and welfare of the individual; 2) purchase of services from the parent, guardian or spouse is cost-effective in comparison to purchase of services from another provider; and, 3) potential conflicts of interest for the provider are identified and monitored by the interdisciplinary team.

c. The interdisciplinary care management team in the PIHP is responsible to monitor and document that the services purchased from the parent, guardian or spouse are actually delivered in accordance with the service plan. This may be accomplished through requiring signed timesheets and announced and unannounced visits or other strategies. The SMA and its contracted EQRO monitor PIHP oversight of all service providers including family caregivers.

- Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

This waiver is provided in conjunction with a s. 1915 (b) waiver that allows for restriction of free choice of providers. However, the contract for PIHPs requires that, for services in the LTC benefit package that involve providing intimate personal needs or when a provider frequently comes into the member's home, the PIHP shall, upon request of the member, purchase services from any qualified provider who will accept and meet the provisions of the PIHP's subcontract for subcontractors of the same service.

Furthermore, 2007 Wisconsin Act 20 requires, at 46.284(2)(c), that DHS's contracts with PIHPs for Family Care specify that PIHPs

must contract with any CBRF, residential care apartment complex, nursing home, ICF-MR, community rehabilitation program, home health agency, day service or personal care provider that agrees to accept the reimbursement rate the PIHP pays to similar providers for the same service that satisfies quality, utilization or other criteria the PIHP requires for other providers of the same service.

As a part of certification of PIHPs DHS looks for certification that the PIHP meets 42 CFR 438.207.

## 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:

The SMA verifies that PIHPs assure that providers continually meet all licensure and/or certification standards that apply to them. Numerator: Number of providers reviewed annually through an SMA validation process that meet all licensure and/or certification standards that apply to them. Denominator: Number of providers reviewed annually through an SMA validation process.

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

		1.5% of Providers, 30 or greater records per PIHP
	<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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:**

The SMA verifies that PIHPs assure non-licensed/non-certified providers continually meet all the standards that apply to them. **Numerator:** Number of non-licensed/non-certified providers reviewed annually through an SMA validation process that meet all standards that apply to them. **Denominator:** Number of non-licensed/non-certified providers reviewed annually through an SMA validation process.

**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):
<input type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>	<input type="checkbox"/> <b>100% Review</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>	<input checked="" type="checkbox"/> <b>Less than 100% Review</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>	<input type="checkbox"/> <b>Representative Sample Confidence Interval =</b>

<input checked="" type="checkbox"/> <b>Other</b> Specify: PIHP / EQRO data validation	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: _____
	<input checked="" type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: 1.5% of Providers, 30 or greater records per PIHP
	<input type="checkbox"/> <b>Other</b> Specify: _____	

**Data Aggregation and Analysis:**

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

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:**

All providers of supportive home care and/or in-home respite have completed training per SMA standards. Numerator: Number of providers reviewed by the SMA who have completed training per the SMA standards. Denominator: Number of providers reviewed by the SMA.

**Data Source** (Select one):

**Training verification records**

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):

<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: PIHP / EQRO data validation	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 1.5% of providers, 30 or greater records per PIHP
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 assigned SMA Oversight team is the SMA’s primary resource for discovery of problems/issues. Every monitoring, quality improvement and quality assurance process may result in the discovery of problems or issues. The processes that could result in such discovery include: Annual Quality Review conducted by the EQRO and SMA, PIHP or State level grievances and appeals; Family Care Ombudsman program reports; review of critical incident reports; review of requests for use of isolation, seclusion and restrictive measures, and discovery of problems or issues when giving an PIHP policy clarification.

**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. In addition, provide information on the methods used by the State to document these items.

In general, SMA oversight teams direct the correction of individual problems. The SMA oversight team assigned to each PIHP discovers problems and issues through: reports from the EQRO related to individual member concerns; Family Care Ombudsman program reports; review of grievances and appeals; review of member incident reports; review of requests for use of isolation, seclusion and restrictive measures; discovery of problems or issues when giving an PIHP policy clarification, complaints to the SMA and from other sources. The team also interacts with PIHP staff on a regular basis and may identify concerns through such communication and direct observation. As needed, the SMA oversight team directs remediation of individual member concerns and provider concerns as well as isolated operational concerns. The SMA oversight team also uses information gathered through direct interaction with the PIHP and from many available sources to identify and direct remediation of systemic problems or issues within the PIHP. SMA oversight teams have the ability to respond quickly to any issue that affects member health or safety identified through routine discovery activities, but also respond quickly to other issues as they are identified.

Each SMA oversight team documents issues and concerns and any resolution or remediation in a tracking system maintained by the SMA. An issue cannot be cleared in the tracking system without approval of the SMA supervisor of the oversight team. The SMA has also developed policies and procedures for the EQRO and SMA oversight teams to report concerns that rise to a level where they require the immediate attention of the SMA.

**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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></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 Qualified Providers that are currently non-operational.

- No
- Yes

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

**Appendix C: Participant Services**

**C-3: Waiver Services Specifications**

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

**Appendix C: Participant Services**

**C-4: Additional Limits on Amount of Waiver Services**

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the



amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

- Other Type of Limit.** The State employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

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

1. Member's private residences, whether owned or rented, including when voluntarily shared with family, friends or chosen residence mates, that are not regulated residential settings for persons with disabilities.
2. Places of integrated, competitive employment.
3. 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 SMA has determined that these settings are not provider owned or controlled residential settings; are integrated in the greater community, or in the case of residences in rural settings are the person's choice and consistent with the character of such communities; do not segregate or isolate participants, except with respect to private residences in rural areas where such is the chosen preference of the person; provide opportunities for regular interaction in daily activities with non-HCBS waiver participants; facilitate individual choice in services, daily activities and assumption of typical, age-appropriate social roles; and support rights to dignity, respect, autonomy and freedom from coercion.

2) To assure continuing compliance with setting requirements the SMA will:

- Put requirements in its SMA-PIHP contract to assure compliance and ongoing assessment of settings in which waiver services are

provided; and

- Inform members, through the Member Handbook, of the settings requirements and how to report any concerns in regards to the settings in which they receive services.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

#### State Participant-Centered Service Plan Title:

Member-Centered Plan

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

- Social Worker**

*Specify qualifications:*

Social Worker certificate requirements of the Social Worker Section of the Marriage and Family Therapy, Professional Counseling, and Social Work Examining Board:

1. Completion of a bachelor's degree from an accredited college or university in psychology, sociology, criminal justice, or other human service program approved by the Social Worker Section.

2. Completion of one of the following:

a. A 400 hour human services internship that involves direct practice with clients and that is supervised by a social worker certified under Wis. Stats. Chapter 457, who has a bachelor's or master's degree in social work.

b. One year of social work employment that involves at least 400 hours of face-to-face client contact in not less than 12 months and that is supervised by a social worker certified under Wis. Stats. Chapter 457, who has a bachelor's or master's degree in social work.

3. Successfully pass the State jurisprudence examination and national examination.

- Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (2 of 8)

- b. Service Plan Development Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant, with the exception of Indian Health Care Providers (IHCPs) providing services to Indian members. For this exception, the following safeguards have been put in place:

The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist (TADRS) is responsible to inform the potential enrollee and/or her/his legal representative about the available service and enrollment options, including managed long term care (Family Care or Family Care Partnership), institutional services, fee-for-service

Medicaid card and self-directed supports waiver (IRIS) services. If the individual is an Indian, the ADRC or TADRS informs the potential enrollee and/or her/his legal representative of 1) the option to choose between an Indian Health Care Provider (IHCP)(if available) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either the IHCP (if available) or PIHP network providers.

IHCPs who provide care management to Indian members are required, via the State-PIHP-IHCP agreement, to educate beneficiaries that they can access services through the IHCP, assuming it has the capacity to provide it, or a PIHP network provider.

## 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.

a. Members are first informed of the person-centered individualized care planning process by the Aging and Disability Resource Center (ADRC) before enrolling in the managed care organization. Upon enrollment, members are provided with a brochure produced by the State Medicaid Agency entitled "Being a Full Partner in Family Care" that describes the care planning, care management and service authorization process the PIHP is required to use, the role members and their families play in these processes, and explains grievance and appeal rights and procedures. In addition, members are provided with an SMA-approved member handbook specific to the PIHP that explains a member's rights and responsibilities as an enrollee in the managed care organization. Likewise, members are informed at the ADRC prior to enrollment and immediately following enrollment by the PIHP of the option to self-direct supports and services. (This option is also explained in both the Being a Full Partner in Family Care brochure and in the member handbook.) This information and support, as with all aspects of the person-centered planning process, is communicated to the member in plain language and in a manner reflecting his or her cultural considerations. This information and support is also communicated in a manner that is accessible to members with disabilities (through the provision of auxiliary aids and services at no cost to the member) and to members who are limited English proficient (through the provision of language services at no cost to the member). The purpose of this process is to provide the necessary information and support to ensure that the member leads and directs the individualized care planning process to the maximum extent possible, and is enabled to make informed choices and decisions.

b. Each member has the right to include anyone she/he chooses in the care planning process. This right is explained in both the Being a Full Partner in Family Care brochure and in the PIHP's member handbook.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a. Upon enrollment, the PIHP is responsible to provide all services in the benefit package that are needed by the member. The PIHP is required to contact the member within three calendar days of enrollment to welcome the member to the PIHP; make certain that any services needed to assure the member's health, safety and wellbeing are authorized; provide the member with immediate information about how to contact the PIHP for needed services; and, schedule a face-to-face contact at a time and location convenient to the member. The initial assessment and service authorizations must be developed and implemented within five (5) calendar days of enrollment and signed within ten (10) calendar days of enrollment. A comprehensive assessment must be completed within thirty (30) calendar days of the enrollment date. A fully developed member-centered plan (MCP), including a service authorization document that addresses all of the member's needs and supports all of the member's long-term care outcomes identified in the assessment, shall be finalized, agreed to, and signed by the member or the member's authorized representative within sixty (60) calendar days of the enrollment date. The assessment and plan of care is developed by an interdisciplinary care management team (IDT). In managed long-term care, the IDT consists of the member and the member's guardian, if any, as well as any other persons requested by the member; a registered nurse and social worker assigned by the managed care organization; and any other appropriate professionals (e.g., therapist, behavioral specialist). In Family Care Partnership, which includes all Medicare and Medicaid services, the IDT includes a nurse practitioner.

b. The IDT uses an assessment protocol that includes a face-to-face interview with the member and that comprehensively assesses and identifies the member's needs and strengths, preferences, informal supports, and long-term care outcomes and identifies any

ongoing conditions of the member that require a course of treatment or regular care monitoring. The protocol must assess: activities of daily living (ADLs) and instrumental activities of daily living (IADLs); physical health and nutrition; safety and risk; member rights and responsibilities, autonomy and self-determination, including the person's understanding of his/her rights, whether the person has a guardian or power of attorney for health care, preferences for executing advance directives, desire to self-manage services, determination of the least restrictive setting if appropriate, personal preferences with regard to services, caregivers, and daily routine; personal values, including results of a life review or futures planning; communication; mental health and cognition including alcohol and other drug abuse issues; presence of informal supports; social interaction and community integration; preferred living situation including identification of a member's preference for a private room for a person considering alternative residential services; education and vocational activities; and, economic resources.

c. Members are first informed about the services available in the PIHP benefit by the Aging and Disability Resource Center before enrolling. Upon enrollment, members are also provided with a brochure produced by the State Medicaid Agency entitled "Being a Full Partner in Family Care" and an SMA-approved member handbook, both of which describe the services available from the managed care organization, including the s. 1915 (c) waiver services.

d. The plan is developed using a member-centered process that identifies: the long-term care and personal experience outcomes; the member's goals and preferences; the needs and preferences identified in the comprehensive assessment; the member's current and preferred living arrangement (including documentation in the plan that the setting in which the member resides was chosen by the member and the alternative home and community based settings that were considered by the member); the services, supports or interventions (paid and unpaid) to be provided in order to meet the identified needs, the services the member elects to self-direct; support for the long term care outcomes and the preferences identified in the comprehensive assessment; strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines; other services outside the LTC benefit package received by the member and how the member's interdisciplinary team will coordinate with those services and providers; the specific period of time covered by the MCP; and, the parties responsible for providing each service (including informal supports). To ensure that the plan is understandable to the member and the individuals important in supporting the member, the plan is written in plain language and in a manner that is accessible to members with disabilities (through the provision of auxiliary aids and services at no cost to the member) and members with limited English proficiency (through the provision of language services at no cost to the member).

e. The member's interdisciplinary team is responsible for coordinating waiver services with other services and service providers that also support the member. Managed long-term care includes all Medicaid-funded long-term care services. The coordination efforts are primarily with Medicare and Medicaid acute and primary health care providers. Most coordination efforts are conducted by the registered nurse on the team, with whom other health care professionals are likely to be more comfortable. Wisconsin Partnership Program includes all Medicare and Medicaid services. Coordination efforts are internal to the interdisciplinary team.

f. The interdisciplinary team, which includes the member, is responsible for development of the member's plan of care. The plan of care results in service authorizations for providers that the interdisciplinary team processes in conjunction with the PIHP network/contracting unit. The interdisciplinary team is responsible for monitoring the delivery of those services and supports. The IDT is also responsible for monitoring the ongoing health and welfare of the member. The IDT is required to conduct a face-to-face visit with a member during each quarter of the calendar year. The PIHP can establish guidelines for care management teams or create a contact standard that exceeds the minimum standard. If a member requests fewer contacts, the IDT can waive the minimum standard after the first six months of enrollment if it documents the request in the member's record and if the member has no current health and safety issues (e.g., the member has a stable medical condition, has strong informal or community ties, and no physical or mental health risks are evident). Under no circumstances shall a member receive less than one face-to-face visit in any twelve month period. IDT staff document requests in the member's record including the reason for the member's request.

g. The member and interdisciplinary team shall review and update the plan of care periodically, but no later than the sixth month after the month in which the previous comprehensive assessment was completed. Care plans shall also be reviewed whenever the member's preferences change, there is a significant change in the member's situation or condition, the plan fails to meet the member's needs or support the planned outcomes, or at the member's request.

## 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.

The PIHP is responsible to assure member health, safety and well-being and implement a policy that expressly prohibits all forms of abuse, neglect, exploitation and mistreatment of members by PIHP employees and providers. The safety and risk policy must be approved by the SMA annually and must include: instruction for interdisciplinary teams in the proper reporting procedures when abuse or neglect is suspected; specific written policies that address decision-making about care as it relates to members' safety and risk, including standards and methods for determining acceptable risk for members including those with a cognitive impairment or mental illness; identification of members' right to freedom from unnecessary physical or chemical restraint; and identification of specific mechanisms to balance member needs for safety, protection, good physical health and freedom from accidents, with overall quality of life and individual choice and freedom.

Application of the PIHP's safety and risk policy reduces risk to individuals by making the interdisciplinary teams responsible for preventing unnecessary risk. PIHP procedures provide teams with appropriate tools for working with each individual to identify risks and assess the level of risk the individual is willing to accept in order to allow for personal freedom. PIHP procedures also provide interdisciplinary teams with directions for identifying abuse and neglect and how to report it to appropriate authorities for response.

The interdisciplinary team monitors the effectiveness of back-up plans.

Each PIHP is required to have a mechanism to monitor, evaluate and improve its performance in the area of safety and risk issues that ensures there are individualized supports in place to facilitate a safe environment for each member, and that its performance is consistent with the understanding of the desired member outcomes and preferences. Family members and other informal supports are included when addressing safety concerns if that is consistent with the member's preference.

The PIHP and its subcontracted providers must comply with s. 51.61 (1) (i), Wis. Stats., and s. DHS 94.10, Wis. Adm. Code, in the use of isolation, seclusion and physical restraints, which may not be used without specific case-by-case approval of the State Medicaid Agency.

The PIHP is responsible for providing members with access to services in the LTC benefit package, coordination with services outside the benefit package and linkages to adult protective services 24 hours each day, seven (7) days a week. This responsibility includes maintaining a 24 hour, (7) days a week coverage/on call system through which members can address access to urgent and emergency services needed immediately to protect health and safety. The interdisciplinary team ensures that provider contracts include arrangements for backup for direct care providers, or that a member's self-directed supports plan includes backup arrangements. Specific arrangements vary from provider contract to provider contract (and self-directed support plan to self-directed support plan) but a typical arrangement might include a designated alternate for each care worker and/or a pool of "on-call" providers available to provide services in the event the regularly scheduled provider is unable to furnish services.

## 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.

Freedom of choice of providers is restricted in this waiver under the companion s. 1915 (b) waiver.

However, for services in the benefit package that involve providing intimate personal care or when a provider frequently comes into the member's home, the PIHP shall, upon request of the member, purchase services from any qualified provider who will accept and meet the provisions of the PIHP's contract for providers of the same service.

For other services, members are informed at enrollment and annually thereafter of the providers in the PIHP's provider network from which they may choose. In addition the member handbook provided to every member at enrollment describes the process for requesting an out-of-network provider in the event that the providers in the PIHP network are unable to meet the member's needs or support the member's outcomes because they do not have sufficient capacity, do not have the specialized expertise, specialized knowledge or appropriate cultural diversity, cannot meet the need on a timely basis or, transportation or physical access to the PIHP providers causes an undue hardship to the member.

The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist (TADRS) is responsible to inform the potential enrollee and/or her/his legal representative about the available service and enrollment options, including managed long term care (Family Care or Family Care Partnership), institutional services, fee-for-service Medicaid card and self-directed supports waiver (IRIS) services. If the individual is an Indian, the ADRC or TADRS informs the potential enrollee and/or her/his legal representative of 1) the option to choose between an Indian Health Care Provider (IHCP)(if available) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either the IHCP (if available) or PIHP network providers. The ADRC or TADRS also provides information about other options available to individuals, including the SSI Managed Care Program where available.

IHCPs who provide care management to Indian members are required, via the State-PIHP-IHCP agreement, to educate beneficiaries that they can access services through the IHCP, assuming it has the capacity to provide it, or a PIHP network provider.

The PIHP is required to allow members to change interdisciplinary teams up to two times per calendar year. In an Indian member chooses to receive care management through the PIHP, and wants to change IDTs, they must be given the choice between selecting a different IDT within the PIHP (up to two times per year, within the same PIHP), or accessing care management through an Indian Health Care Provider (IHCP).

## 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):

Plan of care reviews are conducted on an ongoing basis and carried out concurrently as the PIHP develops and implements the member's service plan. For each PIHP a sample of members are selected at least annually. Data from the Wisconsin long-term care functional screen and the PIHP's encounter data are used to effectively identify populations of waiver members for review based on pre-established targeting criteria. Systematic, random sampling techniques are employed, which ensure that the plan of care review provides valid and reliable information on the quality of care provided.

Documentation of the plan of care for each individual in the sample is made available to the State-designated reviewers, either on-site at the PIHP or off-site at the Medicaid agency. Reviewers knowledgeable about waiver target groups as well as waiver services, eligibility requirements, and the service delivery system review plans of care. The plan of care may also be reviewed in consultation with other professionals within the State Medicaid Agency including nurse consultants, therapy consultants and others who have knowledge of services and needs of persons in the target group.

When a plan of care identifies and addresses all of the member's assessed needs adequately, the care plan is considered approved. If the reviewer finds, after collecting all relevant information, that services in a plan of care do address the member's disabilities and needs in critical areas, or if basic member needs are overlooked in the assessment, an immediate referral will be made to the State Medicaid Agency and the PIHP is contacted. If after further investigation the State Medicaid Agency determines that the effect on the member is serious, the PIHP will be directed to take immediate corrective action to ensure that the essential needs of the member are adequately addressed. In this circumstance, the plan of care will not be approved until identified problems are corrected. The State Medicaid Agency will track and review findings, identify trends and provide a periodic report to the managed care organization. If a PIHP is found to have an unfavorable trend towards non-approval of plans of care, the rate of review may be intensified.

In addition to the review of a statistical sample of care plans, the State Medicaid Agency establishes criteria for and implements targeted reviews of additional care plans, based on the results of the sample reviews and other quality monitoring activities. Such reviews may be targeted to situations where quality monitoring results indicate additional review is needed, for example, specific managed care organizations, specific interdisciplinary teams, specific target populations or members with specific conditions.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- Every three months or more frequently when necessary
- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

*Specify the other schedule:*

- i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

*Specify:*

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a. The member's interdisciplinary team within the PIHP is responsible for day-to-day monitoring of the implementation of the service plan and of the member's health and welfare.

b. Interdisciplinary teams use regular contacts with members and providers to monitor the health and welfare of the member. IDTs may review provider timesheets, provider agency reports, member contacts or other methods to monitor the delivery and effectiveness of services and supports.

c. The frequency with which monitoring is performed is established by the member and the inter-disciplinary team. It normally includes face-to-face contacts with the member each calendar quarter and at least monthly contact by telephone with the member or a provider. The frequency of contacts with the member may be reduced at the request of the member if the member's health and situation are stable.

The PIHP interdisciplinary team and/or business office use the plan of care to generate prior authorizations for service providers. The interdisciplinary team and member verify whether services were in fact delivered in accordance with the plan of care/prior authorization.

Family Care is a s. 1915 (b)/(c) waiver in which choice of service providers is limited to those providers within the PIHP provider network. Members receive a provider network listing at least annually or can access the Provider Network Listing on the PIHP's website that informs them of the most current providers available to them. The member and interdisciplinary team select providers to deliver the services identified in the plan of care according to member preference, geographic proximity if applicable, cultural competency of providers if important to the member, etc.

The interdisciplinary team is responsible to monitor services and the status of the member, to assure that the services support the outcomes identified in the member's member-centered plan, that the service needs identified in the plan of care are met, and that backup services are available and provided as needed.

The interdisciplinary team is responsible to monitor the health and welfare of the member.

The interdisciplinary team is responsible to ensure that the member has access to all services identified in the plan of care, whether paid or unpaid. The interdisciplinary team is responsible to ensure that the member is supported in accessing health care services and to coordinate with the member's health care providers.

The interdisciplinary team is responsible to identify and remediate any problems related to the member's services and health and welfare. Some problems that are deemed critical must be reported to the State (see Appendix G).

The quality management strategy identified in Appendix H describes systematic methods for collecting and compiling information about results, including how problems identified during monitoring are reported to the state.

**b. Monitoring Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant.  
*Specify:*

Entities and/or individuals that have responsibility for service plan monitoring and implementation may not provide other direct waiver services to the participant, with the exception of Indian Health Care Providers (IHCPs) providing services to Indian members. For this exception, the following safeguards have been put in place:

The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist (TADRS) is responsible to inform the potential enrollee and/or her/his legal representative about the available service and enrollment options, including managed long term care (Family Care or Family Care Partnership), institutional services, fee-for-service Medicaid card and self-directed supports waiver (IRIS) services. If the individual is an Indian, the ADRC or TADRS informs the potential enrollee and/or her/his legal representative of 1) the option to choose between an Indian Health Care Provider (IHCP)(if available) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either the IHCP (if available) or PIHP network providers. The ADRC or TADRS also provides information about other options available to individuals, including the SSI Managed Care Program where available.

IHCPs who provide care management to Indian members are required, via the State-PIHP-IHCP agreement, to educate beneficiaries that they can access services through the IHCP, assuming it has the capacity to provide it, or a PIHP network provider.

## 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:**

**Service plans address members' assessed needs and personal goals. Numerator: Number of member-centered plans reviewed by the EQRO that were determined to be comprehensive per criteria by the SMA. Denominator: Number of member centered plans reviewed by the EQRO.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

**Also includes on-site reviews as necessary.**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 1.5% of members; 30 or greater records per PIHP



	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input style="width: 100%;" type="text"/>

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

**Performance Measures**

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

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

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant’s needs.*

**Performance Measures**

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

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

**Performance Measure:**

**Service plans are updated at least annually. Numerator: Number of member-centered plans reviewed by the EQRO that were updated at least annually. Denominator: Number of member-centered plans reviewed by EQRO.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

**Also includes on-site reviews as necessary.**

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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> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 1.5% of members; 30 or greater records per PIHP
	<input type="checkbox"/> 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> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each*

source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

Services identified in the member-centered plan are implemented. Numerator: Number of member-centered plans reviewed by the EQRO that were implemented consistent with the plan. Denominator: Number of member-centered plans reviewed by the EQRO.

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

**Also includes on-site reviews as necessary.**

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> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 1.5% of members, 30 or greater records per PIHP
	<input type="checkbox"/> 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> ):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

**Performance Measures**

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

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

**Performance Measure:**

Members verify they were given a choice of services and providers through signature on the member-centered plan. Numerator: Number of member-centered plans with appropriate signature verifying choice of services and providers. Denominator: Number of member-centered plans reviewed by the EQRO.

Data Source (Select one):

Record reviews, off-site

If 'Other' is selected, specify:

Also includes on-site reviews as necessary.

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):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: EQRO	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input checked="" type="checkbox"/> Other Specify: 1.5% of members, 30 or greater records per PIHP
	<input type="checkbox"/> 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):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other	<input checked="" type="checkbox"/> 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"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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. In addition, provide information on the methods used by the State to document these items.

In general, SMA oversight teams direct the correction of individual problems. The oversight team assigned to each PIHP discovers problems and issues through: reports from the EQRO related to individual member concerns; Family Care Ombudsman program reports; review of grievances and appeals; review of member incident reports; review of requests for use of isolation, seclusion and restrictive measures; discovery of problems or issues when giving an PIHP policy clarification, complaints to the SMA and from other sources. The team also interacts with the PIHP and PIHP staff on a regular basis and may identify concerns through such communication and direct observation. As needed, the oversight team directs remediation of individual member concerns as well as isolated operational concerns. The oversight team also uses information gathered through direct interaction with the PIHP and from many available sources to identify and direct remediation of systemic problems or issues within the PIHP. Oversight teams have the ability to respond quickly to any issue that affects member health or safety identified through routine discovery activities, but also respond quickly to other issues as they are identified.

Each oversight team documents issues and concerns and any resolution or remediation in an oversight team tracking system maintained by the SMA. An issue cannot be cleared in the tracking system without approval of the supervisor of the oversight team. The SMA has also developed policies and procedures for the EQRO and oversight teams to report concerns that rise to a level where they require the immediate attention of the SMA.

- 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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> 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 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

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**Applicability** (from Application Section 3, Components of the Waiver Request):

- Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.  
 **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

- Yes. The State requests that this waiver be considered for Independence Plus designation.**  
 **No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### 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.

a. All waiver services except care management and community residential care services may be self-directed. From among the services that may be self-directed, every member is offered the opportunity to direct some or all of the services he or she receives. Managed care organizations are required to identify the support an individual member may need in order to exercise this option and to provide training opportunities or other assistance as needed.

b. Members may exercise employer authority or budget authority or both. Members may choose to employ a service broker to assist in exercising self-directed supports (SDS) options. Service brokers are subject to criminal background checks and must be independent of any other waiver service provider.

c. Fiscal agents are available to members to provide payments to providers selected by the member using funds authorized by the managed care organization for the member's use. Fiscal agents always provide appropriate withholding of taxes and other required or optional payroll deductions. When using fiscal agent services the member is the common law employer. The cost of fiscal agent services is provided and reported as financial management services. Co-employment agency services are also available to members. Co-employment agencies function as the common law employer while the member continues to direct the worker. The cost of co-employment services is provided and reported as part of the individual service for which the provider is hired by the co-employment agency, e.g., supportive home care. Service brokers may be hired by a member to assist in the direction of services and supports. The cost of a service broker is assumed by the member and reported under the service definition entitled consumer-directed services – support broker. The cost of any direct services authorized and obtained by a member through an SDS plan is reported under the appropriate service definition.

d. Member Direction of Services – called “self-directed supports” (SDS) in Wisconsin – is the provision of a flexible array of services provided to members that include member direction of a specified portion of the member's authorized services. Each managed care organization must have a SDS plan, approved by the State. An approved SDS plan will ensure that SDS is implemented through processes characterized by:

- Support for the member and those close to the member to assist in identifying the member's desired outcomes and the means of achieving those outcomes, in a manner that reflects member preferences as closely as possible;
- Planning that occurs within the limits of an individualized budget based on a standardized method to identify typical service costs for waiver members with similar needs in similar situations;
- An emphasis on identifying and strengthening networks of informal supports and on making use of generic community resources to the maximum extent possible.
- Identification of how members will be supported in service planning, implementation, and how the member's SDS plan will be

monitored to ensure member health and welfare, including ensuring that SDS services are provided by individuals or entities that are qualified to meet the unique needs and preferences of the member.

## 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:

Member direction opportunities are available to members who live in any allowable living arrangement. (Services included in a residential facility's rate can not be member directed, but other waiver services received by the member may be.)

## 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*

Members can choose to direct some of the services as identified in Appendix E-1 g.

## 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.

a. Information about member direction opportunities (e.g., the benefits of member direction, member responsibilities, and potential liabilities) is provided in the "Being a Full Partner in Family Care" brochure that is produced by the State Medicaid Agency. In addition, specific managed care organization member handbooks approved by the State Medicaid Agency must include information about the opportunity for member direction. Finally, as a part of the comprehensive assessment and member-centered care planning process, IDT staff are required to: provide a full and complete explanation of the self-directed services option; query members on their wishes regarding self-directing services; identify in conjunction with the member those authorized services and supports the member wishes to self-direct; explain to the member how a budget would be calculated and, where the member wishes to pursue

self-direction, develop the budget and explain it to the member; explain the member’s responsibilities associated with self-direction and the assistance the PIHP can make available with these; and explain the PHIPs continuing care management role when a member self-directs services, including the circumstances under which self- direction can be limited or terminated.

b. The Being a Full Partner in Family Care brochure and member handbooks are distributed by PIHPs. Face to face communications about self-directed services occur between PIHP IDT staff and the member in the development of the member-centered plan and at least annually as part of care plan reviews.

c. The Being a Full Partner in Family Care brochure and member handbooks are distributed by PIHPs, upon request prior to enrollment, within 10 business days of enrollment, and when significant changes occur.

d. The verbal exploration of self-directed supports described in “a.” above occurs as part of initial care plan development and on a yearly basis thereafter as part of care plan reviews, or more frequently if circumstances make it appropriate or the member requests.

Explanation of the methods PIHPs use to determine self-directed service budgets is provided in E-2:b.ii.

**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
Environmental Accessibility Adaptations (Home Modifications)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Housing Counseling	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Assistive Technology/Communication aids	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Vocational Futures Planning and Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment - Individual Employment Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adult Day Care Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Transportation (Specialized Transportation) - Community Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prevocational Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supported Employment - Small Group Employment Support	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Consultative Clinical and Therapeutic Services for Caregivers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Self-Directed Personal Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Counseling and Therapeutic Resources	<input type="checkbox"/>	<input checked="" type="checkbox"/>



Waiver Service	Employer Authority	Budget Authority
Skilled Nursing Services RN/LPN	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Consumer Education and Training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Supportive Home Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Transportation (Specialized Transportation) - Other Transportation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Consumer Directed Supports (Self-Directed Supports) Broker	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Training Services for Unpaid Caregivers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Financial Management Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Personal Emergency Response Systems (PERS)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Daily Living Skills Training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Adaptive aids	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Day Habilitation Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Relocation services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## 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 may be provided by:

1. private, for profit accounting agencies;
2. private profit or not-for-profit financial management agencies; or
3. individual FMS providers.

These services may be procured through Request for Proposal procedures. Prospective providers may also register on a website.

A new vendor may begin providing support at any time after meeting the required qualifications as indicated in the service contract proposed by the Managed Care Organization and completing a Provider Agreement with the State Medicaid Agency.

There may be more than one FMS providing services to Family Care enrollees under contract with any Managed Care Organization. Members may choose alternate FMS agencies on an individual basis.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities are paid by MCOs according to the terms specified in the contract between the MCO and the FMS entity.

**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:

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- 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:*

Perform provider background checks as specified in Appendix C service provider requirements.

---

Supports furnished when the participant exercises budget authority:

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- 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:*

The FMS entity may act as the Representative Payee.

**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.

1. Fiscal Management Services of the Self-Directed Support payment system:

a. This program is designed to provide a conduit for individual service funds to be held by the FMS until accessed by enrollees and their Support Brokers.

b. The FMS will issue monthly statements to the enrollee and Support Broker, indicating all disbursements made on behalf of the enrollee and balances remaining in the enrollee's account.

2. Content of Report: For this program, the FMS shall submit, at a minimum, and within fifteen (15) days of the end of each period (whether monthly or quarterly), the following reports to the MCO that is responsible for completing all encounter reporting to DHS:

- a. Monthly, the number of financial transactions made.
- b. Monthly and quarterly statements indicating all disbursements made on behalf of the enrollee, including vendor paid, categories of payments, and amount paid to each vendor.
- c. Monthly and quarterly statements indicating balance of funds in each member account.
- d. Quarterly statements indicating aggregate amounts paid by vendor and payment categories and aggregate amounts held in reserve.

3. Other Features and Requirements:

- a. The FMS shall maintain all individual service funds in a separate interest bearing bank account and will maintain a separate internal member account for each individual.
  - b. The FMS shall not commingle individual service funds with any other funds that the Agency holds.
  - c. The FMS shall not request nor transfer funds from the individual services funds to any other program that it provides.
  - d. The FMS shall not influence the enrollee or Support Broker in selecting, contracting with or terminating agreements with Support Brokers, service providers, Fiscal Management Service providers or independent contractors.
  - e. The FMS and MCO staff agree to meet quarterly to review program goals, and progress and barriers encountered in reaching those goals.
  - f. The FMS agrees that during the terms of the agreement the contract may be renegotiated to address changes in utilization, service delivery, or other provisions required by law, policy or funding sources.
  - g. An audit of the funds held in trust may be performed as part of the FMS audit and included in the audit report submitted by the FMS. The audit of funds held in trust shall be performed on the cash basis of accounting.
4. The FMS shall submit by January 31 of the contract year the following:
- a. Legal Name of the Organization;
  - b. Current street address and telephone number;
  - c. Chief Operating Officer/Executive Director;
  - d. Legal Status (Private, Not-for Profit Corporation; Private, For-Profit Corporation, LLC, etc);
  - e. Number of Board meetings the governing body or Board of Directors scheduled for the contract year;
  - f. A list of the Board Officers and their role (President/Chair, Vice President/Chair, Treasurer, Secretary);
  - g. The address and telephone numbers of all Board members, including the Board Officers;
  - h. Listing of all hours/days and dates the Fiscal Management Agency anticipates to be closed (holidays); and
  - i. Appropriate Medicaid provider registration forms.

## 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:*

The member's interdisciplinary team staff is responsible to assess the needs of each individual who elects member direction and to provide support for the member. Examples of support provided are training, sharing information and assistance in locating resources. The SMA has recently released an SDS Best Practice Guide for IDT staff to enhance their abilities to provide support to members who choose SDS with some best practice strategies to assure member health and safety while supporting members' ability to self-direct some of their services.

- 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
Environmental Accessibility Adaptations (Home Modifications)	<input type="checkbox"/>
Adult Residential Care - 3-4 Bed Adult Family Homes	<input type="checkbox"/>
Housing Counseling	<input type="checkbox"/>
Assistive Technology/Communication aids	<input type="checkbox"/>
Vocational Futures Planning and Support	<input type="checkbox"/>
Supported Employment - Individual Employment Support	<input type="checkbox"/>
Adult Residential Care - Community-Based Residential Facilities (CBRF)	<input type="checkbox"/>
Adult Day Care Services	<input type="checkbox"/>
Transportation (Specialized Transportation) - Community Transportation	<input type="checkbox"/>
Prevocational Services	<input type="checkbox"/>
Supported Employment - Small Group Employment Support	<input type="checkbox"/>
Care Management	<input checked="" type="checkbox"/>
Consultative Clinical and Therapeutic Services for Caregivers	<input type="checkbox"/>
Self-Directed Personal Care	<input type="checkbox"/>
Respite	<input type="checkbox"/>
Counseling and Therapeutic Resources	<input type="checkbox"/>
Skilled Nursing Services RN/LPN	<input type="checkbox"/>
Home Delivered Meals	<input type="checkbox"/>
Consumer Education and Training	<input type="checkbox"/>
Adult residential care - 1-2 bed adult family homes	<input type="checkbox"/>
Supportive Home Care	<input type="checkbox"/>
Transportation (Specialized Transportation) - Other Transportation	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Consumer Directed Supports (Self-Directed Supports) Broker	<input checked="" type="checkbox"/>
Training Services for Unpaid Caregivers	<input type="checkbox"/>
Financial Management Services	<input checked="" type="checkbox"/>
Personal Emergency Response Systems (PERS)	<input type="checkbox"/>
Daily Living Skills Training	<input type="checkbox"/>
Adaptive aids	<input type="checkbox"/>
Day Habilitation Services	<input type="checkbox"/>
Relocation services	<input type="checkbox"/>
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	<input type="checkbox"/>

- 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

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### 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:*

The Family Care ombudsman program offers independent advocacy to individuals enrolled in Family Care or Family Care-Partnership or who may potentially be enrolled in these programs. The ombudsman program for individuals under age 60 (including those with intellectual and developmental disabilities) is operated by Disability Rights Wisconsin, the state's Protection and Advocacy Agency. For elders, the ombudsman program is operated by the Board on Aging and Long Term Care, which also operates the ombudsman program for nursing home residents.

Members are required to be informed about the existence of these agencies and how to contact them in the member handbook which is provided to the member upon enrollment. In addition, the Department issued notice of action form that MCOs are required to use includes information about these agencies and the independent advocacy services they provide. Managed care organizations are required to assist members obtain access if this is requested.

In addition to the independent advocacy services available under the ombudsman program, individuals who are receiving services for mental illness, a developmental disability, substance abuse or who have been protectively placed by a court have access to an additional independent advocacy resource, a state-operated grievance system. This system is prescribed by state statute and is operated by the Client Rights Office of the Division of Mental Health and Substance Abuse Services. Individuals covered by this program are required to be informed of its existence, their rights under statute and rule and must be assisted in accessing this program if they request.

## Appendix E: Participant Direction of Services

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### 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:

A member transitioning from self-direction is not terminating Family Care services and disenrolling from the program, only changing how they get their Family Care services.

When the member makes a decision that she or he no longer wants to self-direct services, the member would inform the IDT staff. (This can occur at any time, or the member may communicate the decision during a care plan review, and even if the member does not bring it up IDT staff are required to ask the member about whether the member prefers to continue self-directing services as part of the review.) Once the decision to end self-direction is communicated to the PIHP, IDT staff knows, based on the member-centered plan (MCP), the types and amounts of services the member receives. The IDT meets with the member to select PIHP network providers to replace the member-directed ones. IDT staff ensures that there are no gaps in services by assuring that authorizations end for self-directed services and start for contracted network providers without interruption, according to the schedule in the MCP. The PIHP transmits this information to the providers selected by the member from the PIHP's network and communicates it via written notice and a revised MCP to the member. The PIHP also informs the financial management services (FMS) provider that the member will no longer be receiving fiscal agent services. The member is advised to bring any problems with the transition from self-directed to network providers to the attention of IDT staff, and reported gaps in essential services will trigger PIHP contingency plans for use of backup providers.

The member may use any of the external member resources available for advocacy assistance with these matters, including but not limited to the Family Care Ombudsman Program, the EQRO and the elderly or disability benefit specialist programs available through Aging and Disability Resource Centers (see Appendix A:3).

## Appendix E: Participant Direction of Services

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### 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.

The PIHP is authorized to involuntarily terminate member direction if the member’s health and safety is jeopardized, purchasing authority is mismanaged or the member refuses to report information necessary for the PIHP to adequately monitor the situation. This action is appealable. If member direction is involuntarily terminated for a member, the member’s interdisciplinary team resumes full responsibility for authorization of services and for assuring continuity of services and, as appropriate, providers.

**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

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
	Number of Participants	Number of Participants	
Year 1			9193
Year 2			9638
Year 3			10013
Year 4			10842
Year 5			11247

**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:

Agency plus choice

- 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:

- 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.
- Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- Determine staff wages and benefits subject to State limits
- Schedule staff
- Orient and instruct staff in duties
- Supervise staff
- Evaluate staff performance
- Verify time worked by staff and approve time sheets
- Discharge staff (common law employer)
- Discharge staff from providing services (co-employer)
- Other

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
- Determine the amount paid for services within the State's established limits
- Substitute service providers
- Schedule the provision of services
- Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- Identify service providers and refer for provider enrollment
- Authorize payment for waiver goods and services
- Review and approve provider invoices for services rendered
- Other

Specify:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

To determine budgets for self-directed services, PIHPs estimate what it would cost the PIHP to fund the care plan, or the part of the care plan to be self-directed, in the absence of self-direction. That cost is the basis for the self-directed budget. Usually, this involves determining what the same services and supports in the amounts authorized in the plan would cost if the PIHP purchased them for this person or for one with similar characteristics who was not self-directing. In some situations where in the absence of self-direction the member would likely move into community residential care with a daily rate, or their care would otherwise be paid at a daily rate, such as live-in home care, that rate may be used as the basis for calculating the member's budget. In all circumstances, the member selects the needs and outcomes for which she/he wants to direct supports. Within this overall approach, PIHPs have some flexibility in the methods they use depending upon

member circumstances and preferences. These variations can be categorized as follows:

- **Establishing an Overall Rate**

This approach starts with an established rate determined by the PIHP for the cost of the authorized services and/or goods to be self-directed. PIHPs use an average rate based on their contracted providers that offer the same or similar waiver services multiplied by the authorize amount. Using the established rate, the PIHP creates the member's overall budget. Within that budget, the member has some flexibility to determine wages.

- **Bottom Up Budget**

In this variation, the process starts with the amount of services needed and the cost of goods or services to purchase through an FMS provider (e.g., special medical equipment, assistive technology or home modification). For direct care services, the IDT staff then works with the member to establish possible employee wage levels for the amount of services authorized. The PIHP would add additional costs to the wage baseline for fringe benefit costs. The budget is for a specific time period such as one month, six months or one year.

- **Daily rate**

For members who choose to direct many or all of their services through SDS, a PIHP can use a member's current or projected care plan to establish a daily rate for the services the member will receive. This works well for members needing a significant amount of daily home care, up to 24 hours, especially where workers may not be doing hands-on care but need to be on premises anyway or where the provider lives with the member. It also can be used for members who, in the absence of self-directed supports, would be in community residential care, with the daily SDS rate based on the daily facility rate of the alternate service plus a daily rate for any waiver services outside the facility rate. The daily rate is set to be sufficient to comply with applicable wage and hour requirements for member-employed home care workers.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

IDT staff use an assessment tool to estimate the number of hours needed to meet a member's stated outcomes. As a part of the individualized planning process, members receive a document showing them estimated monthly costs. The process of applying an assessment tool and completing that tool with the member ensures consistency and transparency. Fairness is ensured through the Resource Allocation Decision (RAD) making process and discussion, as well as through the availability of appeal options should a member not be satisfied with his/her Member Care Plan (MCP).

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

#### b. Participant - Budget Authority



- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The interdisciplinary team staff retains responsibility for oversight of the member's implementation of her/his self-directed supports plan and use of her/his self-directed supports budget. (Some PIHP's contracts for fiscal agent services require regular budget authority utilization reports to the interdisciplinary team.) The interdisciplinary team staff reviews the plan and budget and the member's situation if there is significant under-utilization or over-utilization of services and budget authority. The SMA does not prescribe protocols for MCOs to follow in carrying out these reviews. A sampling of member charts is reviewed by an SMA Member Care Quality Specialist on a rotating basis for each PIHP. For members who utilize self direction, special attention is paid to plans and associated budgets.

## Appendix F: Participant Rights

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### 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.

Members are informed of the right to a fair hearing in multiple ways and at multiple times, including prior to enrollment, at the time of enrollment and during enrollment.

The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialists (TADRS) inform potential enrollees of the right to a fair hearing prior to enrollment. This information is contained in the "Being a Full Partner" booklet produced by the State Medicaid Agency which ADRCs give to all potential enrollees. The regional income maintenance consortium determines eligibility for Medicaid and all managed long term care programs and processes enrollments. These agencies use standardized eligibility notification forms that include information about the right to a fair hearing. Once a member is enrolled, the PIHP's member handbook, which is given to every enrollee by the inter-disciplinary team, contains information about the right to a fair hearing. Finally, the interdisciplinary team is required to issue a standardized "notice of action" form, which includes information about the right to a fair hearing, any time a member's services are denied, suspended, reduced or terminated. The "notice of action" form includes information about the right to continuation of services pending the outcome of an appeal. Copies of notices of action, which include information about these rights, are maintained in the member's record. The PIHP must also provide members with written notification of appeal and grievance rights, including the right to request a fair hearing, when the PIHP 1) administers a long term care functional screen that results in a reduction of the member's level of care from "nursing home" to "non-nursing home;" 2) makes a decision in response to a member's grievance or appeal that is entirely or partially adverse to the member; 3) fails to provide services and support items included in the member's individualized service plan; 4) fails to act within the timeframes for resolution of grievances or appeals; and 5) develops an individualized service plan that is unacceptable to the member because a) the plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member or b) the plan does not provide sufficient care, treatment or support to meet the member's needs and support the member's identified outcomes or c) the plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member. The PIHP's member handbook describes the right of the member to continuation of services pending the outcome of an appeal or grievance at any of the levels available (the PIHP's internal grievance and appeal procedure, SMA review or State fair hearing).

The PIHP is required in its contract with the State Medicaid Agency to make assistance available to members to file a request for fair hearing. Both the member's inter-disciplinary team (IDT) and the PIHP's member rights specialist (a position required in the contract) are available to members for assistance. In addition, the State Medicaid Agency contracts for independent ombudsman services that are available to assist members to file a request for fair hearing and to assist the member at the hearing.

## Appendix F: Participant-Rights

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### Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
- Yes. The State operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

a. The State Medicaid Agency operates a dispute resolution process called Department of Health Services (DHS) review. It contracts with the external quality review organization (EQRO) to administer the process.

b. The process is primarily an attempt to negotiate an informal resolution that is mutually acceptable to the member and the PIHP. The EQRO reviews the disagreement with both sides and facilitates discussion to seek to informally resolve the issue/complaint. This is not a formal appeal process in that the State Medicaid Agency does not issue an order as a result of this process unless it finds a PIHP has breached a contractual obligation. A member may elect DHS review at any time for dissatisfaction with any action or omission of a PIHP, or for concerns about quality or any other issue. The DHS review process is also automatically initiated when a member requests a fair hearing. This is called concurrent review. A request for DHS review must be made within 45 days of the event that precipitates the request. Wisconsin Administrative Code DHS 10.54 requires that a DHS review must be completed within twenty (20) business days of receiving a request. The State Medicaid Agency must mail or hand deliver to the member in writing the result of the DHS review within 5 business days of the completion of the review.

c. While members are encouraged to use the informal DHS review process to resolve their concerns, the use of this process is not required for, nor does it limit, the opportunity to request a fair hearing. A member is not required to first undergo DHS review in order to request a fair hearing. If a member requests DHS review, that request and its outcome does not limit the member's right to additionally request a fair hearing. However, if a member elects not to request DHS review and go directly to a fair hearing for resolution of his or her issue, he or she cannot request DHS review following the fair hearing decision. The member will still undergo the DHS review process ("concurrent review" discussed above) which occurs automatically whenever a member requests a fair hearing. If concurrent review does not result in an informal resolution prior to the fair hearing, the member is precluded from requesting DHS review following the fair hearing decision.

The State Medicaid Agency oversight teams use the grievance and appeal data base to monitor trends for each PIHP. In addition, the State Medicaid Agency uses the grievance and appeal database to monitor trends overall.

The EQRO tracks all grievances in a database that the SMA has access to. This database includes all timeline information. In addition, the SMA receives a monthly report from the EQRO detailing the grievances and efforts to mediate a resolution. This report is reviewed by the SMA contract administrators for consistency in practices.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply
- Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

**b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

The State Medicaid Agency is responsible for the operation of the grievance/complaint system. It contracts with the external quality review organization (EQRO) to administer the process.

The State Medicaid Agency oversight teams use the grievance and appeal data base to monitor trends for each PIHP. In addition, the State Medicaid Agency uses the grievance and appeal data base to monitor trends overall.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a. The State Medicaid Agency uses the dispute resolution process described under F-2b, DHS review, to address grievances.

In distinguishing the types of member issues addressed under F-2 and the types of member issues addressed under F-3, it is necessary to distinguish between an appeal and a grievance.

An appeal is a request for a review of an "action." Actions are defined in the DHS/PIHP contract as a (1) denial of or a reduction in functional eligibility, (2) a denial or limited authorization of a requested service in the benefit package, (3) the reduction, suspension or termination of a previously authorized service, (4) the denial, in whole or in part, of payment for a service in the benefit package, (5) the failure to provide services and support items included in the member's individualized service plan in a timely manner, (6) the

failure of the PIHP to act within the timeframes for resolution of grievances and appeals, (7) the development of an individualized service plan that is unacceptable to the member because any of the following apply: a) the plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member or b) the plan does not provide sufficient care, treatment or support to meet the member's needs and support the member's outcomes or c) the plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member, or (8) notification by the PIHP of a decision that was made in response to a member's appeal that is entirely or partially adverse to the member.

A grievance is an expression of a member's dissatisfaction about any matter other than an "action." Common examples of grievable issues are changes in providers, concerns about the quality of care or services, and personal care workers arriving late.

Actions can be pursued through the PIHP appeals process, DHS review and the state fair hearing process.

Grievances can be pursued through the PIHP grievance process, DHS review and the state fair hearing process.

b. The processes and timelines for addressing grievances are the same as those described under F-2b.

c. The mechanisms for resolving grievances are the same as those described under F-2b.

## 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).

The incident types that the SMA requires to be reported for review and follow-up action are:

1. Abuse (physical, sexual, emotional, treatment without consent, unreasonable confinement or restraint);
2. Neglect and self-neglect;
3. Financial exploitation;
4. Any unplanned or unapproved use of restraints or restrictive measures;
5. Any unplanned or unapproved use of isolation/seclusion;
6. Death due to member abuse, neglect, self-neglect, exploitation, accident, restraint, seclusion, suicide, psychotropic medication(s), medication error(s), falls; unexplained, unusual, or suspicious circumstances;
7. Missing person;
8. Any unplanned (e.g. emergency) or unapproved involvement of law enforcement and/or criminal justice system (e.g. not addressed in a restrictive measures or behavior support plan);
9. Medication errors (med omission, wrong med, wrong dose, wrong time, wrong person, wrong route of administration); and
10. Falls

Incidents are to be reported to designated PIHP staff by contracted providers or by PIHP staff no later than one (1) business day after the incident was discovered.

Incidents may be reported by phone, paper form, or use of the respective PIHP's web-based incident reporting system.

- 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.

Referencing the member handbook and/or instructional pamphlet, Interdisciplinary Team (IDT) staff provide training regarding abuse, neglect, and exploitation to PIHP members and/or families and/or legal representatives and/or unpaid direct caregivers at the

time of the initial face-to-face assessment which takes place within 10 days after member enrollment or at the time of the initial comprehensive assessment (to be completed within 30 days of enrollment) and then at each annual reassessment thereafter.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Each PIHP is responsible for evaluating the reports. Reports are evaluated by designated PIHP managers who initiate incident investigations. Each PIHP has an incident review committee to evaluate all incidents and monitor for trends and quality improvement opportunities. The frequency of committee meetings varies by PIHP (weekly, biweekly, monthly, or quarterly).

PIHPs initiate an incident investigation to determine root cause for all incidents.

Designated staff of the PIHP or the provider complete an investigation of the incident and related events to determine and document whether the reported incident occurred and if it did:

- a) The facts of the reported incident (including the date and location of occurrence), the type and extent of harm experienced by the member, any actions that were taken immediately to protect the member and to halt or ameliorate the harm;
- b) The cause(s) of the incident;
- c) Whether reasonable actions by the provider or others with responsibility for the well-being of the member would have prevented the incident; and
- d) Whether any changes in the PIHP's or provider's policies or practices might prevent occurrence of similar incidents in the future.

Investigations are to be completed within thirty (30) calendar days of incident discovery. If information or findings necessary for completion of the investigation cannot be obtained within 30 calendar days for reasons beyond the PIHP's control, the investigation is to be completed as promptly as possible.

Within five (5) business days of completion of each incident investigation, the PIHP is to issue written notice of its investigation results to the member and/or the member's family or legal representative as appropriate.

- 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.

The SMA is responsible for overseeing the integrity of the incident management system operated by the PIHPs. Within a monthly report using a format specified by the SMA, the PIHPs are responsible to report all specified incident types.

Individual member/incident data elements are collected monthly. Data is aggregated and compiled into a monthly SMA incident report and disseminated to Oversight Teams and SMA management staff. Each Oversight Team is responsible to review their respective PIHP's monthly report as issued, monitor for incident trends and any member care-related quality issues/concerns relevant to PIHP incident management. Each SMA oversight team conducts monthly follow-up reviews with its PIHP. Remedial or corrective action is determined, as needed, by the oversight team. All findings and/or follow-up by the SMA oversight team is documented. Additional follow-up may include, but is not limited to, examination of individual member data (as provided in the PIHP's monthly report) and/or individual member record reviews depending on the trends or concerns identified.

Annually, the EQRO will conduct a Quality Compliance Review for performance validation of each PIHP's incident management system. The SMA may also request targeted quality reviews when necessary.

## 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).

Unless specifically indicated otherwise, all of the information provided applies to restraints, restrictive measures, and seclusion.

The “Guidelines and Requirements for the Use of Restrictive Measures” are available at:

[https://www.dhs.wisconsin.gov/bdds/waivermanual/app\\_r.pdf](https://www.dhs.wisconsin.gov/bdds/waivermanual/app_r.pdf)

Each application for a restraint/seclusion must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request for the restrictive measure. (References: Guidelines and Requirements for the Use of Restrictive Measures, pp.1-5; Application form – DHS F-00926, pp.5-6). Any use of seclusion that is not within the scope of the state Guidelines and Requirements is prohibited under any circumstance.

The PIHP is responsible for investigating unauthorized or emergency use of restraints in the context of incident management system investigations. Actions taken with provider deficiencies may include, but are not limited to, mandated training or re-training and additional monitoring by the PIHP/member’s Interdisciplinary staff and /or the PIHP’s Provider Network staff. In egregious situations, provider suspension may occur. Further, the Restrictive Measures Guidelines specify that if the same or a similar emergency occurs more than twice in a six month period, it is no longer an emergency and the restrictive measures planning process for an approved restrictive measure is initiated.

Review and approval of restraints/seclusion requests is conducted by the SMA’s Division of Long Term Care, Restrictive Measures Review Panel and/or the Division of Quality Assurance’s Waivers, Approvals, Variances, Exceptions (WAVE) Committee depending on the target group and type of residence (regulated vs unregulated) of the respective member.

Division of Long Term Care Restrictive Measures Review Panel is comprised of:

- State Restrictive Measures Lead
- Bureau of Managed Care (BMC) Representative ( Member Care Quality Specialist)
- DHS Division of Quality Assurance Representative (RN Consultant)
- Bureau of Center Operations, Developmental Disabilities Coordinator (Psychological Associate)
- IRIS Representative (Self-Directed Supports program)

Waivers, Approval, Variances, Exceptions (WAVE) Committee is comprised of:

- DHS Division of Quality Assurance (DQA), Director: Bureau of Assisted Living (BAL)
- DQA, RN Consultant to the BAL (Lead)
- DQA, Four Regional Directors from Northeast, Southeast, Western, and Southern regions
- DQA, Quality Assurance Program Specialist
- Bureau of Managed Care, RN Consultant (only for RM requests involving PIHP members who are frail elders or persons with physical disabilities and reside in DQA licensed facilities)

Each PIHP’s restrictive measures committee reviews and approves each request prior to submission for state level review and approval.(References: Section 6 Guidelines and Requirements for the Use of Restrictive Measures outlines the criteria for the approval process; WAVE memo 13-016).

For PIHP members who are frail elderly or physically disabled and reside in their own homes or in any unregulated facility, restraint/seclusion are first reviewed and approved by the respective PIHP. Upon approval, the PIHP submits the application to the SMA BMC Restrictive Measures Review Team and the review will be completed within 10 business days of application receipt. The Team will be comprised of:

- BMC Mental Health and Substance Abuse Specialist
- BMC Division of Long Term Care Restrictive Measures Review Panel representative ( Member Care Quality Specialist)
- The respective member’s BMC Oversight Team
- BMC RN Consultant

Documentation requirements related to restraint/seclusion use are specified in the Guidelines and Requirements for the Use of Restrictive Measures. Each restraint/seclusion application must specify the monitoring and documentation plan.

Providers are required to report use of restraint/seclusion to the applicable PIHP according to the “individualized protocol for provider reporting” as approved in the application. Monthly each PIHP reports member data to the SMA in accordance with the SMA’s data reporting specifications.

All individuals involved in the administration of restraints/seclusion must be trained by the SMA, a restrictive measures training expert and/or designated competent PIHP staff. Assurance of training of all individuals involved in the administration of restraints/seclusion is the responsibility of the PIHP within their contracts with respective providers in accordance with SMA-PIHP Contract, Article VIII.D.9.

Restraints/seclusion may be approved for less than but no more than one year; a renewal request and review and approval is required.

- 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:

On a monthly basis, the SMA will collect data on approved restrictive measures from each PIHP in a standardized file format, and load this data into a data warehouse environment. The SMA will extract aggregated data from this environment for analysis, tracking, and trending to identify potential patterns and outcomes, for monitoring and possible quality improvement efforts.

Each SMA Oversight Team is responsible for review of their respective PIHP's monthly incident and restrictive measures data reports; for monitoring restraint/seclusion trends and requests and the use and effectiveness of approved restraints/seclusion. Minimum follow-up consists of review of the report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data (as provided in the PIHP's monthly report) and/or individual member record reviews depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the SMA Oversight Team are documented.

Potential patterns concerning the unauthorized use of restraints associated with certain providers will be obtainable via analysis of the incident management system data. Unauthorized use of restraints (any type) or isolation/seclusion is captured as a member incident within the Incident Management System.

Use of approved restrictive measures is monitored and accounted for by each PIHP's restrictive measures lead. Thus, it could be readily assessed if restraints in use have not been approved. In the context of member-centered care, PIHP IDT staff oversight includes ongoing risk assessment and harm reduction management. If there are any concerns, IDT staff will increase monitoring of the member or situation which could be as frequent as daily member contact.

Members' record reviews could include the member's person-centered plan and approved restrictive measures plan, as well as PIHP tracking data concerning behavioral incidents, antecedent behavior tracking, and use of the restrictive measure(s), and related training documentation. The SMA would also review any appeal and grievance issues related to a restrictive measure.

During the annual EQR process, the individual PIHP's restrictive measures tracking tool is reviewed to ensure timeliness of initial approval and annual renewal. If EQRO discovery leads to out-of-compliance timelines for initial or annual renewal approval, remediation of identified individual or systems issues takes place with follow-up by the SMA PIHP Oversight Team. It may or may not need a corrective action plan, but the SMA PIHP Oversight Team would follow up in their regular meetings with the PIHP.

## 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:

- 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.

Unless specifically indicated otherwise, all of the information provided applies to restraints, restrictive measures, and seclusion. The SMA does not make a distinction between restraints/seclusion and restrictive interventions.

Each application for a restraint/seclusion must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request for the restrictive measure. (References: Guidelines and Requirements for the Use of Restrictive Measures, pp.1-5; Application form – DHS F-00926, pp.5-6). Any use of seclusion that is not within the scope of the state Guidelines and Requirements is prohibited under any circumstance.

Unauthorized and /or emergency use of restraints/seclusion is to be reported as an incident by any person who observes such use or to whom such use is reported by the member. Any report is to be investigated as a member incident.

Review and approval of restraints/seclusion requests is conducted by the SMA's Division of Long Term Care, Bureau of Long Term Support's Behavior Intervention Oversight Committee and/or the Division of Quality Assurance's Waivers, Approvals, Variances, Exceptions (WAVE) Committee depending on the target group and type of residence (regulated vs unregulated) of the respective member. Each committee includes a representative from the SMA. (References: Section 6 Guidelines and Requirements for the Use of Restrictive Measures outlines the criteria for the approval process; WAVE memo 13-016). Each PIHP's restrictive measures committee reviews and approves each request prior to submission for state level review and approval.

For PIHP members who are frail elderly or physically disabled and reside in their own homes or in any unregulated facility, restraint/seclusion are first reviewed and approved by the respective PIHP. Upon approval, the PIHP submits the application to the SMA. A collaborative review and approval is completed by the SMA Behavior Specialist and the respective PIHP Oversight Team.

Documentation requirements related to restraint/seclusion use are specified in the Guidelines and Requirements for the Use of Restrictive Measures. Each restraint/seclusion application must specify the monitoring and documentation plan.

Providers are required to report use of restraint/seclusion to the applicable PIHP according to the "individualized protocol for provider reporting" as approved in the application. Monthly each PIHP reports member data to the SMA in accordance with the SMA's data reporting specifications.

All individuals involved in the administration of restraints/seclusion must be trained by the SMA, a restrictive measures training expert and/or designated competent PIHP staff. Restraints/seclusion may be approved for less than but no more than one year; a renewal request and review and approval is required.

- 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:

Each SMA Oversight Team is responsible for review of their respective PIHP's monthly incident and restrictive measures data reports; for monitoring restraint/seclusion trends and requests and the use and effectiveness of approved restraints/seclusion. Minimum follow-up consists of review of the report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data (as provided in the PIHP's monthly report) and/or individual member record reviews depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the SMA Oversight Team are documented.

PIHPs are required to report any unauthorized use of restraints/seclusion within their member incident management system.

Data are aggregated to enable comparative analysis of trends/patterns across the PIHPs and data variables. Identified concerning trends are examined for quality improvement opportunities.

## 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:

**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).

Unless specifically indicated otherwise, all of the information provided applies to restraints, restrictive measures, and seclusion.

Each application for a restraint/seclusion must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request for the restrictive measure. (References: Guidelines and Requirements for the Use of Restrictive Measures, pp.1-5; Application form – DHS F-00926, pp.5-6). Any use of seclusion that is not within the scope of the state Guidelines and Requirements is prohibited under any circumstance.

Unauthorized and /or emergency use of restraints/seclusion is to be reported as an incident by any person who observes such use or to whom such use is reported by the member. Any report is to be investigated as a member incident.

Review and approval of restraints/seclusion requests is conducted by the SMA's Division of Long Term Care, Bureau of Long Term Support's Behavior Intervention Oversight Committee and/or the Division of Quality Assurance's Waivers, Approvals, Variances, Exceptions (WAVE) Committee depending on the target group and type of residence (regulated vs unregulated) of the respective member. Each committee includes a representative from the SMA. (References: Section 6 Guidelines and Requirements for the Use of Restrictive Measures outlines the criteria for the approval process; WAVE memo 13-016). Each PIHP's restrictive measures committee reviews and approves each request prior to submission for state level review and approval.

For PIHP members who are frail elderly or physically disabled and reside in their own homes or in any unregulated facility, restraint/seclusion are first reviewed and approved by the respective PIHP. Upon approval, the PIHP submits the application to the SMA. A collaborative review and approval is completed by the SMA Behavior Specialist and the respective PIHP Oversight Team.

Documentation requirements related to restraint/seclusion use are specified in the Guidelines and Requirements for the Use of Restrictive Measures. Each restraint/seclusion application must specify the monitoring and documentation plan.

Providers are required to report use of restraint/seclusion to the applicable PIHP according to the "individualized protocol for provider reporting" as approved in the application. Monthly each PIHP reports member data to the SMA in accordance with the SMA's data reporting specifications.

All individuals involved in the administration of restraints/seclusion must be trained by the SMA, a restrictive measures training expert and/or designated competent PIHP staff. Restraints/seclusion may be approved for less than but no more than one year; a renewal request and review and approval is required.

- 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:

Each SMA Oversight Team is responsible for review of their respective PIHP's monthly incident and restrictive measures data reports; for monitoring restraint/seclusion trends and requests and the use and effectiveness of approved restraints/seclusion. Minimum follow-up consists of review of the report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data (as provided in the PIHP's monthly report) and/or individual member record reviews depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the SMA Oversight Team are documented.

PIHPs are required to report any unauthorized use of restraints/seclusion within their member incident management system.

Data are aggregated to enable comparative analysis of trends/patterns across the PIHPs and data variables. Identified concerning trends are examined for quality improvement opportunities.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)



*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
- Yes. This Appendix applies** (complete the remaining items)

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

PIHPs' IDT staff are responsible for monitoring members' medication regimens. IDT staff assess the medication regimens of all waiver participants, regardless of residential setting, as part of routine reassessments – at minimum, every six months or whenever there is a significant change in the member's health or functional status. This monitoring is part of the nursing assessment and includes an evaluation of a member's ability to set-up, administer, and monitor their own medication.

When there is a discrepancy between medications prescribed and medications being taken, the IDT staff nurse is responsible, in accordance with state and professional nursing standards, for clarifying and reinforcing with the member the correct medication regimen.

PIHPs also make selective use of electronic medication compliance management devices, which are pieces of equipment that store a member's medication, notify the member that it is time to take the medication, dispense the correct medications at the appropriate time, and alert care givers and IDT staff when medication regimens are possibly not being followed.

When a complex medication regimen and /or behavior modifying medication is/are prescribed for a member, the IDT staff nurse or other appropriately licensed medical professional shall ensure the member is reassessed, as needed, but at least every six months for the desired responses and possible side effects of the medication, and ensure that all care staff understand the potential benefits and side effects of the medication and that all assessment results and follow-up have been completed and documented in the member record. If a complex medication regimen and /or behavior modifying medication is/are prescribed, the IDT staff nurse or other appropriately licensed medical professional must:

- ensure that the member's individual service plan includes the rationale for use and a detailed description of the behaviors which indicate the need for administration of the medication;
- monitor at least every six months for inappropriate use of the medication, for use contrary to the individual service plan, for the presence of significant side effects, for inappropriate use of the medication as a form of discipline or for staff convenience, or for use contrary to the intended use.

**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.

As stated above, PIHP nursing staff or other appropriately licensed medical professional is responsible for monitoring the member's medication regimens as part of regular reassessment, at least every six months or more often where there is a significant change in health or functional status. This activity is part of the nursing assessment of the member. It includes identification of harmful medication practices such as contraindicated medications, identifying failures to comply with medication regimens, and follow-up with the member, provider staff, prescribers and other relevant health care providers as needed to rectify the situation.

The PIHP must review, document, and report any medication errors that come to its attention. SMA reviews monthly PIHP incident reports for medication errors, trends and/or concerns. Identification of insufficient response to medication errors requires a review and corrective action plan.

When medication errors are the result of nurse error, the Department of Safety and Professional Services completes the oversight and any sanctions. The Department of Safety and Professional Services (DSPS) communicates its oversight activities related to errors made by nurses to PHIPs via:

- A letter to the nurse's employer(s)
- Posting of Board of Nursing disciplinary actions in the Wisconsin Board of Nursing newsletter (found on pp. 4-6 of this link)
  - o <http://dsps.wi.gov/Documents/Board%20Services/Newsletters/Nursing/BON%20Sept%202014.pdf>
  - o <http://dsps.wi.gov/other-services/look-up-orders-and-disciplinary-actions>

Wisconsin RNs are also required to self-report to DSPS:  
<http://dsps.wi.gov/Programs/DLSC/Conviction-Self-Report>

PHIPs are also contractually required to assure all RNs are duly and fully licensed upon and throughout employment. RNs are to report any licensure changes to the PIHP; failure to do so may be cause for termination.

When specifically directed by the SMA, the EQRO will evaluate PIHP performance related to medication management. Currently, the SMA has requested a specific focus review on PIHP medication review, reconciliation and outcomes. Analysis of raw data received is in progress. The EQRO may also be involved if an appeal and grievance situation involves medication management. If an out-of-compliance practice is found, the EQRO communicates with the SMA Oversight Team and RN Consultant.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

##### i. Provider Administration of Medications. *Select one:*

- Not applicable. *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

##### ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Providers are required to assess medications a member takes and the member's ability to control and self-administer medications. Providers administer medications to members who have been found incompetent or lack the physical or mental capacity to self-administer as determined by the member's physician, or to members who request in writing that the provider manage and administer medication.

When a service provider is responsible for the administration of medications to a member, there must be a written order from a physician and a properly labeled prescription, including the dosage. Medications given on an as needed basis require a clear definition of the circumstances under which the medication is given. A registered nurse affiliated with or employed by the provider is responsible to assure that staff who assist with the administration of medications are appropriately trained in administration of the medications that are specific to each member. Staff document each medication administration at the time of administration. Documentation of errors takes place as soon as discovered.

Members that have the capacity to self-administer medications do so and their medications remain under their control. The provider makes available a secure place for the storage of medications in the member's room. A member with the mental and physical capacity to develop increased independence in medication administration shall receive self-administration instruction.

##### iii. Medication Error Reporting. *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**  
*Complete the following three items:*

(a) Specify State agency (or agencies) to which errors are reported:

Providers are required to report medication errors affecting Family Care members to the PIHP. The PIHP must report errors to the Department of Health Services, Office of Family Care Expansion.

In addition, providers licensed by the Department of Health Services, Division of Quality Assurance (DQA) have reporting requirements related to the terms of their licensure. DQA regulates licensed and certified residential facilities including annual onsite monitoring and investigation of complaints and incidents with those facilities.

Providers in a licensed profession may also have license-related reporting requirements enforced by the Department of Safety and Professional Services (DSPS). DSPS regulates licensed professional nurses, such as LPN, RN, APNP, as well as investigation of complaints for professional misconduct.

(b) Specify the types of medication errors that providers are required to *record*:

PIHPs monitor the performance of contracted providers, including identification of potentially harmful practices. All medication errors (medication omission, wrong medication, wrong dose, wrong time, wrong person, and wrong route) must be recorded by providers at the time of incident discovery.

(c) Specify the types of medication errors that providers must *report* to the State:

PIHPs monitor the performance of contracted providers, including identification of potentially harmful practices. All medication errors (medication omission, wrong medication, wrong dose, wrong time, wrong person, and wrong route) discovered by providers must be reported to the PIHP at the time of incident discovery. Therefore providers do not report medication errors directly to the SMA; incident reports to the SMA are provided monthly by the PIHPs. Any necessary corrective action will be taken by the PIHPs per medication administration standards of practice for each particular type of provider.

The DQA and DSPS have standards for reporting specific to categories of licensure. DQA provides ongoing oversight of provider medication administration practices in regulated facilities and takes appropriate regulatory actions if a pattern of errors are discovered.

- 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:

- iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

PIHPs monitor the performance of its contracted providers, including identification of potentially harmful practices. All medication errors discovered by providers must be reported to the PIHP at the time of incident discovery. Therefore providers do not report medication errors directly to the SMA. Any necessary corrective action will be taken by the PIHP per medication administration standards of practice for each particular type of provider. In addition, the DQA provides ongoing oversight of provider medication administration practices in regulated facilities and takes appropriate regulatory actions if a pattern of errors are discovered.

Incident data reports are provided monthly to the SMA by the PIHP. Incident data is reviewed to identify trends and patterns and support improvement strategies.

The external quality review organization (EQRO) evaluates the performance of PIHPs for appropriate medication management as part of annual quality reviews.

## 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. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")***

##### **i. Sub-Assurances:**

- a. Sub-assurance: *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)***

##### **Performance Measures**

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

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

**Performance Measure:**

PIHPs will remediate all substantiated instances of abuse, neglect and/or exploitation.

**Numerator:** Number of substantiated cases of abuse, neglect and/or exploitation for which actions to protect health and welfare were implemented as verified by the SMA. **Denominator:** Number of substantiated cases of abuse, neglect and/or exploitation reported through the incident management system.

Data Source (Select one):

**Critical events and incident reports**

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

**Data Aggregation and Analysis:**

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

- b. **Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

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

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

**Performance Measure:**

**The required investigations of all incidents are completed within required timeframes as specified in the approved waiver. Numerator: Number of incidents that are investigated within required timeframes. Denominator: Number of all incidents that are reported in the incident management system.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

All SMA approved restrictive interventions are implemented by the PIHP and provider(s) as approved. **Numerator:** Number of properly implemented restrictive interventions based on SMA review. **Denominator:** Number of approved restrictive interventions.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

**PIHPs ensure members receive influenza immunizations. Numerator: Number of members during the measurement period who receive an influenza immunization. Denominator: All members continuously enrolled during the measurement period.**

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

	<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input checked="" type="checkbox"/> <b>Other</b> Specify: EQRO data validation	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**PIHPs ensure members 65 and older receive a pneumococcal immunization. Numerator:** Number of members age 65 and older continuously enrolled during the measurement period who have received a pneumococcal immunization. **Denominator:** All members age 65 and older continuously enrolled during the measurement period.

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



	<input style="width: 95%;" 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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: EQRO data validation	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" 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. Additional information for the Performance Measure listed under sub-assurance (c) above:

SMA oversight staff will review individual case files at the PIHP to determine if restrictive interventions are being monitored by the PIHP and that the monitoring shows that the interventions are being implemented as approved. This review applies to all waiver populations.

**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. In addition, provide information on the methods used by the State to document these items.

PIHPs are charged with remediating problems related to incidents; restraints, restrictive interventions and seclusion; and medication errors as they are discovered. PIHPs are expected to remediate problems based on the nature of the incident and the potential for additional harm or reoccurrence of the problems, with rapid remediation expected in instances of highest risk of harm.

SMA oversight staff review reports submitted by PIHPs and review the response of PIHPs to these problems as part of routine oversight activities using data submitted by PIHPs, reports from the EQRO and on-site observations. If issues with the substance or timeliness of remediation is determined to be deficient, the SMA will review requirements and procedures with the PIHP and may request corrective action if warranted.

- 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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input type="checkbox"/> <b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></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 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 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

### Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## Appendix H: Quality Improvement Strategy (2 of 2)

### 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.

The State Medicaid Agency's (SMA) processes for trending, prioritizing and implementing system improvements that are prompted as a result of analysis of discovery and remediation involve the steps outlined below.

1. Individual Issue or Incident Level - When single issues or incidents occur that require remediation, State Medicaid Agency oversight teams discuss those issues with PIHP staff and managers and develop plans for remediation of the issue. If quality concerns are identified in relation to the issue, those are addressed and may be elevated to SMA regional or central office managers. These issues may arise through the review of reports submitted by PIHPs, the findings of the external quality review organization (EQRO) and other sources. This process occurs on a continuous basis as the need arises. Health and safety issues are given priority. Issues that require corrective action are identified in writing by the SMA to the PIHP and the SMA oversight team tracks and documents implementation of the corrective action until the issue is resolved.

2. System Issues at PIHP Level - When systemic issues are identified within a PIHP, SMA oversight teams will take the lead to work with the PIHP to develop plans for system improvements at the PIHP. These issues may be identified through the review of reports submitted by PIHPs, the findings of the external quality review organization (EQRO) as identified above, the receipt of complaints, as well as during annual certification, financial auditing and review of encounter submissions. This process occurs on a continuous basis in addition to the regularly scheduled reviews and audits. An issue may be identified when multiple records during a review indicate an issue or when similar issues are identified over time during regular reviews of PIHP information.

Systemic issues that could affect member health and safety or that involve members with high risk due to complex needs are given priority, but issues that address service gaps, affect financial accountability and could impact SMA compliance with waiver assurances are also prioritized for remediation. Issues that require corrective action are identified in writing by the SMA to the PIHP and the SMA oversight team tracks and documents implementation of the corrective action until resolution of the issue. Significant issues of concern will also be addressed by SMA managers with PIHP managers to ensure they are addressed adequately and promptly. Systemic issues may require changes in PIHP policies and procedures, additional staff and provider training or the implementation of performance improvement projects.

3. Systemic Issues at Statewide Level or Among Multiple PIHPs - When issues that cross multiple PIHPs are identified during the discovery process, the systems improvement activities described above will be implemented as appropriate. In addition, the SMA uses a variety of processes to identify trends that require more far reaching SMA systems improvement activities. The SMA issues technical assistance and policy documents as well as contract changes to address some issues that have been identified among multiple PIHPs.

- a. SMA PIHP oversight process - SMA oversight teams for multiple PIHPs are supervised by regional managers who can identify trends across the PIHPs for which they have responsibility. All of the SMA oversight teams meet on a periodic basis to share information about PIHP performance and best practices in relation to PIHP oversight. The regional managers meet regularly with other regional managers and with all Office of Family Care Expansion (OFCE) managers and discuss issues they are seeing that may cross PIHPs or suggest changes to SMA policies and procedures. OFCE managers meet with managers in the SMA's Bureau of Financial Management and with information systems staff to share information about issues identified in those areas.

- b. SMA policy review - The policy staff within the SMA receive questions from SMA oversight teams and PIHPs regarding interpretation of policy and issues related to policy. Recurring questions or issues brought to these staff are documented, discussed within the unit and brought to management as appropriate. Issues that require immediate response may be addressed through written policy clarifications, technical assistance documents or contract amendments. Other issues may require more in-depth analysis and discussion within the SMA and may result in amendments or changes to future contracts.

- c. SMA review of EQRO discovery - The SMA reviews all reports of discovery by the EQRO to identify issues that cross PIHPs and systems. SMA Quality staff identify and analyze issues that affect the overall Family Care system and recommend potential quality improvement strategies. Strategies are presented to SMA managers and are prioritized based on the impact of the issue on 1) health and safety; 2) compliance with waiver assurances and other Medicaid requirements and 3) other SMA priorities for Family Care quality.

- d. Trending and analysis of performance metrics - The SMA has identified a number of performance metrics that it is tracking and trending over time. Those metrics are available to PIHPs and SMA oversight teams to prompt discussion and to identify successes and areas that need improvement. The metrics are also used by the SMA to compare PIHP performance and to identify program-wide issues. These metrics are relatively new and may be modified over time. The performance metrics are not specified as such in the SMA-PIHP contract although many of them are based on reporting

requirements found in the contract, such as influenza and pneumococcal vaccination rates, member survey results and financial reporting. Another group of these metrics include the results of reviews conducted by the External Quality Review Organization. They are compiled from various sources into a report for each PIHP.

4. Methods of Implementing Quality Improvement Strategies - Quality improvement strategies can be implemented in a variety of ways including:

- a. Modifications to the contract between the SMA and each PIHP - The contract reflects the requirements and expectations of the SMA for the operation of the Family Care program. If the nature of the quality issue is one that warrants a contract modification, it can be done by amendment or as part of the next annual contract cycle, depending on the urgency.
- b. Review process for certification and business plan - Some issues may be addressed by modifying SMA criteria for the annual review of documentation.
- c. Issuance of, or modification to, technical assistance and policy documents - The SMA issues technical assistance and policy documents on an ongoing basis as needed to address a range of issues including improving quality. These documents are sent to the PIHPs and available to members and providers on the SMA’s website.
- d. Modification of EQRO review instructions - The periodic reviews conducted by the EQRO can be customized to address a particular issue of concern--both as a vehicle for discovery and as a way to emphasize a particular improvement strategy.
- e. Focused EQRO reviews - The SMA has the option to assign the EQRO to conduct focused reviews based on discovery of individual or systematic concerns and work with the PIHP(s) on remediation strategies.
- f. Modification of RFP criteria - The request for proposal (RFP) process allows the SMA to establish criteria that re-enforce quality standards.
- g. Statewide performance improvement projects - The SMA-PIHP contract includes a provision allowing the SMA to mandate a statewide performance improvement project to address an issue that is of program-wide concern. The SMA has not required a statewide improvement project in a number of years, but it remains an option if an area of concern is identified by the SMA.
- h. Specialized reporting requirements - The SMA can require the PIHPs to submit materials to monitor progress related to a quality issues.

**ii. System Improvement Activities**

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> 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.

The SMA uses a “Plan, Do, Study, Act” process for quality improvement. Changes that are precipitated by analysis of data collected as a result of discovery activities are monitored using the various discovery methods described elsewhere in this document. These changes undergo the same scrutiny as did the processes or policies they are replacing.

Responsibility for monitoring and assessing system design change rests in the Division of Long Term Care within the SMA. The actual SMA staff who monitor and assess a particular system design change will vary with the nature of the change. Fiscal oversight staff would monitor and assess changes related to fiscal policies or practices, contract specialists would monitor compliance with contract requirements, clinical staff (e.g., RN, behavioral health specialist) would monitor changes within their realm of expertise, and member care quality specialists would monitor changes that directly impact

members. Some changes may precipitate a change in the tools used by the EQRO to ensure the data needed to assess a change is being collected. A change of particular significance may be assessed through a focused review by the EQRO or SMA oversight staff. Because these staff work as teams under the direction of leadership within the SMA, they are able to communicate their observations to other members of the team and to SMA managers. The SMA also meets regularly with the EQRO and gets updates on results of any changes as the information is being gathered.

The processes for monitoring and assessing systems improvement vary. A major guiding principle is that the same measurement or observation by which the need for improvement was identified should be repeated. For example, the success of a systems improvement change developed in response to a care plan review finding that identified insufficient documentation of offers of self-direction would be confirmed by another care plan review. The EQRO annual quality reviews routinely include repeat measurements of any indicators that were observed to be less than satisfactory in the previous year.

When systems improvements are implemented with organized performance improvement projects (PIPs), the specifications for monitoring and assessing the implemented change are developed and adopted in compliance with the standards set forth in the CMS protocol for PIPs. When a PIP is undertaken by a single PIHP, the PIHP develops the process and measures for monitoring and assessing system design changes, which are approved by the SMA and annually validated by the EQRO. If the PIP is a statewide project, the process and measures for monitoring and assessing system design changes are selected by the SMA, with the consultation of the EQRO and the PIHPs.

Changes to systems or processes are communicated to the PIHPs through official SMA transmittals such as technical assistance documents or contact amendments. PIHP leaders are alerted to coming changes at regular meetings. The SMA also maintains several electronic sharing mechanisms by which staff in various PIHP functional areas (e.g., provider network, quality, care management) are alerted to changes. Many systems changes are shared with external stakeholder groups such as the Wisconsin Long Term Care Advisory Council. Not every change will be of broad interest to stakeholders and may not be presented or noted at a meeting, but official documents are posted on the SMA website for public review. The SMA maintains a website that provides information about the Family Care program to the general public, including stakeholders, such as families, providers, agencies and other interested parties. The website includes: general information; program monitoring and evaluation, including Family Care reports; program operations including the PIHP contract, and Family Care requirements.

The results of changes are communicated in many of the same ways. The communication method and frequency will depend on the change. Some changes, although precipitated by discovery, will be relatively routine (e.g., a change in elements in a fiscal report). The contract between the SMA and PIHPs undergoes minor changes annually. A change of this nature would be re-evaluated during the review process for the next contract. The SMA would share results of such a change internally and with the PIHPs to determine if the change had the desired results.

The results of more significant changes (e.g., a change to the care planning process) would be communicated more broadly. Results would be presented to the Wisconsin Long Term Care Advisory Council and other interested stakeholder groups. Results of improvement initiatives of significance are highlighted in the annual report for Family Care and IRIS (Include, Respect, I Self-Direct) self-directed waiver program.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

During this waiver period, the process for periodically evaluating the Quality Improvement Strategy will occur subsequent to the release of the EQRO annual report and will involve the PIHP directors and quality managers, as appropriate. Decisions will be made by the SMA regarding changes in the quality management strategy for the coming year.

## 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).

This waiver is a component of an s. 1915 (b)/(c) waiver.

a. Each PIHP is required by the SMA contract to submit a financial audit conducted by an external independent CPA to the SMA by June 1 of each year (for the prior calendar year ending December 31) or nine (9) months after the close of the county fiscal year (if the PIHP is governed by a single county). The audit must be in accordance with the Generally Accepted Auditing Standards and GAAP (accrual accounting). It must also include compliance testing of program and financial requirements outlined in the SMA Family Care Audit Guide, which includes sampling and testing of payments made for contracted waiver services. The independent CPA audit report requirements include "Letters to Management," management response/corrective action plan for issues identified in the audit

report and/or Letter to Management, and a report on the PIHP internal control environment over financial reporting. The SMA conducts a comprehensive review of the audited financial results and audit report(s) and follows up with the PIHP on identified audit reports and findings, including internal controls and results of compliance testing. Follow up with the PIHP on audit findings requiring corrective action includes additional communications and reporting to the SMA and, as required, steps to show implementation of changes to correct identified deficiencies.

The annual PIHP external independent CPA audits are used as a part of the ongoing SMA fiscal oversight conducted by CPAs staffing that function. The external independent audits are one of many inputs to support the full oversight function.

b. Capitated payments to PIHPs are made through the SMA's CMS certified MMIS rather than as provider billings, and are prorated based on participant actual enrollment dates. The SMA conducts ongoing fiscal oversight of the PIHPs to monitor PIHP reporting of payments made for waiver services. Oversight begins with the annual review and certification of PIHP policies and procedures for claims payments. The criterion established in the SMA review tool includes a description of the PIHP's process for internal audit of claims payments, whether paid through an in-house claims system or through a Third Party Administrator. Annual review and certification of each PIHP's policies and procedures is followed by a quarterly review of reported claims payments against PIHP quarterly financial reporting results. Identified issues in either the policy and procedure submission or the quarterly reconciliation of claims payments against financial reporting may result in an audit of claims payments on-site at the PIHP offices. SMA audit procedures include system walk throughs, sample and tracing of service payments against service authorizations, provider contracts, member eligibility and actual payment for services received. Findings are identified in an SMA report to the PIHP with SMA identified corrective action outlined and followed up on to ensure corrective measures are satisfactory and fully implemented. Heightened fiscal and program monitoring is established and continued by the SMA until there is assurance that PIHP payments for services are accurate.

-At least every three years, each PIHP has an on-site comprehensive financial audit conducted by SMA independent auditors with health care and waiver program expertise. The audit includes sampling and testing of payments made to contracted providers for waiver services to ensure payments are accurate and for eligible, enrolled members.

-The need for off-cycle audit is identified through comprehensive SMA fiscal oversight and includes review of PHIP financial reporting and system concerns identified through communications related to quality, program operations, internal controls, failure to meet solvency and reserve requirements and contracted service provider issues. Financial reporting is used to identify solvency concerns, identify financial trend issues, understand unresolved discrepancies, and potential PHIP fiscal operational system concerns. Review of balance sheet changes, payment for member service expense claims payment development, aging of receivables and payables and notes to the financial reporting may be the underlying source used to conduct a targeted or comprehensive audit. In addition, follow up on findings from annual independent CPA audits, findings identified in the established 3-year cycle audits may be followed up on by the SMA through an audit to evidence correction of the finding prior to the next 3-year cycle audit if warranted.

-Fiscal corrective action plans are developed by the Division of Long Term Care within the SMA specific to the identified fiscal deficiency. Development and SMA approval of new procedures to correct a service provider claims processing issue or an internal control deficiency not immediately corrected upon identification. Satisfaction of corrective action plans are evidenced through both required submissions and documentation from the PIHP to the SMA fiscal oversight CPAs and site visits to observe the actual correction based on the specific fiscal finding. Heightened monitoring of PIHP required fiscal submissions are ongoing until the SMA is confident the finding has been satisfied.

-PIHPs are required to maintain a robust program integrity plan that includes review and audit of provider claims to establish accuracy and to assure procedures are in place to identify potential fraud and abuse in provider claims. The SMA reviews PIHP program integrity plans as part of the annual certification for contracting and identifies gaps and required corrections in PIHP procedures. Audit of actual service payments occurs as follows: during the annual compliance testing by the independent CPA auditors; during the State independent audits conducted on the three year cycle; through required follow-up audits conducted due to identified deficiencies during annual review of the PIHP policies and procedures; and through comparison of financial reporting submissions to reported claims payments submitted to the SMA encounter reporting system.

c. The SMA defines audit requirements and the program specific audit program is conducted by all auditors in addition to required standard audit procedures that meet the Generally Accepted Audit Standards for the entity. In place are: the three year examination (audit) cycle; targeted audits as required; and annual independent CPA audits that include program compliance audit requirements developed by the SMA. This may include qualified CPAs with expertise in the waiver program compliance requirements, such as staff from the Office of the Commissioner of Insurance, using the SMA defined audit program requirements. Standard audit procedures and sampling methods specific to the health insurance industry are used with modifications specific to PIHP program operations and contract requirements. The SMA also uses standard sampling and audit procedures for compliance testing of claims payment systems with verification specific to PIHP program operations and contract requirements. Audit sampling uses a combination of traditional random sampling methods used in audit and auditor selection to ensure samples are representative of the area of testing.

Sampling instructions for external independent CPAs are outlined in the SMA Family Care Audit Guide available on the SMA's website:

<http://www.dhs.wisconsin.gov/LTCare/ProgramOps/fiscal/index.htm>

The SMA has currently contracted with the OCI to conduct the 3-year cycle audits and the SMA has CPA auditors with specific industry and program expertise to conduct those and/or off cycle and targeted audits.

For services provided by IHCPs, IHCPs will submit claims to PIHPs that will be included in the approved encounter reporting process and used by the SMA to ensure the integrity of provider billings for Medicaid payment of waiver services. The SMA will monitor the costs for waiver services, to include self-directed services, in encounter reporting against statewide program experience for similar services to evaluate whether costs are reasonable and to identify areas of concern. The IHCPs will submit a comprehensive annual financial audit conducted by an independent CPA firm. IHCPs will be required to submit a cost allocation methodology for the SMA's approval prior to the submission of cost reporting. IHCPs will submit cost reports to the SMA to demonstrate the IHCP's full costs for providing waiver services to members. The SMA's Office of Inspector General (OIG) and other SMA staff will review the annual cost report to validate that: 1) the total costs are consistent with the costs reported on the tribe's comprehensive annual audit; 2) the cost report was developed using the cost allocation methodology approved by the SMA; and 3) that costs reported on the waiver cost report are removed from the IHCP's Federally Qualified Health Center (FQHC) cost report. The SMA will request additional information or conduct additional audit sampling and testing work as required to evaluate cost allocation and further establish compliance with the requirements.

## 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. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

**i. Sub-Assurances:**

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)**

**Performance Measures**

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

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

**Performance Measure:**

**Claims reviewed by independent auditors during required annual audits are in compliance with claims standards. Numerator: Number of claim payments that are found in compliance with claims standards. Denominator: Number of claims payments reviewed by auditors.**

**Data Source (Select one):**

**Financial audits**

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> ):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input checked="" type="checkbox"/> <b>Other</b> Specify: Independent Auditor	<input checked="" type="checkbox"/> <b>Annually</b>	<input type="checkbox"/> <b>Stratified</b> Describe Group: <input type="text"/>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>	<input checked="" type="checkbox"/> <b>Other</b> Specify: Per SMA Family Care Audit Guide
	<input type="checkbox"/> <b>Other</b> 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):
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> Specify: <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:**

Capitation payments to PIHPs are made in accordance with CMS approved actuarially sound rate methodology. Numerator: Capitation payments made to PIHPs at the approved rate through the CMS certified MMIS. Denominator: All capitation payments made to PIHPs through the CMS certified MMIS.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

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):



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

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<input checked="" type="checkbox"/> <b>State Medicaid Agency</b>	<input type="checkbox"/> <b>Weekly</b>
<input type="checkbox"/> <b>Operating Agency</b>	<input type="checkbox"/> <b>Monthly</b>
<input type="checkbox"/> <b>Sub-State Entity</b>	<input type="checkbox"/> <b>Quarterly</b>
<input type="checkbox"/> <b>Other</b> Specify: <input type="text"/>	<input checked="" type="checkbox"/> <b>Annually</b>
	<input type="checkbox"/> <b>Continuously and Ongoing</b>
	<input type="checkbox"/> <b>Other</b> 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 SMA pays a monthly capitation to the PIHP for each member, based on Family Care eligibility criteria. Functional eligibility is documented by a nurse or social worker using the SMA's automated long term care functional screen. Financial eligibility is verified and documented by a county income maintenance worker using the SMA's Client Assistance for Re-Employment and Economic Support (CARES) system. The information about functional and financial eligibility is stored in the SMA's CMS certified MMIS.

The SMA's Fiscal Agent makes the monthly capitation payment based on the level of care, eligibility and enrollment of members as documented in MMIS. No payment can be made for a member who does not have Medicaid eligibility and a level of care assessment that shows that functional eligibility is documented in MMIS for the program. The MMIS system ensures proper coding and payment of PIHP claims through system logic that is reviewed and tested annually and includes retroactive changes to either increase or decrease a capitation payment to reflect changes in eligibility and/or level of care. The system will not provide payment for a member who has lost eligibility or has been terminated from the program for any

reason, and will automatically generate retroactive payments and/or recoupment to accommodate lags in information transfer.

**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. In addition, provide information on the methods used by the State to document these items.

The PIHP is contractually required to perform monthly reconciliation of actual capitation payments received against the PIHP's internal enrollment systems and to perform a "back end" reconciliation of capitation payments against information obtained from the CARES and CMS certified MMIS data systems. The PIHP and SMA work together to identify the cause of and remedy any discrepancies. Manual override of MMIS claims may only be made through the SMA's Fiscal Agent, which requires hard copy documentation to support a change and authorization by designated SMA MMIS representatives. Manual changes may not be made without documentation demonstrating accuracy of the change and authorization by designated SMA Family Care program management. PIHPs reconcile payments received against their records and provide audit and communication of expected vs. paid capitations through a monthly reconciliation process that is contractually required. Unresolved issues requiring manual intervention by the SMA are reported monthly by PIHPs. Review of the PIHP capitation reconciliations and issue resolutions are part of the PIHP compliance audit requirements as outlined in the SMA Family Care Audit Guide.

- 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>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: PIHP	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></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).

This waiver is a component of an s. 1915 (b)/(c) waiver. Appendix I is a component of the 1915 (c) waiver. The payment method to reimburse the PIHPs is a per member per month (PMPM) capitation developed by the SMA’s contracted actuary to be actuarially sound and submission rate methodology with the CMS managed care rate setting checklist are approved by CMS. Therefore, payment requirements identified in the SMA contract for the provision of member services are incorporated into the above rate development process. The PIHP is responsible for establishing service provider rates for waiver services for which it contracts. The incentive to negotiate and establish competitive rates that result in cost effective services to meet identified member outcomes is critical to the financial viability of the PIHP. Article VIII.N.7 of the SMA contract with the PHIP outlines the payment

requirements for the PIHP with their contracted service providers. In addition, analyses to assess the level of provider rate increases from one year to the next. The level of and provider rate increases allowed to flow into the base costs during the rate setting process has been limited, by policy decision, in prior years to support the development of the trend as described in Section IV of the 2014 capitation rate report ([http://dhs.wisconsin.gov/ltcare/StateFedReqs/capitationrates/2014 capitation rate report.pdf](http://dhs.wisconsin.gov/ltcare/StateFedReqs/capitationrates/2014%20capitation%20rate%20report.pdf)). This analysis and limitation, in conjunction with the contract requirement listed above, represent the SMA's primary oversight mechanisms of the provider rate setting process for waiver services.

The SMA's contract with PIHPs contains provisions with respect to the appropriate payment of providers in Article VIII.N.6. Given that Family Care is a capitated managed care program, a PIHP has some flexibility in the establishment of its provider fee schedule, as long as it is in compliance with this Article. The SMA works closely with its contracted actuarial firm during the annual capitation rate development process to analyze the full set of encounter data that is submitted by the PIHPs.

The SMA's contract with PIHPs contains provisions with respect to the appropriate payment of providers in Article VIII.N.6. Given that Family Care is a managed care program, a PIHP has some flexibility in the establishment of its provider fee schedule, as long as it is in compliance with this Article. The SMA works closely with its contracted actuarial firm during the annual capitation rate development process to analyze the full set of encounter data that is submitted by the PIHPs. Analyses are carried out to ensure that the Medicaid fee schedule is being employed where required, per Article VIII.N.7, and the CMS managed care rate setting checklist. In addition, analyses assess the level of provider rate increases from one year to the next and provider rate increases allowed to flow into the base costs during the rate setting process has been limited, by policy decision, in prior years to support the development of the trend as described in Section IV of the 2014 capitation rate report ([http://dhs.wisconsin.gov/ltcare/StateFedReqs/capitationrates/2014 capitation rate report.pdf](http://dhs.wisconsin.gov/ltcare/StateFedReqs/capitationrates/2014%20capitation%20rate%20report.pdf)). This analysis and limitation, in conjunction with the contract requirement listed above, represent the SMA's primary oversight mechanisms of the provider rate setting process for waiver services.

The SMA approves care management rates for care management services provided directly by the PIHP. Care management is a significant and distinct service under the program model. SMA review of the rates is based on PIHP submission of direct costs and allocated costs with and include a description of the allocated cost methodology to achieve the proposed unit rate. Total annual projected costs are divided by projected annual units of service to derive a unit cost. In addition The review and approval includes benchmarking against other PIHP rates and program experience over time history for the same internally provided services. PIHP unit rates reflect the PIHP costs associated with the provision of this service based on the SMA contractual requirements. PIHP unit rates for care management are incorporated into the actuarially sound capitation rate methodology.

The annual audit process is used to verify actual costs and cost allocation to those services. Finally, service access and quality are considered as justification for approval of internally provided services if the service is also available from an outside contracted service provider.

The annual audit process is used to verify actual costs and cost allocation to those services.

Indian Health Care Providers (IHCPs) of waiver services receive an initial payment from the PIHP at a rate negotiated between the PIHP and the IHCP. The SMA makes a wraparound payment/recoupment to/from the IHCP for waiver services to Indian members so that the total of the payments the IHCP received from PIHPs, the member, Medicare, third party payers, and the SMA equals the IHCP's full cost of providing waiver services to Indian members. The IHCP's costs for providing waiver services to Indian members will be determined based on cost reports the IHCP submits to the SMA. The SMA will determine the amount of the wraparound payment/recoupment by comparing the IHCP's costs from the cost report to revenue the IHCP received from members, Medicare, third party payers, and the payments the PIHPs made to the IHCP based on Indian member encounter records. The list of Indian members will come from the IHCP and will be cross-referenced against the SMA's Medicaid eligibility files.

- 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:

This waiver is a component of an s. 1915 (b)/(c) waiver.

PIHPs authorized waiver services and provider claims are submitted to a contracted third party administrator (TPA) or the PIHP if processing claims in-house. Claims are processed against the PIHP service authorization and against the contracted provider rates.

Each contracted PIHP must develop a compliant TPA process as outlined in the SMA contract with the PIHP. The PIHP is required to have an internal audit process to sample and verify the TPA processes claims in accordance with the authorization and the contracted rates. The SMA validates this is done through annual review of PIHP policies and procedures for claims processing and the process is tested during the sampling and audit of services paid during the independent annual audit, 3-year cycle audits and periodic SMA audits of the PIHP.

Indian Health Care Providers (IHCPs) of waiver services will submit claims to the PIHP or the PIHP's contracted TPA to receive payment at the rate negotiated between the PIHP and the IHCP. The IHCP will separately submit a cost report to the SMA for the SMA's wraparound payment/recoupment to/from the IHCP.

## 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.*)

- 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:

This waiver is a component of an s. 1915 (b)/(c) waiver.

Capitated payments to PIHPs are made through the SMA's CMS certified MMIS system, which assures that payments are made only for eligible individuals by validating against the enrollment record for managed care participants. The PIHPs authorize services through a plan of care and the interdisciplinary team assures that services were delivered. Both the annual financial audit by independent CPA firms and financial audits conducted by independent State auditors include sampling and testing claims payments, as well as verification of eligibility, authorization and provision of services.

Wraparound payments the SMA makes to Indian Health Care Providers (IHCPs) will be eligible for 100% federal financial participation. The wraparound payments/recoupments will be limited to those Indian members the IHCP identifies and to services provided to the Indian member while the Indian member was eligible for and enrolled in the Medicaid waiver program.

- 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:

The SMA's Fiscal Agent maintains eligibility and enrollment information for each participant who is enrolled in a PIHP. A capitation payment is made each month by the SMA's Fiscal Agent to the PIHP for each enrollee. Payments are adjusted for partial months of enrollment on a prorated basis.

## 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.

Not applicable. All waiver services are included in the SMA's contract with the PIHP.

## 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:

PIHPs are either departments within a county government, government districts, public entities, or private non-profit entities. PIHPs are direct providers of care management services. Therefore, payments for care management services are made to a public, private non-profit, and Government providers for care management services.

The underlying entity type differs but there is no difference in the operation of the program contracted by the SMA or the contract requirements for the PIHPs. The county government PIHP is operated by a single county but structured as a separate department of the county and operated as a separate enterprise. Although the County has taxing authority, the contracted PIHP is at risk for the program operated by the County.

The Districts were created through statute by groups of Counties with the specific purpose of operating the SMA contracted program. The Districts do not have taxing authority and the Counties that formed the districts do not bear financial risk at the County level. The PIHPs operated under a district are risk bearing and operated as private enterprises.

The public entity PIHP, a for-profit entity, and the private non-profit 501(c)(3)s and are operated no differently from the County or District PHIPs. Regardless of entity type, all contracted PIHPs are risk bearing and required by contract to keep funds and accounting segregated from other operations, whether County, District or Public.

The SMA fiscal oversight function includes review of required financial reporting submissions to include both contracted PIHP operations and other operations to support the review and validation that capitation payments are segregated and used to support payments for waiver participants contracted Medicaid services and the infrastructure required to support those services.

## 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.

The monthly capitated payment to PIHPs is not reduced or returned in part to the SMA in any way that results in a disparity between the amount that is claimed to CMS and the amounts actually paid to PIHPs.

## Appendix I: Financial Accountability

### I-3: Payment (7 of 7)

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.
- The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- 
- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
  - This waiver is a part of a concurrent 1115/1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

## 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:

- 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:

PIHPs and residential settings (other than the personal home of the member) where the State (PIHP) furnishes waiver services are required to separate the cost of room and board from the cost of allowable waiver services.

The SMA permits PIHPs to choose one of three options for segregating room and board from service costs: an actual cost method and two flat rate methods. Each has strengths and drawbacks and because of that, the SMA has left the choice of a method to each PIHP. Each PIHP can only use one method to ensure consistency within that organization.

#### Actual Cost Methodology

This method requires calculation of actual room and board costs for each community residential facility with which the PIHP contracts. Facility-specific costs are split between care and supervision on the one hand and room and board on the other. Total costs attributable to room and board are divided by the number of residents licensed or certified for the living arrangement to get a room and board rate.

#### A. Costs Attributable to Room and Board Rent, mortgage payments, title insurance, mortgage insurance.

- Property and casualty insurance
- Building and/or grounds maintenance costs
- Resident's food
- Household supplies and equipment necessary for the room and board of the individual
- Furnishings used by the individual (does not include office furnishings)
- Utilities, resident phones, cable TV, etc.
- Property taxes
- Specific individual special dietary needs

#### B. Costs attributable to Care and Supervision. The following are allowable elements in residential provider rates for which FFP can be claimed:

- Staff costs:
  - o Salaries\*
  - o FICA
  - o Staff health insurance costs (benefits)

- o Worker's compensation
- o Unemployment compensation
- o Staff travel
- o Staff liability insurance
- o Staff development/education
- o Resident travel (includes depreciation on vehicle)
- o Administrative overhead-contractor's costs to do business, including:
  - o Office Supplies and Furnishings
  - o Percentage of administrative staff salaries
  - o Office telephone
  - o Recruitment
  - o Audit fees
  - o Operating fees/permits/licenses
  - o Percentage of office space costs
  - o Data processing fees
  - o Legal fees
  - o Agency liability insurance

\*In certain circumstances a staff person's wages and benefits may need to be apportioned between room and board costs and care and supervision. For example, a live in manager of a facility may have time apportioned for supervision and support, as well as building and ground maintenance.

A PIHP that uses this method is responsible for assuring that each residential care provider with which it contracts uses this method for identifying the portion of the facility rate attributable to room and board, for maintaining documentation or auditing providers to verify the accuracy of these calculations, and for updating this information annually.

#### Flat Rate Methodologies

These methods use a standard rate as the room and board cost for every residential care facility, or depending on the method, the rate can vary by county and type of residential facility.

A. SSI-E Payment Standard - SSI-E or the SSI Exceptional Expense Supplement represents the highest combined federal and state SSI payment amount in Wisconsin. Eligibility for the supplement is based on qualifying for SSI and either residing in community residential care or needing at least 40 hours a month of supportive services in one's personal home. The flat rate equals the SSI-E payment amount (\$900.77 in 2014) minus a personal needs allowance the PIHP may set at either \$80 or \$100 a month (must be the same for all members in community residential care in the PIHP's service area). This flat rate method is used regardless of whether the member receives SSI or her/his income comes from other sources. Since the SSI-E amount changes annually, the PIHP must update this room and board flat rate annually. A PIHP using this method with a \$100 personal needs allowance would have a flat room and board rate of \$800.77 in 2014.

B. HUD Fair Market Rate (FMR) Method - This method uses HUD FMR rental amounts as a proxy for housing costs. HUD FMR rents are set at the 40% percentile of surveyed rental costs reflecting modest but reasonable housing, include utilities, vary by county and apartment size, and are updated yearly. PIHPs using this method use the prior year's HUD FMR efficiency rent for owner-occupied Adult Family Homes; the one bedroom rent for corporate Adult Family Homes and Community-Based Residential Facilities; and the two bedroom rent for Residential Care Apartment Complexes. The board portion is set at a flat amount equal to the maximum Supplemental Nutrition Assistance Program (SNAP, called FoodShare in Wisconsin), allocation for one person plus a small amount for ancillary costs not included in the FMR or Foodshare figures. Figures are updated yearly.

The SMA permits PIHPs to choose from among the actual cost and two flat rate methods because each has strengths and drawbacks. The actual cost method is the most accurate when based on accurate data and calculations and reimburses real costs needed to sustain the facility and attract residential providers to serving members. However, the yearly calculations may be administratively burdensome and as a cost-based method, it lacks incentives to control room and board costs which frequently may exceed what members can afford to pay.

Flat rate methods provide more control over room and board rates. They are simple to calculate, transparent, and predictable for providers to make decisions about working with the Family Care Program. Members and potential members know prior to enrollment and/or admission to the facility what their financial obligation will be. However, flat rate methods may establish an amount which does not cover every facility's costs and members may pay more or less than the "real" room and board cost of the facility where they reside. These methods produce a reasonable proxy measure that is simpler to calculate and verify but at the expense of possible departures from actual costs.

Since each PIHP uses one method, there is consistency within each PIHP. The flat rate methods are based on widely used, available proxy data generated externally for other purposes and so verification is not necessary. If a PIHP uses actual costs, it is required to audit a sample of residential providers to verify the data used in the calculations and to make that material available to the SMA as part of any fiscal review.

## Appendix I: Financial Accountability

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## I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

- a. Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

*Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

*Specify:*

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

- a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

- a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

#### a. Co-Payment Requirements.

##### iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

#### b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

## Appendix J: Cost Neutrality Demonstration

### J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: 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	24924.37	6301.03	31225.40	61731.78	3140.52	64872.30	33646.90
2	26697.06	6726.60	33423.66	65519.64	3361.14	68880.78	35457.12
3	27426.55	6950.80	34377.35	66960.78	3463.85	70424.63	36047.28
4	27979.83	7122.52	35102.35	68048.90	3549.62	71598.52	36496.17
5	28955.54	7393.19	36348.73	70042.95	3684.25	73727.20	37378.47

## 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:	
		Nursing Facility	ICF/IID
Year 1	52532	37083	15449
Year 2	55072	39220	15852

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:	
		Nursing Facility		ICF/IID	
Year 3	57216	40962		16254	
Year 4	61954	44883		17071	
Year 5	64266	46761		17505	

## 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 the year is calculated by summing the product of each month's projected enrollment multiplied by the number of calendar days in each month. Monthly projected enrollment is generally based on historical enrollment experience in the Family Care and Partnership programs. Additional capacity is added to ensure Factor C is not exceeded in the event of unforeseen enrollment spikes. However, in counties that have people participating in legacy HCBS waivers or on a waitlist, projected enrollment is based on the number of people in the legacy waivers or on a waitlist multiplied by the statewide proportion of eligible individuals that have chosen to enroll in the Family Care waiver. The legacy waiver enrollment and the waitlists are the number of people known to be eligible for long term care. These numbers have been stable historically. When a county transitions, members have the option to enroll in either the Family Care or IRIS program. The historical statewide proportion of members that have chosen to enroll in Family Care during the initial transition is used.

Family Care implementation in the remaining counties is dependent on legislative approval. Transition period assumptions are preliminary and are used for budgeting purposes only. Actual transition periods will be determined upon consultation with MCOs, counties, ADRCs, and other interested parties after MCO contracts have been awarded.

Transition to the Family Care waiver in seven northeast Wisconsin counties begins in CY2015; Rock County begins 7/1/2016; Florence, Forest, Oneida, Taylor, and Vilas begin 7/1/2017; Dane begins 2/1/2018; Adams and remaining tribal members begin 7/1/2018. Waiver and waitlist enrollment in counties implementing prior to 7/1/2018 is based on State approved transition plans. Adams County and tribal member enrollment is based on legacy waiver and waitlist data as of 3/31/2018. The transition periods for counties with existing waivers range from one to six months. The "transition period" is the length time it takes a county to transition their existing waiver population to Family Care or IRIS once the transition begins. This is dependent on the size of the population transitioning and PIHP and ADRC capacity. Rock County is assumed to transition over a five month period; Brown, Dane, and Shawano counties are assumed to transition over a four month period; Marinette County is assumed to transition over a three month period; Door, Kewaunee, and Oconto counties are assumed to transition over a two month period; and Adams, Florence, Forest, Menominee, Oneida, Taylor, and Vilas counties as well as tribal members are assumed to transition within a single month. Persons on a waitlist are assumed to be enrolled evenly over 36 months. The State has enrolled persons from waitlists in expanding counties evenly over 36 months since May 2009. Counties are required to submit a transition plan for State approval, which includes a requirement that the waitlist population be enrolled evenly over 36 months. The Department has already communicated to ADRCs the current number of individuals enrolled in the waivers or on the waitlist. This information provides a good basis by which to estimate of the total number of individuals who will receive enrollment counseling at the ADRC by the end of the 36 month period. The Department will continue to communicate with ADRCs to ensure they are fully informed of anticipated enrollment.

The number of unduplicated participants served during the year is calculated by adding the number of members expected to disenroll during the year to the project