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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

General changes-- Updated language throughout the waiver application to reflect current policy and practice, clarify processes where necessary, improve organization, and better respond to the waiver application prompts based on CMS technical guidance.

B.3.e – Checked “waiver capacity is managed on a statewide basis” since the waiver program is now statewide and there is no longer a waitlist.

B.5.b.iii – Checked “Medically needy income standard” instead of “AFDC standard” to align with current practice.

B.8 – Updated to align with SMA-PIHP contract regarding access for LEP persons.

C-1/C-3 — The service definitions for Daily Living Skills Training, Day Habilitation, Prevocational Services, Supported Employment—Individual Employment Support, Supported Employment—Small Group Employment Support, and Vocational Futures Planning and Support were updated to describe the scope and intended outcomes of the services more accurately.

C-1/C-3 – CIE Exploration was made into an independent service. CIE Exploration was previously covered under the Supported Employment- Individual Employment Support service definition.

C-1/C-3 — Communication Aids was separated from the Assistive Technology definition into a separate independent service category, renamed “Communication Assistance.”

C-1/C-3 – Adaptive aids will no longer be an independent service. Adaptive aids items and services are now covered under the Assistive Technology service.

C-1/C-3 – Vehicle Modifications was made into an independent service. Vehicle modifications was previously covered under Adaptive Aids. Adaptive aids items and services are now covered under Assistive Technology.

C-1/C-3 – Health and Wellness was added as a service along with appropriate provider types and qualifications.

C-1/C-3 – The Housing Counseling service definition was modified to align more closely with CMS proposed core definition for Housing Counseling.

C-1/C-3 - Added nutrition standard requirement to Home Delivered Meals service.

C-1/C-3 – Remote Monitoring and Support service was added along with appropriate provider types and qualifications.

C-1/C-3 – Adult Residential Care- 1-2 bed adult family homes was renamed Residential Services (1-2 Bed AFH).

C-1/C-3 – Adult Residential Care- 3-4 Bed Adult Family Home, Adult Residential Care- Community Based Residential Facility, and Adult Residential Care- Residential Care Apartment Complex were merged into a single service category renamed Residential Services (Other). Each residential setting is now a separate provider type.

C-1/C-3 – TNCs (Transportation Network Companies) were added as an allowable provider type for both Specialized Transportation- Community Transportation and Specialized Transportation- Other. Individual drivers and Specialized Transportation Agencies were added as allowable provider types for Specialized Transportation- Community Transportation.

C.5 – Updated language describing how the SMA ensures compliance with the HCBS settings rule.

D.1.e – Added the updated definition of vulnerable/high-risk members.

D.2.a – Added information about systemic monitoring of service plan implementation.

D. Quality Improvement– Updated to include remediation plans for performance measures found to be deficient by CMS in 2023.

E.1.i.iv – Added language requiring MCOs to audit claims paid by FMS providers to monitor the integrity of financial transactions and improve oversight of FMS providers.

G.1 – Added information about the SMA’s new incident management system, the Adult Incident Reporting System (AIRS), including an updated list of incidents required to be reported, processes for the PIHP to investigate incidents, and how the SMA

will use AIRS to provide oversight of incident reporting and PIHP incident investigations.

G.2 and G.3 – Updated to reflect that emergency or unapproved use of restrictive measures and medication errors will be reported to the SMA using AIRS.

G. Quality Improvement—Updated to reflect new processes for discovering individual and systemic issues and remediating individual problems using AIRS.

I.2.b – Removed language to comply with CMS technical guidance. Detailed response is not required for waivers submitted with a concurrent 1915(b) waiver.

J.2.b – Removed outdated language describing how length of stay calculations account for the waitlist. There is no longer a waitlist.

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

1. Request Information (1 of 3)

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

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

Family Care and Family Care Partnership Waiver Renewal 2025

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: WI.0367
Waiver Number:WI.0367.R05.00
Draft ID: WI.018.05.00

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

Regular Waiver

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

01/01/25

Approved Effective Date: 01/01/25

PRA Disclosure Statement

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

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

C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

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)

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.0007.R07.01 is the previously approved 1915(b) waiver. With this 1915(c) waiver renewal, the State has also submitted a corresponding 1915(b) waiver renewal (WI.0007.R08.00).

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

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

☒ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §1932(a) of the Act.**
Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

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

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

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

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

Family Care is a comprehensive and flexible managed long-term care program, which strives to foster independence and quality of life while recognizing the need for individualized support. Family Care gives frail 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 access to services.
QUALITY – Improve the overall quality of the long-term care system by focusing on achieving members' health and social outcomes.
COST-EFFECTIVENESS – Create a cost-effective long-term care system for the future.

Family Care is a risk-based capitated program that incorporates the consumer-centered values of Wisconsin's home and community-based programs in a managed care service delivery system. The target groups include frail elders, adults with physical disabilities, and adults with intellectual or developmental disabilities who have long-term care needs. The State Medicaid Agency (SMA) contracts directly with prepaid inpatient health plans (PIHPs) to deliver comprehensive waiver services plus long-term care Medicaid State Plan services, including nursing facility services, home health, personal care, durable medical equipment, disposable medical supplies, therapies, and outpatient mental health and AODA services.

Family Care became statewide in 2018 and has achieved lower per person costs than the fee-for-service HCBS waiver programs that it replaced. The program is designed to provide incentives for 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, PIHPs have significantly reduced costs and maintained members' health and functioning in the community.

Additionally, in 18 counties, eligible persons may choose the Family Care Partnership Program. Partnership 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 Medicaid and Medicare services. For dual eligible members, Medicare services are provided through Medicare Advantage Fully Integrated Dual Eligible (FIDE) Special Needs Plans.

The SMA monitors the contracts with PIHPs and uses an external quality review organization (EQRO) to implement a multi-level quality management system within the PIHPs and for managed long-term care on a statewide level. Monitoring activities include annual quality reviews with each PIHP, annual care management reviews, including review of a sample of member individualized service plans, review of reports submitted by the PIHP, ongoing review of grievances and appeals, ongoing review of critical incidents and other adverse events for members, and ongoing review of utilization data for each PIHP. Additionally, 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.

Pursuant to a waiver amendment, effective 7/1/18, PIHPs are not at risk for services rendered to Indian members who receive care management from an Indian Health Care Provider (IHCP).

3. Components of the Waiver Request

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

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

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

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

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

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the

participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals

with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

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

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

In June 2023, the SMA extended an invitation to all interested parties (including program members, family, friends, caregivers, PIHPs, advocates, tribes, and providers) to provide any ideas they would like the SMA to consider in preparing this waiver renewal. The SMA received over 1500 submissions and conducted extensive review of the submissions to identify specific suggestions for changes to the waiver and common themes. The SMA used this feedback to draft a waiver renewal that is responsive to the needs of program members, family, friends, and caregivers and other interested parties.

On 6/5/2024, major Wisconsin newspapers published public notices that the draft Family Care and Family Care Partnership 1915(c) and (b) waiver renewal applications were available on the SMA's website for a 30-day public input period, at https://www.dhs.wisconsin.gov/familycare/waiver-renewal.htm. The SMA also sent out an e-mail message and used social media posts to invite interested parties to review the draft waivers during the public input period. As described in the newspaper publications and electronic messages, members of the public could request paper copies of the waiver renewal applications by calling 855-885-0287. The public had the option to submit comments to the SMA by email (dhsltcpubliccomment@dhs.wisconsin.gov) or mail. The public input period ended July 5, 2024.

Wisconsin tribes received written notice that the draft waiver renewal applications were available on the SMA's website for a 30-day tribal input period on 6/7/2024. The SMA also provided tribal consultation on 6/6/2024 at the Tribal Health Directors Meeting. The written notice and meeting notes are available upon request.

A full list of public and tribal input received and SMA responses is included in this application.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

Last Name: Van Sicklen

First Name: Kelly

Title: Managed Care Policy Section Manager

Agency: DHS/Division of Medicaid Services

Address: 1 W. Wilson Street, Room 527

Address 2: P.O. Box 7851

City: Madison

State: **Wisconsin**

Zip: 53707-7851

Phone: (608) 267-3264 **Ext:** ☐ **TTY**

Fax: (608) 266-5629

E-mail: kelly.vansicklen@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

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will

continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: KELLY VANSICKLEN

State Medicaid Director or Designee

Submission Date: Oct 10, 2024

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

Last Name: Van Sicklen

First Name: Kelly

Title: Managed Care Policy Section Manager

Agency: Department of Health Services

Address: 1 W Wilson Street

Address 2:

City: Madison

State: **Wisconsin**

Zip: 53707

Phone: (608) 267-3264 **Ext:** ☐ **TTY**

Fax: (608) 266-5629

E-mail: kelly.vansicklen@dhs.wisconsin.gov

Attachments

Attachment #1: Transition Plan

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

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

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

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

Several services have been reworked to align with CMS technical definitions.
- Adaptive Aids has been removed as a service category. Adaptive Aids items and services have been moved to the Assistive Technology service definition, except for Vehicle Modifications which have been moved to an independent service category.
- Communication Aids have been removed from the Assistive Technology service description and will be an independent service category renamed “Communication Assistance”.

These changes do not narrow or limit coverage of any services or supports. Therefore, the SMA does not anticipate that these changes will result in any loss or reduction of services provided to members. Members will be notified of the change during their next required meeting with PIHP IDT staff, after the new waiver start date of January 1, 2025.

Additionally, Adult Residential Care-CBRF, Adult Residential Care-RCAC, and Adult Residential Care-3-4 Bed Adult Family Home services have been merged into a single service category called “Residential Services-Other” with each type of residential setting becoming a separate provider type. There was significant overlap in service definitions and unnecessary distinctions specific to the provider types, rather than service coverage. These changes do not narrow or limit coverage of any residential services or supports. These changes will not result in any loss or reduction of services provided to members. Members will be notified of the change during their next required meeting with IDT staff, after the new waiver start date of January 1, 2025.

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.

Completed.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Public and Tribal comments received and SMA responses are summarized below:

Comment: Care managers should be social workers. There is a gap of knowledge and skill amongst those of us who have this certification and those who don't.
Response: The SMA declines to change the provider qualifications for Social Service Coordinators at this time. The current qualifications balance the need for quality service provision with the high demand for human services professionals.

Comment: Our younger members tend to be isolated and lonely more so than our elderly members. It would be great to see some social opportunities available for this group to get together with each other that is not elder focused. Response: Services that are solely social or recreational may not be covered under the waiver per Centers for Medicare and Medicaid Services (CMS). However, members may receive Day Habilitation services to help improve socialization and community integration skills.

Comment: Add peer mentoring to the waiver contract as well as community supported living. Response: Services available through "Community Supported Living" are already available under existing waiver services. The SMA may consider Peer Mentor services for a future waiver amendment or renewal.

Comment: Modify the Care Management waiver service to require the IDT to also do a comprehensive assessment and reassessment of unpaid natural supports to assess the ongoing capacity of natural supports to implement a proportion of the care plan. Response: The proposed changes already include the addition of "comprehensive assessment and reassessment" and "monitoring the delivery and quality of paid and unpaid services" provided by natural and community supports. This assessment and ongoing monitoring includes an assessment of the capacity of these supports to implement a portion of the care plan.

Comment: Add Future and Succession planning within Care Management services and Training for Unpaid Caregivers services. Discussions with unpaid caregivers should include exploration of Assistive Technology, Remote Monitoring and Support, and Accessible Adaptations as supports that may assist unpaid caregivers with providing natural supports for longer. Response: The proposed changes to Care Management already include "a plan to ensure continuity of the member's independence, care, living arrangements, and preferences in the face of changes in circumstances." Discussion of possible services that may complement services provided by natural and community supports already occurs during the development of the member-centered plan.

Comment: Separate the administrative portion of Supportive Home Care and FFS Personal Care from the wages paid to care workers into distinct services. Supportive Home Care and FFS Personal Care Admin should itemize spending into administrative cost categories and the amounts spent on those categories should be reported to the Department and publicly available. Average wages paid to workers should be reported by MCO to the Department and publicly available. Response: In the waiver, 'services' are defined and distinguished by their purpose in maintaining the member in the community and delaying or avoiding institutionalization. The administrative and direct care costs of Supportive Home Care serve the same purpose for the member (to provide the service as defined in the waiver), so cannot be defined as separate services. State Plan personal care services are out of the scope of the waiver, as are reporting requirements and direct care worker wages.

Comment: Expand circumstances under which payment to relatives/legal guardians for providing waver services, specifically to include circumstances in which there are authorized care plan hours that are supposed to be covered by paid workers that were filled by natural supports (i.e. because no one to hire, worker doesn’t show up). Response: The language in the proposed waiver does not prohibit payment to relatives/legal guardians in the circumstances described by the commenter. As long as the circumstances under C.2.d and e are met, a relative or legal guardian may provide services, regardless of the reason why their services are needed.

Comment: Add interpretation services as an allowable expense to Training for Unpaid Caregivers. Response: Interpreters may not be covered under training for unpaid caregivers. Providers of Training for Unpaid Caregivers may choose to provide materials in other languages, if necessary.

Comment: Remote Monitoring and Support- modify the first bullet so that it reads “a discussion with the member and legal decision maker, if applicable,” as many members have retained their civil rights to make their own decisions. Response: The SMA has made the recommended change.

Comment: Remote Monitoring and Support- modify the Provider Type from “Vendor” to "Remote Support Service Provider". We believe this more accurately reflects providers who have roles that span across the service definition—assessment, acquisition and installation of devices, and ongoing remote monitoring and response roles. Response: The SMA has made the recommended change.

Comment: Remote Monitoring and Support- Item C requires documentation of what “less intrusive” methods have been tried

and failed, which implies that Remote Monitoring and Supports is more intrusive than paid staff. We suggest modifying this requirement by removing the words “less intrusive” and “and failed,” such that there is a record of alternatives that have been tried but no presumption that they are more or less intrusive than Remote Monitoring, and no burden to demonstrate other service deliveries have failed in order for a member to exercise their preference to try Remote Monitoring. Response: Less intrusive methods of meeting a member's need that may be tried before using Remote Monitoring and Support could include a variety of behavioral interventions, PERS, or other solutions that do not involve more intrusive remote or in-person monitoring. Additionally, within the service, Remote Monitoring and Support encompasses a variety of monitoring technologies ranging from less intrusive motion or pressure sensors to more intrusive audio or video enabled devices. When authorizing or re-authorizing the service, PIHP interdisciplinary team (IDT) staff must, if possible, maximize the member's privacy and individual rights by trying less intrusive monitoring methods to meet the member's need before moving to more intrusive methods.

Comment: Remote Monitoring and Support- Item E. We are unclear what kind of data will be collected on the individual and reviewed, how it will be evaluated and by whom, and what metrics will be used measure effectiveness of the service. Item F. We are concerned that periodic reviews are framed such that removal to access of the service is presented as an end goal. We suggest restructuring the sentence to say “periodic review to assess whether the member wishes to continue Remote Monitoring and Support service delivery and whether additional modifications or changes are needed to meet member health and safety needs.” Response: As with all services, IDT staff are required to periodically review the service to determine whether the level of support continues to be appropriate. This may include considering data about how often remote supports are used and whether any additional in-person or back-up supports were needed. This could include an adjustment to the types or locations of devices used or termination of the service due to advancement of independent living ability or increased need for in-person support. These reviews take place every six months during the reassessment and member-centered plan update.

Comment: Remote Monitoring and Support- We note that access to Remote Monitoring and Support services may depend on members’ access to internet connectivity or a landline. For members living in residences that have reliable internet connections and provide the subscription services needed to access the internet, access to Remote Monitoring and Support is possible. For members with unstable connections or who are unable to afford subscription services on fixed, low incomes there is a barrier to access for these services that may be preferable to member and lower cost for the system. Response: Internet services may not be covered under this service. Members without reliable access to internet or telephone services may have their need met with in-person services.

Comment: Include volunteer drivers as providers of Specialized Transportation- Community Transportation and Home Delivered Meals. Response: An additional provider type is not necessary. Volunteer drivers may provide waiver transportation services as long as they meet provider qualifications. Volunteer driving programs may not be home delivered meal providers unless they provide the home delivered meal service, including meal preparation, in addition to delivery.

Comment: Will Transportation Network Companies (TNCs) be exempt from background checks and other requirements applicable to transportation providers? Response: TNC drivers are not exempt from background checks. TNC licensure through the WI Department of Safety and Professional Services (DSPS) requires TNC providers to perform background checks on drivers that are similar to background checks performed for other waiver providers. Additionally, TNCs require that drivers have adequate liability insurance, cars in good repair, and a valid driver's license. These requirements are the same as what is required for other waiver transportation providers.

Comment: Will individual contract drivers would be reimbursed or the company itself, and what complaint/grievance process is in place in the event a requested driver does not show up, does not have an accessible vehicle, or refuses to pick up people with I/DD, mobility equipment, or service animals? We note that refusal to pick up people with disabilities on basis of perceived condition or accommodation needs and a limited fleet of accessible vehicles are known issues with TNCs. Response: Reimbursement will be to the TNC provider rather than the contracted driver. Like other transportation providers, TNCs have grievance processes that members can use to report specific drivers or incidents. They also have policies prohibiting discrimination and allowing for disciplinary action, including deactivation of the driver's account, if the driver engages in discrimination. Members can also grieve to the MCO who can work with the TNC provider to solve problems or request action against a specific driver.

Comment: TNCs costs vary and can be dynamic; rates are adjusted based on factors including time and distance of route, traffic, current rider-to-driver demand and it may be impossible for riders or MCOs to know the cost of a particular trip in advance. Response: When determining whether to authorize the service, PIHPs evaluate whether using TNCs is a cost effective option for the member.

Comment: TNC have uneven distribution and operation in the state and are not available in many areas. The business model lends itself to higher density markets; many parts of Wisconsin do not have meaningful TNC options. Response: The SMA

recognizes that this provider type may be more prevalent in urban areas, and has proposed other changes to transportation providers to expand rural access as much as possible.

Comment: Transportation (Specialized Transportation) - Community Transportation. We request this language be removed from the service description: “whenever possible, family, neighbors, friends or community agencies who can provide this service without charge will be utilized.” Response: The SMA declines to remove the referenced language from the Transportation (Specialized Transportation)- Community Transportation service. The language identified is CMS language associated with this service.

Comment: Daily Living Skills Training- We recommend adding Mobility Managers as a provider type for mobility and travel training. Response: Mobility Managers may provide the service under the current provider types listed.

Comment: It is still unclear in the waiver application where a denial of rights would fall under the grievance and complaint system and not an adverse benefits determination. Denial of human rights needs to be specifically included in the description. Response: Under 42 CFR 438.4, a grievance is any expression of dissatisfaction about any matter other than an adverse benefit determination. Denial of rights does not fall under the definition for adverse benefit determination, so would be a grievance. The SMA intentionally uses the federal definition of grievance to ensure that the definition can be broadly applied to many situations or circumstances that result in member dissatisfaction, including denial of rights.

Comment: Add an ongoing requirement for providers to document their implementation of the setting rule. Maine created a similar checklist for providers to document ongoing compliance implementing the setting rule in both residential and non-residential settings. Response: As described in C-5, the SMA has several processes in place to ensure ongoing compliance with the settings rule, including, but not limited to, periodic site visits. Guidance documents and checklists are out of scope of the waiver renewal. The comment has been forwarded to the Settings Rule compliance team for their consideration.

Comment: Establish a pathway in the current waiver structure to include peer mentoring for individuals. We recommend including it in any of the following service areas: Daily Living Skills, Consumer education and training, Health and Wellness, Day Habilitation. Response: Individuals with disabilities may already provide the services listed as described in the waiver as long as they meet the required provider qualifications for that service. Creation of a distinct waiver service for peer mentoring may be considered as part of a future waiver amendment or renewal, but will not be considered for the 2025 waiver renewal.

Comment: Add language placing a timeframe on prevocational services and allowing prevocational services to reauthorized only when the member is receiving services to obtain community integrated employment (CIE), either from Vocational Rehabilitation or waiver CIE services. Response: The proposed service definition includes the following language: "Services are expected to occur over a defined period of time as determined by the member and their interdisciplinary team." The SMA declines to limit this service to a specific amount or duration, instead recognizing that members have individualized needs and progression toward their goal of CIE that may require different amounts or duration of this service. However, the definition is written to emphasize that the expected outcome of the service is measurable gains that contribute to the member's engagement to obtain or maintain competitive integrated employment.

Comment: Include requirements for prevocational services to demonstrate progress toward the achievement of the successful outcome of this service (CIE). Metrics to verify and measure progress should be done regularly and evaluated at least annually in the member’s care plan meeting. When pre-vocational services are not making verifiable and measurable progress, the care plan should be revised to take a different approach to the service—either changing service delivery settings, changing predominant activities done by the participant during the service, changing service providers, or changing the service provided (e.g. Supported Employment). Response: The proposed service definition includes this requirement. The definition is written to emphasize that the expected outcome of the service is measurable gains that contribute to the member's engagement to obtain or maintain competitive integrated employment. To that end, the service requires the completion of six month progress reports designed to demonstrate a member's progress toward meeting a goal of at least part time competitive integrated employment.

Comment: Supported Employment. We recommend the addition of a bullet under CIE Job Coaching to provide assistance to workers on correct and appropriate use of technology required by the job. We recommend adding language to the Workforce Incentive Benefits Counseling tasks to provide accurate and applicable information about the Medical Assistance Purchase Plan (work incentive program for people with disabilities) and ABLE accounts. Response: The activities listed are meant to be illustrative and not exhaustive. If appropriate for the member, job coaching may include assistance with use of technology and work incentive benefits counseling may include providing information about the MAPP and ABLE accounts.

Comment: Vocational Futures Planning and Support. The service definition is intended to “address barriers to employment due to the member’s disability, benefits, or life circumstances.” We would include non-driver status and lack of internet access as

external life circumstances that are barriers to employment. We appreciate the inclusion of assistive technology assessment and workforce incentive benefits analysis and encourage this bullet be expanded to cover savings opportunities offered by MAPP Independence Accounts and ABLE accounts. Response: "Barriers to employment due to disability, benefits, or life circumstances" would include non-driver status. Likewise, work incentive benefits analysis would include providing information about MAPP and ABLE accounts.

Comment: Daily Living Skills Training. We recommend under Task Analysis and Systemic Instruction adding rights education and abuse, neglect and financial exploitation education as an allowable service. Response: The activities listed under each service component are meant to be illustrative and not exhaustive. If appropriate for the member, daily living skills training may include rights education, and instruction about abuse, neglect and financial exploitation as part of self-advocacy training.

Comment: Consumer Education and Training. We recommend increasing the allowable amount for consumer and education to match inflationary costs. Inflationary costs have risen just over 21% since 2020 when the last waiver period began. The increase would produce a new amount of $3000 annually. Response: The SMA has updated the annual limit for Consumer Education and Training from $2500 to $3000 to adjust for inflation.

Comment: Health and Wellness. We appreciate the inclusion of Sexuality Training under this service and recommend the inclusion of training to help participants recognize sexual, emotional, verbal, and physical abuse and what steps to take if they find themselves in an abusive relationship. Response: The proposed definition includes training on "making informed choices about relationships," which may include training to help members recognize sexual, emotional, verbal, and physical abuse and what steps to take if they find themselves in an abusive relationship.

Comment: Housing Counseling. We recommend adding “non-driver transportation options, pedestrian features, and access to community assets” to the list of items under Community Integration Assessment. Response: The list of topics under Community Integration Assessment is meant to be illustrative and not exhaustive. The Community Integration Assessment may also include non-driver transportation options, pedestrian features, and access to community assets as well as other needs/preferences if these are important to the member.

Comment: D.1.b - is the correct radial button checked? The radial button selected says “may provide” the first sentence in the narrative says, “may not.” Response: The correct button is checked. Entities/individuals that have responsibility over service plan development may not provide direct waiver services unless they are an IHCP or culturally appropriate provider approved by the SMA. Therefore, the correct option is to select that entities/individuals that have responsibility for service plan development may provide other waiver services.

Comment: Health and Wellness- Recommend consider removing ‘experience’ as an applicable qualification to providing services as this could be open to interpretation. Response: The SMA declines to make this change to Health and Wellness provider qualifications. Some providers of this service, like Native American Healers, may not have formal licensure, certification, or training. These providers will be vetted on a case-by-case basis. The SMA is creating guidelines to ensure that this process is appropriate and standardized.

Comment: E.1.i.iv requires PIHPs to audit claims paid by FMS. Recommend the SMA consider removing the PIHP as the employer. Response: The audit claims sample testing requirement and template has a new section added for sample/testing of the SDS claims to satisfy CMS requirements. The PIHP is responsible for claims paid, whether by their TPA or by a contracted financial management services vendor that processes payments for SDS services.

Comment: C1/C3 Consultative Clinical and Therapeutic Services “Services are provided by state licensed or certified professionals or agencies that deliver services limited to their areas of formal education and training and/or as directed by their professional code of ethics.” Recommend the SMA consider how PIHPs will credential new services in the waiver. Language in waiver states that the agencies that deliver services are limited to their areas of formal education and training and/or as directed by their professional code of ethics.” This is vague for some of the service areas and may add difficulty in meeting credentialing standards that PIHPs must follow. Response: Counseling and Therapeutic Resources does not include new services. Providers of Consultative Clinical and Therapeutic services must be state licensed or certified counselors or therapists, so there is little ambiguity in their scope of practice or professional code of conduct.

Comment: B.1.n- Unduplicated Number of Participants. Just a comment that these numbers seem high. Response: The numbers are correct. These are unduplicated participant counts which include anyone enrolled for any length of time at any point during the year, whether they were in for a day or the entire year. This includes all new participants, all disenrolled participants, and those enrolled for the entire year.

Comment: Supportive Home Care. In this definition, it includes language on “home modifications, such as ramps.” Is this an error? Response: The SMA has edited the service definition to remove the language.

Comment: C.2.a- Caregiver background checks. [Commenter] continues to have some concerns over this for services such as Uber, or Lyft. How will this be accomplished? Response: TNC drivers are not exempt from background checks. TNC licensure through DSPS requires TNC providers to perform background checks on drivers that are similar to the background checks performed for other waiver providers. TNC drivers are not considered “caregivers” under Wis. Stat. 50.065. Additionally, TNCs require that drivers have adequate liability insurance, cars in good repair, and a valid driver's license. These requirements are the same as what is required for other transportation providers.

Comment: D.1.b- The IHCP or provider of culturally appropriate services is required to ask the member to sign an attestation that will be attached to the MCP indicating…member has been provided this information every 12 months as part of the annual comprehensive assessment. The commenter was understanding that this was no longer in place. Does DHS intend to include it again? Response: The SMA has updated the language to remove reference to the attestation form.

Comment: D.2.a- Statement that monthly contact (in person or by phone) must be conducted by an IDT staff member with the member. Currently this includes members' legal representative or collateral contact. Is this changing? Response: The SMA has updated the language to reflect the current SMA-PIHP contract language: "monthly contact with the member, legal decision-maker or individual authorized by the member to speak with IDT staff."

Comment: Why did the SMA categorize Adult Residential Care the way it did, with 1-2 bed AFHs becoming a separate category and all others being clumped into other. Response: Waiver services are organized by purpose. Since the purpose of residential services is the same regardless of type of setting, different types of settings were grouped under the same service category, with each setting being a different provider type. 1-2 Bed Adult Family Homes was separated into another service category because 1-2 Bed Adult Family home services may be provided by a relative, guardian, or legally responsible person. This option is not allowable for RCACs, CBRFs, and 3-4 Bed Adult Family Homes.

Comment: The waiver is lacking in initiatives to better support members with IDD and mental health diagnoses. Response: Members have access to the full range of mental health services offered through the Medicaid State Plan and waiver, including, but not limited to, mental health and AODA counseling, therapy, day treatment, and alternative therapies such as art, music, and equestrian therapies. Other mental health services, such as comprehensive community services (CCS) and community recovery services (CRS) are covered fee-for-service. The SMA has other initiatives to address the need for high-quality coordinated care for members with IDD and mental health diagnoses. Those initiatives are outside the scope of the waiver renewal.

Comment: D.1.f- The member handbook only states the member should talk to their IDT if interested in out-of-network providers; this is not enough information to adequately support members. Response: The SMA-PIHP contract requires the PIHP to inform members about the full range of provider choice available to them. For services in the benefit package that involve providing intimate personal care or when a provider regularly comes into the member's home, the PIHP must purchase services from any qualified provider at the member's request. For other services, member's must choose a provider from the PIHP's provider network. If the PIHP is not able to provide the service in-network, the PIHP is required to adequately and timely authorize and arrange for services with non-network providers.

Comment: This proposed waiver renewal does not include sufficient requirements for MCO’s to support increased engagement with CIE for Family Care members or require new investment by MCOs into this part of the program. Response: Employment goals, including competitive integrated employment (CIE), are assessed and discussed with the member during the member-centered planning process. If interested in competitive integrated employment, members may have access to several different services to support their employment goals, including Prevocational Services, CIE Exploration, Vocational Futures Planning, Small Group Supported Employment, and Individual Supported Employment. Additional requirements for PIHPs related to engaging members in CIE are outside the scope of the waiver renewal.

Comment: Transportation Network Companies (TNCs) must be held to the same standards (background checks and other requirements) as other transportation service providers. Additionally, TNCs must accept riders with service animals and be incentivized to make accessible vehicles available. Response: TNC drivers are not exempt from background checks. TNC licensure through DSPS requires TNC providers to perform background checks on drivers. Additionally, DSPS requires TNCs to require that drivers have adequate liability insurance, cars in good repair, and a valid driver's license. These requirements are the same as what is required for other waiver transportation providers.

Comment: Require PIHPs to have nutrition requirements for Home-Delivered Meal services purchased and to work with network providers to shift the focus from food security (access to sufficient calories) to nutrition security (access to healthful, nourishing

foods). Studies conducted on medically tailored meals and produce prescriptions, have shown promising results in improving health outcomes and reducing healthcare costs. Response: The SMA has updated the Home Delivered Meals service definition to include a requirement that meals meet nutrition standards and be medically appropriate for the member.

Comment: Implement adequate back-up systems to ensure members have contact information for a PIHP staff member who can assist them when their case manager is unavailable (vacation, sick, training, etc.). Response: The SMA-PIHP contract requires the PIHP to be responsible for providing members with services necessary to support outcomes twenty-four hours a day, seven days a week. This includes access to services in the benefit package, such as care management. The SMA-PIHP contract requires the PIHP to develop and submit a policy and procedure describing how their 24 hour coverage/on-call system meets requirements detailed in the SMA-PIHP contract.

Comment: Create an option for members to self-direct their transportation services using an approved budget and plan for authorized transportation services. Response: Members have the option to self-direct both Specialized Transportation-Community Transportation and Specialized Transportation- Other (self-directed non-emergency medical transportation).

Comment: Require care plans to include the transportation services necessary to support community integration and all care plan goals to achieve a self-reported high quality of life for Family Care participants. Response: PIHPs authorize waiver services, including transportation services, based on members' individualized assessed needs.

Comment: Unbundle transportation services from residential care provider reimbursement. Response: State administrative code requires 3-4 Bed Adult Family Homes, CBRFs, and RCACs to provide transportation.

Comment: The ADRC or TADRS, as indicated by B.7, apparently does not inform the potential enrollee and/or his/her legal representative about ICF/IID (intermediate care facility for individuals with intellectual disabilities) services. Is the option of ICF/IID services provided as an option in lieu of Medicaid HCBS in Wisconsin? Response: ADRCs provide individuals with information about an array of long-term care services, including ICF/IDDs. The list of options provided is not exhaustive, as indicated by the phrase “including but not limited to.” The list is not meant to exclude intermediate care facilities.

Comment: Remote Monitoring and Support- add training for family members, especially caregivers, to ensure they understand the requirements involved in the system and the information housed within it. Response: The service definition for Remote Monitoring and Support includes "training and technical assistance for the member or, where appropriate, legal decision-maker or family members."

Comment: Clarify if the member’s family and Circle of Support are included in service planning, as their involvement is crucial for ensuring effective and personalized care. Response: Members may include anyone they wish in developing and updating the member-centered plan, including family and other supports. This is described in the waiver and in the SMA-PIHP contract.

Comment: Implementing specialized care coordination services focusing on the unique needs of individuals with Alzheimer's, involving a multidisciplinary team to address medical, social, and emotional needs effectively, would be highly beneficial. Developing person-centered care plans that consider the individual's preferences, abilities, and life history will foster a sense of familiarity and security. Response: This is the program model. Care management is individualized, involves an interdisciplinary team, and is focused on identifying and authorizing services to support the member's personal experience outcomes, long-term care outcomes, needs, preferences, natural supports, and ongoing clinical and functional conditions that require long-term care.

Comment: To better serve members from diverse backgrounds, ensuring program materials, communication, and staff can accommodate different languages is vital. Offering interpretation services and providing written materials in multiple languages will help members from various linguistic backgrounds feel more comfortable and included. Response: As described in B.8, PIHPs and ADRCs are required make written materials in the prevalent non-English languages spoken in Wisconsin (or the PIHP's service area), and use interpreters or telephonic interpretation when needed.

Comment: Personalized care plans should respect individual cultural practices and preferences. Response: The SMA-PIHP contract requires the member centered planning process to "reflect cultural and other identity considerations of the individual."

Comment: Clarify items (C) and (F) under the section “Before authorization of Remote Monitoring and Supports, the following must be documented in the MCP:”
Item (C) states “Less intrusive methods of meeting the need that have been tried but did not work.” As described in the waiver renewal draft, “Remote monitoring and support enhances or increases a member’s independence and ability to live, work, or meaningfully participate in the community by providing real-time support using two-way communication and non-invasive monitoring technology”. Can the SMA provide clarification regarding what types of less intrusive measures should be

documented in the MCP?
Item (F) states “Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.” There are times when Remote Support services need to be terminated due to an advancement in independent living ability or increasing need for in-person staff, we’re assuming the “termination” referred to above encompasses both cases. Similar to other services, could this review take place during the annual review of services in the individual’s MCP/ISP? Response: Less intrusive methods of meeting a member's need that may be tried before using Remote Monitoring and Support could include a variety of behavioral interventions, PERS, or other solutions that do not involve more intrusive forms of remote or in-person monitoring. Additionally, within the service, Remote Monitoring and Support encompasses a variety of monitoring technologies ranging from less intrusive motion or pressure sensors to more intrusive audio or video enabled devices. When authorizing or re-authorizing the service, PIHP interdisciplinary team (IDT) staff must, if possible, maximize the member's privacy and individual rights by trying less intrusive monitoring methods to meet the member's need before moving to more intrusive methods. Similarly, as with all services, IDT staff are required to review the service to determine whether the level of support continues to be appropriate. This could include an adjustment to the types or locations of devices used or termination of the service due to advancement of independent living ability or increased need for in-person support. These reviews take place every six months during the reassessment and member-centered plan update.

Comment: PIHPs should not be required to provide the same care management services that a licensed assisted living provider is already mandated to provide under Wisconsin state law – DHS 83.35 (CBRF), DHS 88.06 (AFH), and DHS 89.26 (RCAC). Response: Prohibited by 42 CFR 441.301(c)(1)(vi), “providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan . . . .” PIHPs are expected to provide care management to all members, regardless of living arrangement. Care management is an integral part of the program.

Out of Scope Comments:

Comment: Please waive all fees including the $700 hundred every 3 years. Response: Provider fees are outside the scope of the waiver renewal.

Comment: I received and email about the Waiver renewal and I have questions about the email [phone number]. Response: The SMA contacted the individual about the waiver renewal.

Comment: Increase the pay for family caregivers as some family caregivers are not able to work outside the home. Some caregiving roles outside the home are in the range of $17.00/hr to $26.00/hr. Response: Payment rates for family caregivers are outside the scope of the waiver renewal. Members with budget authority determine wages for family caregivers within their SDS budget. The SDS budget is based on the rate paid by the PIHP to contracted providers for the same or similar services or an agreed-upon rate determined by the member/PIHP interdisciplinary team staff.

Comment: Hold agencies more accountable when they "drop" clients. Open an investigation of why the client was "dropped" and charge them for any financial hardship they may have caused. Keep a running total of all hours and pay out to the family member that may have had to quit or reduce their hours at their job because of this hardship to care for their family member and blacklist that agency. Response: This comment is out of the scope of the waiver renewal. More information is needed to respond.

Comment: Is the waiver only for skilled nursing and hospitals? I own a 16-bed CBRF and after scanning over it, I don't see that option? Response: The SMA sent the provider information about the waiver renewal.

Comment: There are many unused personal care hours on most member's care plans. Many members do not want personal care assist. Response: PIHPs authorize services, including personal care, based on members' assessed needs. Members have a right to refuse services if they do not want them.

Comment: Could providers have an optional free app based caregiver training program available to them to meet all expected training requirements rather than developing our own? Response: The SMA provided information about the SMA's free online training and certification program for direct care workers.

Comment: Why is there no oversight for the facilities that are owned by investors. It appears they can do how and what they want without any fear of answering to anyone. It seems like investors are interested in dividends at residents’ expense. Response: Oversight and licensing of facilities are outside the scope of the waiver renewal. All facilities must be licensed or certified to provide waiver services to members.

Comment: Is there anywhere in the revisions that addresses how [PIHP] is placing Members with Providers, allowing them to be

disenrolled and leaving the Provider without payment for months to get the Member re-enrolled and assigned a Case Management Team? This along with the back log of payments owed from the EVV system are bankrupting the Smaller Providers. Response: This comment is outside the scope of the waiver renewal. More information is needed to respond. The SMA contacted the commenter to request more information.

Comment: Require PIHPs to report the number of hours natural supports are providing care plan services, what services are being provided, and the proportion of the care plan supported by natural supports. Response: Reporting is outside the scope of the waiver renewal.

Comment: In the Department's summary of waiver changes, the description of who can use Remote Monitoring and Support Services is concerning. The summary states "it is for members who want more independence and do not need in-person assistance." Members should not have to demonstrate they have no need for in-person assistance to access these services. Prior to advances in technology, in-person service delivery was the default as there were no alternatives; this is no longer the case. While this limitation on who may use the service does not appear in the waiver service definition, we are concerned that implementation language should avoid creating limiting factors or artificial barriers on which participants are allowed use or can be denied access to this service. Response: Comments on informational summary documents are outside the scope of the waiver renewal. The SMA does not plan to limit Remote Monitoring and Support to members who have no need for in-person services, rather the SMA intends that Remote Monitoring and Support not replace in-person services that are necessary for a member's health and safety.

Comment: Include language that PIHPs must maintain their own incident management systems as well as the state. It is implied in the document but not specifically documented. Response: The language proposed responds to the CMS prompt. Requirements related to the PIHP incident management system are described in detail in the PIHP-SMA contract.

Comment: We recommend adding that the following data will be collected through the AIRS system to allow for tracking and trending: Incident data –The date, time, type, and the individual who experienced it. Participant status by plan, region, etc. – Counts of the numbers of individuals served and monitored by the incident reporting system are critical to put the incident data into context and to do basic comparisons of rates across regions and PIHPs. Demographics of participants – Demographic data from eligibility systems or other administrative sources can be valuable to identify groups with higher incident rates and to improve comparisons across regions or PIHP's. Key demographics would include age groups and disability type or level. For equity analyses and additional insights, additional breakdowns, such as race/ethnicity, gender, or language spoken, can be helpful. Residence type or service group – Residential type, service group or other key distinctions related to services received or level of need can also be useful to identify groups with higher incident rates and to improve the comparability of findings across plans or regions. Functional assessment data – Adding functional assessment data provides an opportunity to better account for different levels of needs and risks among individuals served in comparisons across agencies, plans or vendors. Response: The language proposed responds to the CMS prompt. Additional suggestions related to the design and functionality of the AIRS system are out of the scope of the waiver renewal.

Comment: Produce an annual public facing report on the reportable incidents impacting health and safety by PIHPs. Work with stakeholders including PIHPs, service providers, and advocacy organizations to determine what information is important to include in a report. Response: Reporting is outside the scope of the waiver renewal.

Comment: We suggest restructuring rates for CIE (Competitive Integrated Employment) providers and making payments based on hours worked and sustained employment as strategies that can increase CIE provider capacity. Response: Rate restructuring is out of scope of the waiver renewal. PIHPs negotiate rates with providers.

Comment: The fact that Family Care includes Remote Monitoring and Support as a cover service is tempered by the skeptical view of such services currently held by the Division of Quality Assurance of DHS. So long as regulators reflexively impose barriers to deploying these types of services, providers will be forced to turn to non-licensed, certified settings that afford greater flexibility to support innovative models of service delivery. Response: DQA regulation of residential facilities is outside the scope of the waiver renewal.

Comment: We respectfully suggest that, beginning with the next five year waiver cycle, efforts begin very soon to form groups of stakeholders to brainstorm solutions to the most pressing issues that prevent Family Care from being as successful as it could be: housing, transportation, technology, regulation, the LTCFS, and workforce. These efforts should include reviewing the experiments being undertaken in other states that are helping providers to support individuals with disabilities in the most person-centered fashion. Response: The member-centered planning process includes assessing all member needs, including health-related social needs. Family Care and Family Care Partnership cover several services that may address health-related social needs for individuals with disabilities, including housing counseling, home delivered meals, relocation services, and

transportation. Coverage of housing costs, such as rent, are not allowable under 1915(c) waivers. Section 1115 waivers are outside the scope of this waiver renewal.

Comment: The waiver renewal should identify how MCOs will be held responsible for creating and implementing a comprehensive plan to meet the community integration needs and desires of each member, how performance will be measured and appropriate accountability measures for MCO's to ensure compliance. Response: This is the program model.

Comment: An increase in care management quality should be a priority. The proposed waiver should include plans from DHS to address challenges impacting the quality of care management and appropriate accountability measures for PIHP's to ensure compliance. Response: The SMA-PIHP contract requires the PIHP to set competency standards for PIHP staff providing care management services. This includes providing or arranging for training to ensure staff meet competency standards and monitoring the quality of services provided.

Comment: Include mechanisms for both Family Care providers and participants to report and document services that were not received, delivered incompletely/partially, late, provided by substitute staff or were completed by family members or informal supports because paid/authorized providers were unable/unavailable. Response: Reporting is outside the scope of the waiver renewal.

Comment: Require collection of data elements that demonstrate geographic access, provider-client ratios, and timely access to care can be met for all services offered, or that a plan to increase provider capacity has been developed and is being implemented. Response: Data collection and reporting are outside the scope of the waiver renewal.

Comment: Add a requirement for PIHPs to include reporting of the number of hours natural supports are providing care plan services – both planned and unplanned. This information will allow for the creation of emergency plans, should the natural supports become ill or otherwise unavailable, and will identify the increased unplanned reliance on natural supports (indicating provider network adequacy issues, as well as additional needs to support family caregivers). Response: Reporting is outside the scope of the waiver renewal.

Comment: Reinstate retroactive eligibility for Family Care benefits back to application date. Retroactive coverage is available for those receiving care in institutions for up to 3 months prior to the date of application, but for those receiving care in the community retroactive eligibility is not even available back to the date of their application. Response: Eligibility depends on the results of a functional screen that does not occur until after an application is made at the ADRC and enrollment into an PIHP (Wis. Stat. 46.286(1)(a); (3)(a); DHS 10.36(1)).

Comment: Increase oversight of denials, complaints/appeals, and under-utilization of specific services and analysis to watch for patterns or trends related to frequently denied or delayed services. This would help to identify where additional training or stronger contract language may be needed. Response: The SMA already performs these functions.

Comment: Mandate and fund an Ombudsman to Family Care participant ratio of 1:2500. Response: The Ombuds contract is out of scope of the waiver renewal.

Comment: Make additional information available on the PIHP scorecard including profit/loss figures, rates of service denial, data related to the percentage of grievances/appeals, and specialty services. Response: The PIHP scorecard is out of scope of the waiver renewal.

Comment: Information regarding agencies/organizations (such as PIHPs) and other state regulated providers under a Corrective Action Plan should be available online to the public and ADRC staff to allow individuals to make fully informed decision regarding which program to enroll in, which agency to select, and from whom they wish to receive services. Response: Posting information about corrective action plans is outside the scope of the waiver renewal.

Comment: Create an option to "pause" an individual's program membership for a brief period (2 weeks, 1 month, etc.). Response: The SMA has established processes to allow for more timely reenrollment into Family Care and Family Care Partnership after a member is released from incarceration. More information about this process can be found in the ADULT LONG-TERM CARE PROGRAMS: ENROLLMENT AND DISENROLLMENT RESOURCE GUIDE.

Comment: We recommend that input from a diverse cross-section of HCBS users and providers be specifically sought out to ensure the community voice and voice of lived experience is included when designing or modifying HCBS programs and policies. Response: In addition to the required public comment period, the SMA completed extensive external engagement in 2023 prior to drafting the waiver renewal. This included soliciting input from members, family, caregivers, and other individuals

with lived experience.

Comment: Assess the current Family Care program information to ensure information regarding services and processes can easily be found online, is available in print (including large print and Braille) for those without access to online materials and are available in the languages needed. Response: Information provided to members is in compliance with CMS regulations at 42 CFR 438.10. The SMA will continue to consider ways to improve program information provided to members.

Comment: Require PIHP staff and HCBS providers to receive cultural competency training and require providers to deliver services in a culturally appropriate manner (including culturally relevant activities and delivery of culturally appropriate meals). Response: The SMA-PIHP contract requires PIHPs to permit members to choose providers from the PIHP network based on cultural identity and preference and cover services out-of-network when there is not appropriate cultural diversity in network.

Comment: We have growing concerns regarding the increased presence of private equity/real estate investment firms in long-term care service provider ownership. Low reimbursement rates contribute to the shortage of direct care workers. There is no place in these programs to provide large profits to providers. Wisconsin must do all it can to restrict bad actors from operating in this state and to regulate providers to ensure sustainability and ensure workers are paid a living wage. Response: Capitation rates must be actuarially sound. PIHPs and providers negotiate rates.

Comment: We agree and appreciate the SMA's position of continuing to pursue Pay for Performance (P4P) initiatives within the Family Care program. In particular, the Assisted Living Quality Improvement program that is tied with the Wisconsin Coalition for Collaborative Excellence in Assisted Living (WCCEAL) is a great start. Unfortunately, while the intent of this program is good, all of the incentives are provided directly to the PIHP. To further enhance and promote quality within assisted living facilities, all funding and incentives as part of the Assisted Living Quality Improvement program and any other P4P initiatives should be provided directly to the assisted living facility. Response: Pay for Performance initiatives are outside the scope of the waiver renewal.

Comment: We completely agree with the intent of a Risk Corridor to "address variances in costs for all benefit services other than care management". With that being said, we believe any recoupment made by the Department from a PIHP as part of the Risk Corridor should be directed back to assisted living facilities as part of a directed payment. This will help ensure all necessary funding is being directed as appropriate to assisted living facilities. Response: The risk corridor is outside the scope of the waiver renewal.

Comment: [Commenter] recommends the SMA collaborates with the Wisconsin Division of Quality Assurance on any remote monitoring/support initiatives to ensure assisted living facilities are in compliance with their PIHP contract and any regulatory requirements. In particular, that regulatory flexibility is allowed when assisted living facilities utilize remote monitoring and support. Response: Division of Quality Assurance (DQA) regulation of residential facilities is outside the scope of the waiver renewal.

Comment: [Commenter] continues to have concerns around coverage for services such as yoga, reiki, etc. We strongly encourage the department to work with MCOs to assist in clarifying and providing more specificity in these areas, including network adequacy standards and the requirement from the SMA that all providers be Medicaid certified. Response: The SMA forwarded the comment to the team responsible for implementation of the waiver changes.

The following supportive comments were received:

Comment: Thank you for the modification and enhancement to technology and health/wellness.
Comment: We are pleased to see Remotes Supports and Services added to the Family Care waiver.
Comment: Daily living skills training. We appreciate that this service includes training on communication and technology skills, use of adaptive or assistive devices, and mobility and travel training.
Comment: We support the concept of allowing Transportation Network Companies (TNC) to be an allowable provider for Family Care members, in the spirit of expanding options for non-drivers.
Comment: We appreciate the inclusion of the detailed information related to the new AIRS system.
Comment: [Commenter] supports the decision to highlight Remote Monitoring and Support as a separate service available under Family Care. Using technology to monitor members from another location offers significant benefits to Family Care members.
Comment: We are pleased to see some of our recommendations (creation of a health and wellness service and additional provider types for several services) have been included in the SMA's waiver application.
Comment: We appreciate that Remote Monitoring and Support has been added as an independent service. We are also pleased to see more provider types added for transportation, respite, home-delivered meals, and day habilitation services.
Comment: Health and Wellness services have been added to include healthy lifestyle activities such as exercise classes, cooking

classes, wellness services like meditation and yoga. These additions are significant for promoting overall well-being among program members, especially those with dementia, by offering structured activities that can help maintain physical health, reduce stress, and provide cognitive stimulation.
Comment: The addition of Remote Monitoring and Support services is particularly beneficial for members seeking more independence without the need for in-person assistance. This service covers technology and live remote support, which is crucial for those with dementia who may need regular check-ins and safety monitoring. It allows caregivers to provide support and ensure the safety of their loved ones even from a distance, enhancing peace of mind for both members and their families.
Comment: The inclusion of Transportation Network Companies like Uber and Lyft as allowable provider types for both Specialized Transportation-Community Transportation and Specialized Transportation-Other enhances transportation options for members. This is particularly important for individuals with dementia who may no longer drive but need reliable transportation to medical appointments, social activities, or day programs. Additionally, the inclusion of individual drivers and Specialized Transportation Agencies for Specialized Transportation-Community Transportation will improve accessibility and convenience, ensuring that members can maintain their independence and stay engaged in the community.
Comment: The updated definition of vulnerable or high-risk members now better encompasses individuals who are more susceptible to abuse, neglect, or exploitation due to their physical or cognitive impairments, lack of social support, or other risk factors. This broader definition is essential for identifying and providing targeted support to those with dementia, who often face increased vulnerability due to cognitive decline and social isolation.
Comment: The new Adult Incident Reporting System (AIRS) is an important enhancement for tracking and investigating incidents involving vulnerable members. AIRS includes an updated list of reportable incidents, processes for the PIHP to investigate these incidents, and oversight by the SMA to ensure proper incident reporting and investigation.
Comment: The updated requirements for reporting the emergency or unapproved use of restrictive measures and medication errors to the SMA using AIRS are crucial for maintaining high standards of care. This standardized approach ensures that such incidents are properly documented and addressed, enhancing the overall safety and well-being of program members. For individuals with dementia, who may be particularly vulnerable to medication errors or inappropriate use of restraints, this oversight is vital.

Comments received during Tribal Consultation:

Comment: Nice adding opportunities for transportation. Uber/Lyft will not help tribes because they are rural. Many tribes have transportation services, so maybe funding these services will help with transportation issues with the tribes.
Comment: Tribe has robust transportation program and have tried to get certified for reimbursement. Do not believe Uber/Lyft will work so would like contract with transportation department to provide these services. Response: SMA responded with understanding that TNCs may be less available in rural areas and noted that the additional individual provider type can be used to support transportation by family or other volunteers that meet provider qualifications. The SMA offered to discuss barriers to PIHPs contracting with tribal transportation services at a separate meeting.
Comment: Really like expansion to use traditional healers and culturally appropriate health and wellness. Believe this is the first time this has happened.
Comment: Glad there is movement on traditional healers.
Comment: Understand in the waiver application, using broad language [for traditional healing services]. Going to need to further define for PIHPs. Will further discussions be held with the tribes? For instance, traditional medicine can include gathering plants. Would the tribes be included in describing services? Also will they be involved in rate setting? Response: The SMA brought this suggestion to the waiver implementation team to follow up with the tribes.

Appendix A: Waiver Administration and Operation

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

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

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Division of Medicaid Services

   (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.:*

PIHPs:
1) Conduct home visits with each assigned member and their support system to develop a comprehensive member-centered plan;
2) Conduct annual level of care re-evaluation activities using the State's automated long term care functional screen;

3) Continually assess members' physical, environmental, and social needs and identify and respond accordingly to member health and safety risks;
4) Develop individual member centered plans (MCPs);
5) Perform prior authorization of waiver services;
6) Conduct utilization management functions;
7) Recruit and contract with providers;
8) Execute the Medicaid provider agreements; and
9) Develop and implement local QA/QI plans.

External Quality Review Organization (EQRO):
1) Reviews MCPs to ensure waiver requirements are met;
2) Assists the SMA in conducting training and technical assistance concerning waiver requirements;
3) Assists the SMA in QA/QI monitoring of PIHPs;
4) Evaluates PIHP performance improvement projects and assists with training and technical assistance for PIHP staff that are responsible for performance improvement projects;
5) Validates PIHP performance measures;
6) Assesses compliance with federal requirements related to member rights, access to services, structure and operations, measurement and improvement, and grievance systems;
7) Performs an Information Systems Capability Assessment of PIHPs;
8) Provides technical assistance to both the SMA and the PIHPs with regard to quality management activities and responsibilities, such as reviewing indicators of member health and well-being;
9) Administers or validates consumer or provider surveys of quality of care, including collaborating with the SMA in developing and testing new quality-discovery methods;
10) Administers the Family Care hotline for member complaints; and
11) Gathers information about member complaints, mediate, and refer members to advocacy representatives or the SMA.

Family Care Ombudsman Program:
1) Provides information and education on member rights;
2) Investigates member complaints;
3) Attempts resolution to resolve member complaints through informal strategies (negotiation, and mediation, support of consumer self-advocacy, and work with internal advocates);
4) Assists members in filing grievances, complaints and appeals, and administrative hearing requests;
5) Assists members in filing for administrative hearings;
6) Provides individual case advocacy to members in the grievance, appeal, and administrative hearing processes;
7) Provides legal representation for members in the grievance, appeal, and administrative hearing processes; and
8) Identifies and reports to the SMA patterns of member issues and ADRC or PIHP non-compliance issues.

Aging and Disability Resource Centers (ADRCs) (independent public entities):
1) Provide information and assistance;
2) Provide preadmission pre-enrollment options 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 and community outreach activities.

Tribal Aging and Disability Resource Specialist (TADRS)
1) Provide information and assistance;
2) Provide preadmission pre-enrollment options counseling;
3) Conduct level of care evaluation activities using the SMA's automated long term care functional screen (optional);

4) Make referral to other program eligibility activities on behalf of the SMA; and
5) Carry out prevention and community outreach activities (optional).

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

Appendix A: Waiver Administration and Operation

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

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

DHS Division of Medicaid Services

Appendix A: Waiver Administration and Operation

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

Methods vary by agency type:

1. PIHPs (primary agencies performing waiver operational & administrative functions)

a. The SMA-PIHP contract identifies federal & state requirements, including waiver assurances: i.) PIHP administration of the level of care tool; ii.) care planning; iii) provider network adequacy; iv.) provider management; v.) monitoring of member health and safety; vi. grievance and appeals rights; and viii.) financial accountability. The contract is the vehicle for implementing many system improvements. SMA oversight teams & content experts monitor compliance with the contract through review of policies and procedures, regular reports, & complaint investigations. The contract is reviewed & renewed every two years, with interim amendments issued as needed.

b. WI statutes require the SMA to certify PIHPs annually & prohibits the SMA from contracting with a PIHP that has not been certified. An initial certification is performed for each new PIHP that wishes to contract with the SMA. If two or more PIHPs merge or a PIHP is acquired, the newly merged or acquired entity must also complete the initial certification process. During the initial and annual certification process, the SMA reviews the PIHPs internal policies and procedures for ensuring compliance with all applicable federal, state and contractual requirements. The SMA also completes a site readiness visit prior to issuance of initial certification. Certification criteria are reviewed & modified by the SMA, where appropriate, on an annual basis.

c. An SMA oversight team is assigned to each PIHP. This team includes content experts in contract, fiscal, & quality compliance. Additional experts are consulted as needed. Teams review & respond to member-specific concerns as they are submitted or discovered. For PIHPs, teams monitor their ongoing operations through review of periodic reports including: grievances & appeal reports, member incidents, encounters, financial reports, annual EQRO reports, audited PIHP year-end financial reports, & others required by contract. Based upon review results, the team initiates immediate remedial action, imposes corrective action plans, monitors the plans, & documents the remediation. Teams hold regular meetings with PIHPs to discuss care management & provider issues, as well as program changes, expectations, & contract clarifications.

Teams also provide technical assistance & monitoring of PIHP activities; provide support & recommendations for resolving issues, including relocations of members from institutions & care for members with complex behaviors; respond to & investigate complaints about Member-Centered Plans (MCPs), services, poor quality, or allegations of abuse or discrimination; & track and close member issues in the SMA's tracking system. When significant changes are needed, the SMA requires PIHPs to create & implement remediation plans. The teams verify & document compliance with those plans.

2. EQRO - The SMA contracts with an EQRO to conduct independent quality reviews of PIHP processes & outcomes, including the MCP & provider quality assurances.

a. The EQRO is selected via a competitive process & must meet all federal requirements. SMA oversight includes contract & programmatic oversight to ensure reviews are conducted consistent with the SMA’s priorities. The SMA reviews sampling criteria, determines review criteria to be used by the EQRO, reviews & provides input into criteria for identifying trends, reviews all EQRO reports, meets regularly with the EQRO, & reviews contract requirements as needed. EQRO performance is measured by: i. the level & quality of assistance & support provided to the SMA in quality monitoring activities; ii. the quality of periodic monitoring reports & the annual EQRO report; iii. performance of optional EQRO activities; & iv. compliance with the EQRO contract. EQRO activities occur annually unless specified below.

b. The EQRO conducts an Annual Quality Review (AQR) for each PIHP to validate PIHP compliance with federal regulations & SMA contract components, including waiver requirements. The AQR consists of the Care Management Review & the Quality Compliance Review: i. Care Management Review - the EQRO completes a file review focusing on how members’ needs are being met. The EQRO reviews the standards regarding member assessments & MCPs to ascertain if they are comprehensive, timely, & responsive to member changes; ii. Quality Compliance Review (QCR) - The EQRO conducts the mandatory QCR & evaluates PIHPs’ compliance with 42 CFR § 438, Subpart E and applicable CMS guidance. The EQRO conducts the required Quality Compliance Review (QCR) for each PIHP. The EQRO & the SMA coordinate to develop the SMA’s expectations or standards for PIHPs, including compliance thresholds & rules for compliance scoring for each federal and/or regulatory provision or contract requirement. The QCR assesses the strengths and weaknesses of the PIHP related to quality, timeliness, and access to services, including health care and LTSS.

The SMA has expanded the QCR beyond the requirements specified in 42 CFR 438, and includes other state statutory, regulatory, and contractual requirements. The review is divided into three groups of standards: i. PIHP Standards which include provider network, care management, and enrollee rights: ii. Quality Assessment and Performance Improvement (QAPI); and iii. Grievance Systems. Standards are reviewed in a two-year cycle for each PIHP. The first year of the cycle includes the PIHP Standards, followed by QAPI and Grievance Systems standards in the second year. At the discretion of the SMA, additional standards may be reviewed in any year of the cycle.

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

d. The EQRO conducts performance measure validation annually, & as needed, & conducts focused studies as directed by the SMA.

i. Hotline - The EQRO staffs the SMA hotline, through which members can report their concerns & request SMA review.

3. OIG - The SMA's OIG monitors & audits Medicaid providers, and responds to/investigates complaints of fraud and abuse .

4. Wisconsin Aging & Disability Resource Centers (ADRCs) and Tribal Aging and Disability Resource Specialists (Tribal ADRSs) – ADRCs and Tribal ADRSs are the contracted local/regional non-state entities that perform waiver operational and administrative functions. ADRCs and Tribal ADRSs disseminate information regarding the waiver to potential members using SMA provided materials; assist individuals with waiver enrollment; monitor enrollment processes on an ongoing basis; and conduct level of care evaluation activities.

a. The SMA provides ADRCs and Tribal ADRSs with unbiased, person-centered enrollment counseling materials that meet CMS requirements for readability and availability in prevalent languages. The SMA reviews the materials on an annual basis.

b. The SMA provides technical assistance and oversight for ADRC and Tribal ADRSs. Oversight mechanisms include: SMA Regional quality specialists centrally located to ADRCs and tribes; monitoring quality of eligibility determination services (both functional and financial) and enrollment services; and ensuring ongoing training opportunities for ADRC staff and Tribal ADRSs. SMA oversight for Tribal ADRSs further include desk reviews to ensure consistency & accuracy; ongoing technical assistance regarding the Tribal ADRS scope of work, including functional screen; & specialized training opportunities for Tribal ADRSs.

c. The SMA conducts ongoing quality reviews for level of care evaluations using the automated Long Term Care Functional Screen and provides feedback and remediation to the ADRCs and Tribal ADRSs. The SMA provides a variety of training and continuing knowledge activities for certified screeners. The SMA also conducts quarterly screen liaison calls and provides screen reviews upon request.

d. ADRC governing boards review complaints and grievances received from individuals regarding the ADRCs. The SMA has instituted a statewide ADRC complaints and grievance appeal policy that is used resolve complaints and to inform individuals of their grievance rights. The SMA accesses ADRC and Tribal ADRS client tracking databases for quality assurance reviews and independent investigations of complaints and grievances.

e. ADRCs operate under a contract with the SMA. They submit periodic reports to the SMA regarding information and assistance functions and monthly expenditures. ADRCs also submit annual reports to the SMA. On-site reviews are conducted annually by the SMA. ADRC customers are surveyed via a neutral third-party evaluator to evaluate their options and enrollment counseling experience.

5. SMA-Ombudsman contract requirements

a. SMA-Ombudsman contract – performance expectations: i. timely, informative response to member calls and written communications; ii. competency -- 100% of ombudsman must meet the ombudsman entity's core competency

expectations as measured in annual performance reviews; iii. collaboration with fellow Ombudsman – work effectively with the ombudsman for individuals aged 60 & older to identify common issues & coordinate improvement efforts; iv. collaboration with PIHPs -- Ombudsman must meet at least annually with the PIHPs to discuss advocacy issues & promote collaboration on patterns of known concern; v. Encourage informal case resolution when possible. Ombudsman must resolve at least 75% of cases informally (i.e., without PIHP appeal for fair hearing).

b. SMA Ombudsman contract –internal quality assurance expectations: i. a quarterly report on the above performance expectations; ii. sending an annual survey to individuals measuring their satisfaction with the Ombudsman's service. The results are reported to the SMA, and if results are unsatisfactory, the SMA can require a corrective action plan; iii. participate in & present data at meetings upon SMA request; iv. supervisors perform regular case progress reviews and annual case file reviews; v. conduct monthly case rounds; vi. supervisors perform annual casework file reviews; vii. annual performance reviews conducted for all staff.

6. Other performance issues may be reported by agencies that provide advocacy services.

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver

program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
All PIHPs undergo an annual Quality Compliance Review (QCR) conducted by the EQRO. Numerator: Quality Compliance Review points earned by PIHPs in annual EQRO review process. Denominator: Total Quality Compliance Review points possible.

Data Source (Select one):
Other
If 'Other' is selected, specify:
EQRO Report

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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: Number of PIHPs needing remediation for which the SMA requires a corrective action plan. Denominator: Number of all PIHPs that have findings determined to require remediation.

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
EQRO Report

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

☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PIHPs implement corrective actions within the timeframe 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*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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

b. Methods for Remediation/Fixing Individual Problems

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

In general, SMA oversight teams direct the correction of individual problems. The team assigned to each PIHP discovers problems and issues through EQRO reports related to individual member concerns; Ombudsman program reports; review of grievances and appeals; review of member incident reports; review of requests for use of restrictive measures; the provision of technical assistance; complaints to the SMA; and other sources. Teams interact with PIHPs on a regular basis and may identify concerns through these interactions. The oversight team directs remediation of individual member concerns, as well as isolated operational concerns, on an as-needed basis. Teams may also use information gathered through direct interaction with the PIHP, or other sources, to help identify, document, and direct remediation of systemic problems or issues within the PIHP. Teams have the ability to respond quickly to any issue that affects member health or safety that are identified through routine discovery activities, and can respond quickly to other issues as they are identified. The SMA has also developed policies and procedures for the EQRO and oversight teams to report and document issues that require the SMA's attention and the resolution or remediation of such issues.

ii. Remediation Data Aggregation

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

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

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

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 Â§441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	18	64	
	☒	**Disabled (Other)**	18	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☒	**Developmental Disability**	18		☒
	☒	**Intellectual Disability**	18		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**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:

Members in the aged or disabled target group who have physical or other disabilities and 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	70974
Year 2	72886
Year 3	74797
Year 4	76707
Year 5	78618

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	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

All persons who have a nursing home or ICF level of care who enroll in the CMS-approved companion § 1915 (b) waiver 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**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **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: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [x] **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)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [x] **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:

- Parents and Other caretaker relatives specified in 42 CFR § 435.110;
- Pregnant women specified in 42 CFR § 435.116;
- Children Under Age 19 specified in 42 CFR § 435.118;
- Former Foster Care Youth (up to age 26) specified in 42 CFR § 435.150;
- Transitional Medical Assistance specified in § 1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of the Act;
- Extended Medicaid Due to Spousal Support Collections specified in 42 CFR § 435.115;
- Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase Since April, 1977 specified in 42 CFR § 435.135;
- Disabled Widows and Widowers Ineligible for SSI Due to an Increase of OASDI specified in 42 CFR § 435.137;
- Disabled Widows and Widowers Ineligible for SSI Due to Early Receipt of Social Security specified in 42 CFR § 435.138;
- Disabled Adult Children specified in § 1634(c) of the Act;
- Working Disabled specified in § 1619(b) of the Act;
- Targeted Low-Income Children specified in 42 CFR § 435.229;
- Reasonable Classifications of Individuals Under Age 21 specified in § 435.222;
- Independent Foster Care Adolescents Under Age 21 specified in § 435.226;
- Children with Non IV-E Adoption Assistance specified in 42 CFR § 435.227;
- Aged, Blind, or Disabled Individuals Eligible for but Not Receiving Cash specified in 42 CFR § 435.210 and § 435.230;
- Individuals Eligible for Cash except for Institutionalized Status specified in 42 CFR § 435.211;
- Institutionalized Individuals Eligible under a Special Income Level specified in 42 CFR § 435.236;
- Individuals Receiving Hospice Care specified in § 1902(a)(10(A)(ii)(VII) and § 1905(o) of the Act;
- Medically Needy Pregnant Women specified in 42 CFR § 435.301(b)(1)(i);
- Medically Needy Children Age 18 through 20 specified in 42 CFR § 435.308;
- Individuals Needing Treatment for Breast or Cervical Cancer (under age 65) specified in 42 CFR § 435.213;
- Protected Medically Needy Individuals Who Were Eligible in December 1973 specified in 42 CFR § 435.340;
- Blind or Disabled Individuals Eligible in 1973 specified in 42 CFR § 435.133;
- Institutionalized Individuals Continuously Eligible Since 1973 specified in 42 CFR § 435.132;
- Individuals Who Lost Eligibility for SSI/SSP Due to an increase in OASDI Benefits in 1972 specified in 42 CFR § 435.134; and
- Individuals Who are Essential Spouses specified in 42 CFR § 435.131

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage: ☐

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

Specify dollar amount:

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

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

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Medically needy with spend down: For individuals who are aged or have a physical disability, the SMA 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 individuals with an intellectual disability, the SMA will use the average of the monthly rates charged to 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 period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

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

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

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The state uses the post-eligibility rules at 42 CFR 435.726 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:

A personal maintenance allowance equal to the sum of the following:
1. A basic needs allowance equal to 100% of the SSI federal benefit rate, plus the state supplement payment (SSP), plus the state SSI-E payment rate, rounded to the nearest whole dollar.
2. For employed members, an allowance equal to the first $65 of earned income and one-half of the remaining earned income.
3. A special housing amount that includes housing costs over $350 per month.
4. Special exempt income, which includes court-ordered support payments, expenses associated with a guardianship or an SSA-approved PASS plan, impairment related work expenses, and some costs associated with real property listed for sale.

The personal maintenance allowance may not exceed 300% of the SSI federal benefit rate.

Family Care and Family Care Partnership utilize a managed care delivery system. Under this system, the SMA pays the PIHP a uniform capitated rate per member that covers both § 1915(c) waiver services and other State Plan long-term care services. To ensure that a member's maximum cost share amount (PETI) does not exceed the actual amount the SMA pays for their § 1915(c) waiver services, the SMA calculates the dollar value for the portion of the average capitation rate that is attributable to § 1915(c) waiver services. The resulting dollar value may be charged for their monthly cost share (PETI).

○ **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:

A personal maintenance allowance equal to the sum of the following:
1. A basic needs allowance equal to 100% of the SSI federal benefit rate, plus the state supplement payment (SSP), plus the state SSI-E payment rate, rounded to the nearest whole dollar.
2. For employed members, an allowance equal to the first $65 of earned income and one-half of the remaining earned income.
3. A special housing amount that includes housing costs over $350 per month.
4. Special exempt income, which includes court-ordered support payments, expenses associated with a guardianship or an SSA-approved PASS plan, impairment related work expenses, and some costs associated with real property listed for sale

The personal maintenance allowance may not exceed 300% of the SSI federal benefit rate.

Family Care and Family Care Partnership utilize a managed care delivery system. Under this system, the SMA pays the PIHP a uniform capitated rate per member that covers both § 1915(c) waiver services and State Plan long-term care services. To ensure that a member’s maximum cost share amount (PETI) does not exceed the actual amount the SMA pays for their §1915(c) waiver services, the SMA calculates the dollar value for the portion of the average capitated rate that is attributable to §1915(c) waiver services. The resulting dollar value serves as the maximum amount that a member may be charged for their monthly cost share (PETI).

- ○ **Other**

  Specify:

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

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

B-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: 1

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

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

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

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- (●) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

Level of care determinations for new applicants are made by the SMA through the SMA-developed screening tool, determined through input and assessment performed by certified screeners at Aging and Disability Resource Centers or Tribal Aging and Disability Resource Specialists. Reevaluations of level of care for members are made by the SMA through the same SMA-developed screening tool.

- ( ) **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 individuals who have a license to practice as a registered nurse in Wisconsin, pursuant to Wis. Stat. § 441.06, or a Bachelor of Arts or Science degree or more advanced degree in a health or human services related field (e.g. social work, rehabilitation, psychology), and a minimum of one year experience working with at least one of the target populations. Individuals permitted to perform level of care evaluations are certified as screeners after confirming that they have the required education and experience and passing an online course, which includes tests of their knowledge of instructions and criteria for level of care determination. To maintain their certification, the SMA requires each screener to undergo a review to evaluate their knowledge and skills at least once every two years. The SMA maintains electronic records of these test results.

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 Home 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 are 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.

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 SMA to determine the appropriate nursing home or ICF/IID level of care for waiver applicants. The functional screen was developed with SMA registered nurses who evaluated Physician Plans of Care to determine Medicaid eligibility for nursing home residents. It has been evaluated by the SMA 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 applicants is gathered by certified screeners at Aging and Disability Resource Centers or Tribal Aging and Disability Resource Specialists. The screener gathers information during an in person meeting with the applicant using the SMA's automated long-term care functional screen, which returns a level of care for the individual. Information for annual reevaluations of level of care is gathered by PIHP certified screeners in person through the same process. The SMA, through an ongoing process as described in the SMA-PIHP Contract, monitors the accuracy of the information provided by the PIHP.

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):*

Assessment to determine annual reevaluation of level of care is a PIHP responsibility. Each PIHP uses an internal tracking system to ensure that a member's level of care is reevaluated at least every 365 days.

The long-term care functional screen's result is automatically sent from the functional screen electronic system to the Medicaid Management Information System (MMIS) and the Medicaid eligibility system. The MMIS system also verifies both Medicaid and functional eligibility for all members on a monthly basis and disenrolls members who do not meet eligibility requirements. When an annual Medicaid eligibility recertification is completed, the Income Maintenance (IM) agency verifies that members have a completed annual functional screen. If a functional screen has not been completed within the last 365 days, the IM agency closes the long-term care Medicaid eligibility.

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 by the SMA in its automated long-term care functional screen computer system (FSIA).

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
All applicants enrolled in a PIHP must 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

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

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
PIHPs remediate level of care evaluation errors upon notification of error by SMA.
Numerator: Number of level of care evaluation errors remediated annually by PIHP.
Denominator: Number of level of care evaluation errors identified annually by SMA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Administrative Data

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

Data Aggregation and Analysis:

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

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 inconsistencies in level of care evaluation (LOC) 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 Functional Screen Information Access system(FSIA).

During the annual Care Management Review (CMR), the EQRO reviews consistency between the functional screen and the member's member-centered plan. The CMR includes a random sample of members each year. The EQRO delivers the functional screen consistency results to both the PHIP and the SMA. The PHIP remediates any identified inconsistencies for each individual record review. If the overall score is less than 85%, the SMA requires the PHIP to develop and submit a remediation plan to the SMA for approval. Once a remediation plan is approved, the SMA will follow the progress of the PHIP's plan until completed.

b. Methods for Remediation/Fixing Individual Problems

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

Individual problems with level of care determinations are typically discovered by the SMA in one of three ways: (1) The SMA requires each PIHP to appoint a screen liaison who has primary responsibility for coordinating communication with the SMA regarding screen results. The screen liaison contacts the SMA about unexpected results of the functional screen; (2) The SMA discovers errors when reviewing screens with results that are under appeal; or (3) The SMA quality reviewers or EQRO reviewers discover errors during regular sampling of past screens. In all cases, the SMA contacts the Aging and Disability Resource Center, Tribal Aging and Disability Resource Specialist, or PIHP to ascertain the correct facts and to direct correction of the screen, if possible. Correction is verified via observation of the corrected screen in the functional screen information access 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)

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

The Aging and Disability Resource Center (ADRC) or Tribal ADRS must assure potential members who request access to and indicate potential eligibility are informed of the available service and enrollment options, including but not limited to home care, community services, residential care, nursing home care, post hospital care, and case management services. A potential member will document their choice by signing an enrollment form, which is maintained by the ADRC or Tribal ADRS.

If the individual is an Indian, the ADRC or Tribal ADRS informs the potential enrollee and/or legal representative of 1) the option to choose between Tribal Case Management (if available) and the PIHP for care management services and 2) the option to choose to receive benefit package services from the IHCP (if available), PIHP network providers, or both.

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 SMA-developed and owned enrollment forms are maintained by the Aging and Disability Resource Center or Tribal Aging and Disability Resource Specialist. Copies of member-centered plans are maintained by the PIHP. Members' choices are documented in the ADRC tracking system. The ADRC specialist or Tribal ADRS indicates what options the member was given, what the member chose, and details regarding reasons for the option that was chosen if provided. It is stored in the member's record which is accessible to the Office for Resource Center Development (ORCD).

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 (ADRCs) and Tribal Aging and Disability Resource Specialists (Tribal ADRS) are required to have SMA-developed forms and other materials related to managed long-term care available in the prevalent non-English languages spoken in Wisconsin. ADRCs are also required to obtain interpreters or telephonic interpretation services when needed by an applicant or member.

For all written materials for members and potential members, the SMA requires the PIHP to
- use easily understood language and format;
- use a font size no smaller than 12 point; and
- be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of the member or potential member with disabilities or limited English proficiency.

For written materials that are critical to obtaining services, including, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, the SMA requires the PIHP to ensure those materials:
- be made available in the prevalent non-English languages in the PIHP's service area.
- be made available in alternative formats and through the provision of auxiliary aids and services upon request of the potential member or member at no cost.
- include taglines in the prevalent non-English languages in the State and in a conspicuously visible font that explain the availability of written translations or oral interpretation to understand the information provided; information on how to request auxiliary aids and services; and the toll free number of the resource center providing choice counseling, and the toll free and TTY/TDY telephone number of the PIHP's member/customer service unit.

Finally, PIHPs must provide interpreter services when needed by members to ensure effective communication regarding treatment, medical history, and health education and information. The PIHP must offer interpretation services 24 hours a day, 7 days a week, in any language spoken by the member. Professional interpreters shall be used when needed where technical, medical, or treatment information is discussed.

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	Assistive Technology
Other Service	CIE Exploration
Other Service	Communication Assistance
Other Service	Consultative Clinical and Therapeutic Services for Caregivers
Other Service	Consumer Education and Training
Other Service	Counseling and Therapeutic Resources
Other Service	Environmental Accessibility Adaptations (Home Modifications)
Other Service	Health and Wellness
Other Service	Home Delivered Meals
Other Service	Housing Counseling
Other Service	Personal Emergency Response Systems (PERS)
Other Service	Relocation services
Other Service	Remote Monitoring and Support
Other Service	Residential Services (1-2 Bed AFH)
Other Service	Residential Services (Other)
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	Vehicle Modifications
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:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
04 Day Services	04060 adult day services (social model)
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Adult day 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, and supervision and/or protection.

Services may include:
- Personal care and supervision;
- Light meals;
- Medical care; and
- Transportation to and from the adult day care center.

Services must be provided in a non-institutional community-based setting. PIHP interdisciplinary team (IDT) staff must specify the number of hours of service in the member’s member-centered plan.

Transportation between the member's place of residence and the adult day care center may be provided as a component 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).

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

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	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. Admin. Code DHS 105.14

Other Standard *(specify):*

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

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:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Care management services are provided by an interdisciplinary care management team (IDT). The member is the center of the IDT. The IDT consists of the member and, at minimum, a registered nurse (RN) and a social services coordinator, and may also include other professionals as appropriate to the needs of the member, as well as family, legal decision maker, or other informal supports requested by the member. The IDT staff, which includes the RN and social service coordinator, have the primary responsibility of member-centered care management. The IDT completes and oversees the initial comprehensive assessment of needs and the reassessment process, the results of which are used in developing the individual's member-centered plan (MCP). The IDT identifies the member's strengths, natural and community supports, 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 staff also coordinate activities that help members and their caregivers to identify other service needs and gain access to medical, social, rehabilitation, vocational, educational, and other services.

Care management is always provided by individuals employed by the PIHP or by a sub-contract agency of the PIHP. 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 and providers of culturally appropriate services, 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 MCP. When the only willing and qualified entity to provide care management and/or develop MCPs 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 includes:
- Comprehensive assessment and reassessment of the member's strengths, abilities, functional limitations, natural and community supports, lifestyle, personal circumstances, values, preferences and choices.
- Development of the MCP, including a plan to assure continuity of the member's independence, care, living arrangements, and preferences in the face of changes in circumstances.
- Coordination and authorization of the purchase of paid services identified in the MCP.
- Monitoring the delivery and quality of the paid services and unpaid services provided by natural and community supports identified in the MCP.
- Coordination of paid services identified in the MCP with health care services and services provided by natural and community supports.
- Monitoring of the member's home, work, and life circumstances along with ongoing health and well-being.
- Maintenance of a member record and all documentation associated with the authorization, 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 Social Service Coordinator
Agency	Indian Health Care Provider
Agency	PIHP or contracted Registered Nurse

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Care Management

Provider Category:

Agency

Provider Type:

PIHP or contracted Social Service Coordinator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Social worker certified in Wisconsin under Wis. Stat. Ch. 457 with a minimum of one (1) year of experience with at least one of the target populations, or
- A minimum of a four year bachelor's degree or more advanced degree in human services area with a minimum of one (1) year of experience working with at least one of the target populations, or
- A four year bachelor’s degree or more advanced degree in any other area with a minimum of three (3) years experience in social service care management or related social service experience working with persons in the target populations.

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: Care Management

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:

Agency

Provider Type:

PIHP or contracted Registered Nurse

Provider Qualifications

License *(specify):*

PIHP RN or contracted RN- Wis. Stat. Ch. 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):*

Minimum of one year experience working with at least one of the target populations.

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:

Education

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:**

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

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

Service Definition *(Scope):*

Daily living skills training provides person-centered education and training on member-specific skills to perform activities of daily living and instrumental activities of daily living, including skills intended to increase independence and participation in community life.

This service includes:
- An inventory to establish baseline levels of skills and independence;
- Task analysis and systematic instruction in:
  - Money management, organizational skills, safety and situational awareness, and routine daily activities;
  - Health, fitness, and self-care skills;
  - Home care maintenance, shopping, nutrition, and food preparation;
  - Mobility and travel training;
  - General communication and technology skills not related to using assistive technology or communication devices;
  - Self-advocacy; and
  - The skills necessary for accessing and using community resources.

This service can only be provided in the member's residence or in integrated community settings. This service cannot be provided in a non-residential, facility-based setting.

Personal care provided to a member during the receipt of this service may be included in this service or may be covered under another waiver service so long as there is no duplication of payment.

This service excludes training the member to use assistive technology or communication devices, which are covered under Assistive Technology or Communication Assistance, respectively.

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

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	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):*

- Accreditation by a nationally recognized accreditation agency, or
- A minimum of two years of experience working with the target population 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 must also meet the Training and Documentation Standards for Supportive Home 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: Daily Living Skills Training

Provider Category:

Individual

Provider Type:

Daily living skills trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

A minimum of two years of experience working with the target population 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 must also meet the Training and Documentation Standards for Supportive Home Care.

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:**

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

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

Service Definition *(Scope):*

Day habilitation provides activities and supports to foster the acquisition of generalized skills and opportunities for the member to actively participate in integrated community-based activities that build on the member's interests, preferences, gifts, and strengths. Day habilitation reflects the member's person-centered goals regarding community connections and involvement. This service promotes maximum participation in integrated community life while facilitating meaningful relationships, friendships, and social networks with members of the broader community who share similar interests and goals for community participation. Services are aimed at supporting members to reach the highest level of independence and, where possible, reducing or eliminating the need for paid supports to engage in personally meaningful community activities. Services provided must be consistent with the member's member centered plan (MCP).

Day Habilitation includes:

- Development of an inventory to establish baseline levels of skills and independence;
- A wide variety of activities focused on the development, retention, and improvement of self-help, socialization, and adaptive skills;
- Daily opportunities to engage in community life and interact with members of the broader community who do not receive HCBS;
- Community mapping;
- Supports designed to foster, through experiential and adult learning, the acquisition of positive social skills, interpersonal competence, greater independence, and the ability to communicate personal choices and preferences;
- Coordination with needed therapies in the member-centered plan, such as physical, occupational, or speech therapy;
- For members with degenerative medical conditions, supports and community involvement opportunities that are designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills;
- Retirement activities;
- Supports to participate in volunteer opportunities not related to vocational goals;
- Skills in arranging and using transportation; and
- Completion of six-month Day Habilitation reports to the PIHP.

This service may be provided in a disability-specific, provider owned and controlled (facility-based) setting or a non-disability-specific (community-based) setting. When this service uses a provider owned or controlled setting for a portion of the service delivery, the service delivery is considered facility-based. When this service uses a community setting 100% of the time, the service delivery is considered community-based. Community-based service delivery may use a provider owned or controlled setting as a hub or base, but cannot provide services in that setting. 'Community setting' is further defined in C-5.

Day habilitation must be provided separately from the member's residence or other residential living arrangements.

When services are provided in community settings, the service is expected to be provided in small groups no larger than three (3).

Transportation between a member's place of residence and the service setting or site where the member starts and ends the service each day may be included as a component of day habilitation activities or under Specialized (community) Transportation, but not both. Transportation between the service setting and one or more community sites is always included in the service.

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 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, however different types of non-residential habilitation services may not be billed during the same period of the day.

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). This service cannot involve volunteering for the day

habilitation provider.

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

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	Day Habilitation Agency- Facility Based
Individual	Day Habilitation Provider- Community Based
Individual	Day Habilitation Provider- Facility Based
Agency	Day Habilitation Agency- Community Based

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:

Day Habilitation Agency- Facility Based

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Facility is HCBS compliant per 42 CFR 441.301(c)(4), and

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

Additionally:
- Providers of personal care/assistance must meet the Training and Documentation Standards for Supportive Home Care.
- Providers of transportation must meet qualifications for Specialized Transportation- Community Transportation.

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: Day Habilitation Services

Provider Category:

Individual

Provider Type:

Day Habilitation Provider- Community Based

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Service delivery is 100% community-based, and
- A minimum of two years of experience working with the target population providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment, or similar services.

Additionally:
- Providers of personal care/assistance must meet the Training and Documentation Standards for Supportive Home Care.
- Providers of transportation must meet qualifications for Specialized Transportation- Community Transportation.

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: Day Habilitation Services

Provider Category:

Individual

Provider Type:

Day Habilitation Provider- Facility Based

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Facility is HCBS compliant per 42 CFR 441.301(c)(4), and
- A minimum of two years of experience working with the target population providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment, or similar services.

Additionally:
- Providers of personal care/assistance must meet the Training and Documentation Standards for Supportive Home Care.
- Providers of transportation must meet qualifications for Specialized Transportation- Community Transportation.

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: Day Habilitation Services

Provider Category:

Agency

Provider Type:

Day Habilitation Agency- Community Based

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Service delivery is 100% community-based, and

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

Additionally:
- Providers of personal care/assistance must meet the Training and Documentation Standards for Supportive Home Care.
- Providers of transportation must meet qualifications for Specialized Transportation- Community Transportation.

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

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

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

Service Definition *(Scope):*

Prevocational services are designed to create a person-centered path for members to achieve or maintain at least part-time participation in competitive integrated employment (CIE). CIE is defined at https://dwd.wisconsin.gov/dvr/partners/cie/definition.htm. This service involves community-based learning, work experiences, and community-based volunteering where the member can develop general, non-job-task-specific strengths, skills, knowledge, and experience that contribute to employability in CIE. Services are expected to occur over a defined period as determined by the member and their interdisciplinary team (IDT). The expected outcome of this service is measurable gains in knowledge, skills, personal strengths, and experiences that contribute to the member's engagement to obtain or maintain CIE with the highest possible wage. The member must have a documented outcome of CIE in their member-centered plan to receive this service. When this service is authorized for a member already working in CIE, the service must focus on goals related to ensuring the member's success in, and ability to sustain, CIE.

Prevocational services include:

- Community-based exploration and experiential opportunities that facilitate a member's desire for, and ongoing participation in CIE at the highest possible wage;
- Services and skill-building opportunities that are matched to the member's interests, strengths, priorities, abilities, and conditions for success in CIE;
- Development of general skills that lead to CIE, including:
  - The ability to communicate effectively with supervisors, co-workers, and customers;
  - Express and understand expectations;
  - Adherence to generally accepted community workplace conduct;
  - The ability to follow directions and attend to tasks;
  - Utilizing workplace problem-solving skills and strategies;
  - Learning to network;
  - Developing interview skills;
  - Creating resumes and portfolios;
  - Managing conflicts;
  - Learning and applying general workplace safety; and
  - Mobility training.
- Volunteering opportunities;
- Completion of a six-month progress report and service plan document for the interdisciplinary care management team (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.

This service may be provided in a disability-specific, provider owned and controlled (facility-based) setting or a non-disability-specific (community-based) setting. When this service uses a provider owned or controlled setting for a portion of the service delivery, the service delivery is considered facility-based. When this service uses a community setting 100% of the time, the service delivery is considered community-based. Community-based service delivery may use a provider owned or controlled setting as a hub or base, but cannot provide services in that setting. 'Community setting' is further defined in C-5.

Each member's prevocational service plan shall include opportunities to participate in community-based activities that are consistent with the intended outcome of the service and that facilitate the member's interactions with people from the broader community who do not receive HCBS. This includes opportunities and support specific to pursuing CIE in the community.

Unless used to support Project SEARCH, community-based prevocational services are expected to be provided in small groups no larger than three (3). This service can be provided on an individual basis as appropriate for member's needs.

Prevocational Services are not considered outcomes in and of themselves, nor is any prevocational service, including paid training, considered to be employment if service authorization is required to ensure the continued availability for the member's participation in the paid training.

Prevocational services may be provided to supplement, but not duplicate services that are available and provided to a member 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).

Prior to authorizing this service, the member's record documents that this service is not otherwise available to the member through a program funded by Vocational Rehabilitation under section 110 of the Rehabilitation Act of 1973, as amended, and for members ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

Participation in prevocational services is not a prerequisite for participation in CIE or authorization of any other employment services provided under the waiver. Members who receive prevocational services may also receive educational, supported employment, and/or day services. A member-centered 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 paid training as part of prevocational services shall be compensated in accordance with applicable Federal and State laws and regulations. This service cannot involve volunteering for a service provider contracted by a PIHP or volunteering in situations where a member must be paid under state and federal labor laws.

Waiver funding is not available for vocational services (paid work as opposed to time-limited paid training) delivered in facility-based settings where members are supervised for the primary purpose of producing goods or performing services.

Transportation between the member's residence and the site where the member starts and ends this service each day may be included as a component of prevocational services or under specialized (community) transportation but not both. Transportation between the facility and one or more community site(s) is always included in this service.

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 it may be covered and reimbursed under another waiver service so long as there is no duplication of payment.

Prevocational services may be provided to supplement, but may not duplicate supported employment or vocational futures planning and support services. This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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
Individual	Prevocational Services Provider- Community Based
Individual	Prevocational Services Provider- Facility Based
Agency	Prevocational Services Agency- Community Based
Agency	Prevocational Services Agency- Facility Based

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Individual

Provider Type:

Prevocational Services Provider- Community Based

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Service delivery is 100% community-based, and

At least one of the following:
o CESP certification from National APSE, or
o ACRE Basic Employment Certificate in Supported Employment, Community Employment, or Customized Employment, or
o A DVR contracted provider of Supported Employment Services, or
o A minimum of two years of experience working with the target population providing employment-related services.

Additionally:
If personal care services are provided, the provider must meet the Training and Documentation Standards for Supportive Home Care.

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

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: Prevocational Services

Provider Category:

Individual

Provider Type:

Prevocational Services Provider- Facility Based

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Facility is HCBS compliant per 42 CFR 441.301(c)(4), and

At least one of the following:
o CESP certification from National APSE, or
o ACRE Basic Employment Certificate in Supported Employment, Community Employment, or Customized Employment, or
o A DVR contracted provider of Supported Employment Services, or
o A minimum of two years of experience working with the target population providing employment-related services.

Additionally:
• If personal care services are provided, the provider must meet the Training and Documentation Standards for Supportive Home Care.

• If transportation services are provided, the provider must meet the qualifications for Specialized Transportation- Community Transportation.

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: Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Services Agency- Community Based

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Service delivery is 100% community-based, and

At least one of the following:
o Accreditation by a nationally recognized accreditation agency, or
o A DVR contracted provider of Supported Employment services, or
o A minimum of two years of experience working with the target population providing employment-related services.

Additionally:
• If personal care services are provided, the provider must meet the Training and Documentation Standards for Supportive Home Care.

• If transportation services are provided, the provider must meet the qualifications for Specialized Transportation- Community Transportation.

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: Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Services Agency- Facility Based

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Facility is HCBS compliant per 42 CFR 441.301(c)(4), and

At least one of the following:
o Accreditation by a nationally recognized accreditation agency, or
o A DVR contracted provider of Supported Employment services, or
o A minimum of two years of experience working with the target population providing employment-related services.

Additionally:
• If personal care services are provided, the provider must meet the Training and Documentation Standards for Supportive Home Care.
• If transportation services are provided, the provider must meet the qualifications for Specialized Transportation- Community Transportation.

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:	Sub-Category 1:
09 Caregiver Support	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:

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

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

Service Definition *(Scope):*

Respite care services are services provided for a member on a short-term basis to ease the member's family or other primary caregivers' daily stress and care demands. These services provide a level of care and supervision appropriate to the member's needs while the family or other primary caregiver(s) are temporarily relieved from daily caregiving 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. Respite may also be provided by licensed camps.

The cost of room and board is excluded, except when provided as part of Respite Services furnished in a facility approved by the State that is not a private residence or a residential care complex, CBRF, or adult family home.

The receipt of Respite services precludes the member from receiving other waiver services such as Adult Day Care, Nursing Services, and Supportive Home Care on the same day the member receives Respite Services, unless clear documentation exists that service delivery occurred at distinct times from Respite Services regardless of how the Respite payment is structured.

Respite services may not be furnished for the purpose of compensating relief or substitute staff for a waiver residential service. The costs of such staff are met from payments for the waiver residential service.

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

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	Camp
Agency	3-4 Bed Adult Family Home
Agency	Community Based Residential Facility (CBRF)
Agency	Nursing Home
Agency	Residential Care Apartment Complex
Agency	Personal care agency
Agency	Supportive home care agency
Agency	Hospital
Agency	1-2 bed adult family home
Individual	Individual respite provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Camp

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. ATCP 78

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: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

3-4 Bed Adult Family Home

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. 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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Community Based Residential Facility (CBRF)

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. 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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Home

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. DHS 132 and 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: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Residential Care Apartment Complex

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

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

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:

Supportive home care agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Training and Documentation Standards for Supportive Home 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

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. DHS 124

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: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

1-2 bed adult family home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

WI Medicaid Standards for Certified 1-2 Bed Adult Family 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: 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

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:	**Sub-Category 1:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03010 job development
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Supported employment-individual employment support services are comprised of five components that assist members to obtain and maintain competitive integrated employment (CIE). CIE is defined at https://dwd.wisconsin.gov/dvr/partners/cie/definition.htm.

1. CIE Job Development

CIE Job Development is designed to support a member through job development to obtain CIE. CIE Resulting from job development must be consistent with the member's person-centered employment goals, including type of work, preferred hours, and income desired. Job development includes:

a. Written goals, preferences, and conditions for success prior to the start of the service;
b. Obtaining sufficient knowledge of the member to effectively match their interests, skills, strengths, personality, and conditions for success to a prospective employer and job;
c. Direct and indirect time networking with businesses on behalf of the member to find and create CIE opportunities;
d. Job duty negotiation and representation on behalf of the member with prospective employers; and
e. Assessing and negotiating the types of assistance and accommodations a member may need to fully perform and maintain their job.

CIE Job Development may not be authorized for a member already engaged in CIE unless: (1) the member desires to augment their existing CIE with an additional employment opportunity that meets the criteria for CIE; (2) the member wishes to obtain a promotion to a different job title and/or a higher wage; or (3) the member wishes to obtain more hours in their current employment that meets the criteria for CIE, and the member needs time-limited assistance to request and negotiate additional hours.

2. CIE Job Coaching

CIE job coaching consists of job training and performance-related supports for a member. CIE job coaching includes:

a. Task analysis of the job;
b. Structured intervention techniques, including job site training via systematic instruction, to assist the member in learning to perform job tasks;
c. Teaching and modeling appropriate work ethics, interpersonal skills, and other soft skills necessary to ensure success in CIE, including travel and mobility skills;
d. Engagement with the member's supervisor and co-workers;
e. Evaluation and facilitation of necessary job accommodations;
f. Performance assessments to measure progress in learning tasks and skills required to successfully sustain CIE;
g. Assisting the member to develop self-advocacy skills at work; and
h. A job coach fading plan.

Job coaching supports for self-employment should never supplant the member's role and responsibility in all aspects of operating their business.

3. Workplace Personal Assistance (WPA)

Workplace personal assistance provides on-going employment supports and personal assistance at the workplace for the member to sustain CIE when job coaching for independence is no longer needed. This service is used to assist a member in tasks where independent mastery has been determined not possible due to physical, behavioral health and/or emotional challenges. CIE Workplace Personal Assistance includes:

a. Assistance with personal care while at work;
b. Assistance during paid and unpaid breaks;
c. Motivational and behavioral supports;
d. Physical supports using the concept of partial participation;
e. Supervision supports to maintain safety in the workplace;
f. Assisting the member to maintain employment by working with the employer on scheduling, performance expectations, transportation, communication, and promoting skill acquisition; and
g. Check-ins with the employer regarding work performance and expectations.

Workplace Personal Assistance can be provided in addition to CIE job coaching only when a member has a portion of their job where they are expected to become independent, through assistance from a job coach, and has another portion of the job where they are not expected to be able to become independent. Job coaching and WPA services may not be provided for the same unit of time.

4. Partners with Business (PwB)

Partners with Business enables a member to maintain CIE with a combination of natural and paid employment

supports provided directly by their employer, who is recruited, trained, supported, and backed-up by a qualified supported employment provider. PwB can augment natural support with formal paid supports provided by a designated co-worker. The supported employment provider reimburses the employer for the co-worker(s) support that is beyond what is typically available to workers without disabilities filling the same or similar positions. PwB includes:

a. Facilitating and establishing the PwB arrangement, including:

i. Utilization of the PwB support analysis;

ii. Negotiation of PwB supports with the employer;

iii. Implementation of co-worker background checks;

iv. Implementation of a PwB agreement;

v. Development of a co-worker support plan, that outlines the direct support provided by a co-worker that a job coach/WPA would otherwise provide

b. Training for the co-worker(s) providing PwB support, including:

i. Training specific to the member, including the support plan, communication style, learning style, and specific needs related to performing and maintaining their job; and

ii. Ensuring the co-worker completes the DHS WPA web-based training if providing assistance with personal care.

c. Supporting the employer, supervisor, and co-workers supporting the member, including:

i. On and off-site follow-along back-up supports;

ii. Providing assistance with supports typically provided by the co-worker when temporarily unavailable; and

iii. Monthly check-ins with the employer and member, at minimum.

d. Fading expectations should be in place to maximize the independence of the employed member while also ensuring that the member can successfully maintain CIE.

The employer may only be reimbursed for supports identified through the PwB support analysis that would otherwise be provided by a job coach or WPA. Reimbursement is based on units of service that would otherwise need to be provided by a Supported Employment provider, as determined through the PwB Support Analysis.

The amount of time authorized for PwB is negotiated with the employer and is: 1) reflective of the needs the member has for the co-worker provided supports above and beyond negotiated natural supports and supervisory/co-worker supports that are otherwise available to employees without disabilities, and 2) is based on the specific amount of time the co-worker(s) is providing direct support to the member as determined by the PwB Support Analysis.

PwB is only authorized when the member agrees to the arrangement and the employer prefers to provide CIE supports, rather than job coach and/or WPA supports.

Natural supports for the member, already negotiated with, and provided by, the employer prior to the implementation of PwB are not reimbursable under PwB.

5. Work Incentive Benefits Counseling

Work Incentive Benefits Counseling provides the member individualized information about their benefits and how earnings could affect them. The information offers the member guidance to make informed choices about employment. Work Incentive Benefits Counseling includes:

a. Verifying the member’s current benefits;

b. Identifying benefits that may change as a result of increased work earnings;

c. Identifying options and costs for health and long-term care benefits;

d. Predicting foreseeable points of benefit changes;

e. Providing contact information for agencies to which the member will need to report earnings;

f. Providing accurate and appliable information regarding Social Security work incentives;

g. Developing a written summary of an individualized member-centered work incentive benefits analysis;

h. Holding an in-person meeting with the member to explain the individualized written work incentive benefits analysis; and

i. Providing follow-along services for up to one year for questions and clarifications about benefits.

Supported employment-individual support services may not be provided in a small-group format. The ratio is always 1:1 for this service.

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

Supported employment- individual employment support services may not include volunteer work, regardless of the setting.

Supported employment-individual support services may be provided only in non-disability-specific settings in the community, which are not leased, owned, operated, or controlled by a service provider.

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 supported employment- individual employment support services, the member's record documents that the service is not otherwise available under a program funded by Vocational Rehabilitation under the §110 of the Rehabilitation Act of 1973, as amended, and for individuals ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §1401 et seq).

Supported employment- individual support services do not include incentive payments, subsidies, or unrelated vocational training expenses, such as (a) incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment or (b) wages or other payments that are passed through to users of supported employment services.

Supported employment-individual employment support services may be reimbursed on a unit-of-service or outcome basis. Payment may include different methods, such as coworker support models and payments for work milestones, such as length of time on the job, or number of hours the member works.

The cost of transportation from a member's residence and the sites where the member starts and ends the service each day may be included in the reimbursement paid to the supported employment provider or may reimbursed under specialized (community) transportation, but not both.

Personal care may be a component of supported employment- individual support services, but may not comprise the entire service. Personal care 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 supportive home care or self-directed personal care, but not both.

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

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
Individual	On the job support person

Provider Category	Provider Type Title
Agency	Supported employment agency
Individual	Work Incentive Benefit Specialist
Agency	Work Incentive Benefits Counseling Agency

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):*

Certified Employment Support Professional (CESP) certification from national APSE, or
ACRE Basic Employment Certificate in Supported Employment, Community Employment or Customized Employment, or
DVR contracted provider of Supported Employment or Customized Employment, or
A minimum of two years of experience working with the target population providing supported employment.

Additionally:
If personal care services are provided, the provider must meet the Training and Documentation Standards for Supportive Home Care.

If transportation is provided, the provider must meet the qualifications for Specialized Transportation-Community Transportation.

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:

Agency

Provider Type:

Supported employment agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Accreditation by a nationally recognized accreditation agency, or
Division of Vocational Rehabilitation (DVR) contracted provider of Supported Employment or Customized Employment services, or
A minimum of two years of experience working with the target population providing employment related services.

Additionally:
If personal care services are provided, the provider must meet the Training and Documentation Standards for Supportive Home Care.

If transportation is provided, the provider must meet the qualifications for Specialized Transportation-Community Transportation.

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:

Work Incentive Benefit Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DVR contracted provider of Work Incentive Benefits Services, or
Community Work Incentive Coordinator (CWIC) certification or completion of a similar comprehensive training program.

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:

Agency

Provider Type:

Work Incentive Benefits Counseling Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DVR contracted provider of Work Incentive Benefits 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:

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

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

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

Service Definition *(Scope):*

A support broker is an individual who assists a member in planning, securing, and directing self-directed supports (SDS). The direct assistance provided by the support broker depends on the needs of the member and includes assistance, if needed, with recruiting, hiring, training, managing, and scheduling workers. The extent of the services provided is specified in the member-centered plan (MCP).

The services of a support broker are paid for from the member's self-directed supports budget. 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).

Consumer directed supports broker services excludes the cost of any direct services authorized and obtained by a member through an SDS plan, which are paid for and reported under the appropriate service definition.

Consumer directed supports broker services excludes the cost of fiscal agent services, which is paid for and reported as financial management services.

Consumer directed supports broker services are limited to members who self-direct some or all of their waiver services.

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

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
Individual	Individual support broker
Agency	Support broker agency

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):*

Ability to identify the unique needs/preferences of the member.
Knowledge of the available providers for services in the member's geographic area.

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:

Agency

Provider Type:

Support broker agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Ability to identify the unique needs/preferences of the member.
Knowledge of the available providers for services in the member's geographic area.

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:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Financial management services assist members and their families in managing service dollars or their personal finances to prevent institutionalization. This service includes a person or agency paying service providers after the member or legal decision-maker authorizes payment to be made for services included in the member's approved self-directed supports plan.

This service includes facilitation of the employment of staff by the member or legal decision-maker by a financial management services provider or fiscal intermediary performing as the member's agent such employer responsibilities as processing payroll, withholding federal, state, and local tax and making tax payments to appropriate tax authorities; and performing fiscal accounting and making expenditure reports to the member or family and state authorities, as indicated in the member's self-directed supports plan and budget for services. Additional information about the scope of Financial Management Services is listed in Appendix E-1-i.

Financial management services are purchased directly by the PIHP or IHCP and made available to the member to ensure that appropriate compensation is paid to providers. Additionally, this service includes the provision of assistance to members who are unable to manage their own personal funds. This service includes assistance to the member to effectively budget personal funds to ensure sufficient resources are available for housing, board, and other essential costs. This service includes paying bills authorized by the member or legal decision-maker and keeping an account of disbursements.

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.

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	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):*

A PIHP or IHCP 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 member or legal decision-maker, promptly issues payments as authorized, documents budget authority, and summarizes payments in a manner that can be readily understood by the member or legal decision-maker.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP or IHCP

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):*

A PIHP or IHCP 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 member or legal decision-maker, promptly issues payments as authorized, documents budget authority, and summarizes payments in a manner that can be readily understood by the member or legal decision-maker.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP or IHCP

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:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Assistive technology is an item, piece of equipment, software, mobile application, or product system acquired commercially, modified, or customized that enables members to (1) increase their ability to perform ADLs and IADLs or control the environment in which they live and (2) access, participate, and function in their community and in competitive integrated employment. This service category includes assistive technology typically referred to as adaptive aids. Assistive technology services directly assist a member in the selection, acquisition, or use of an assistive technology device.

With the exception of Vehicle Modifications, which has been made into a stand-alone service, all activities and items previously covered under adaptive aids are now coverable under this service.

Assistive technology includes the following:

(A) 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 in the customary environment of the member;

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices, including electronic technology, software, and mobile applications for the member;

(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, interventions, or services associated with other services in the member-centered plan;

(E) training or technical assistance for the member or, where appropriate, 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.

The assistive technology service also includes:
(1) the purchase of a fully trained service dog from a reputable provider with experience providing structured training for service dogs;
(2) the post-purchase training with a reputable provider experienced in providing structured training for service dogs necessary to partner a fully trained service dog with its owner (i.e. enable the fully trained service dog and the member to work together); and
(3) the ongoing maintenance costs, including acute and primary veterinary care, of a fully trained service dog obtained from a reputable provider with experience providing structured training for service dogs based on DHS guidelines.

For the purpose of coverage as assistive technology, a service dog is a dog that has been individually trained by a reputable provider experienced in providing structured training for service dogs to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person’s disability.

Excludes costs related to a dog that does not meet the definition of a service dog for the purpose of coverage as an assistive technology benefit (i.e. emotional support dog, therapy dog, dog training to become a service dog, household pet).

This waiver service is only provided to individuals ages 21 and over. All medically necessary Assistive Technology for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan. This service excludes coverage for technology for which the primary use is communication assistance; technology for communication assistance is covered under the communication assistance service.

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
Individual	Independent Practice Veterinarians
Agency	Qualified Health Professional Agency
Agency	Veterinary Clinic
Individual	Qualified Health Professional
Individual	Service Dog Trainer or Provider
Agency	Service Dog Trainer or Provider Agency
Agency	Durable Medical Equipment or Durable Medical Supply Vendor or Assessor
Agency	Assistive Technology Vendor or Assessor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Independent Practice Veterinarians

Provider Qualifications

License *(specify):*

Wis. Stats. 89.06

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: Assistive Technology

Provider Category:

Agency

Provider Type:

Qualified Health Professional Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Veterinary Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employing or contracting with licensed veterinarians (Wis. Stats. 89.06)

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: Assistive Technology

Provider Category:

Individual

Provider Type:

Qualified Health Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Professionals with current state licensure or certification in their field of practice.

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

Provider Category:

Individual

Provider Type:

Service Dog Trainer or Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable provider with experience providing structured training for 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Service Dog Trainer or Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable provider with experience providing structured training for 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Durable Medical Equipment or Durable Medical Supply Vendor or Assessor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code DHS 105.40

Other Standard *(specify):*

UL or FCC standards for electronic devices.

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

Provider Category:

Agency

Provider Type:

Assistive Technology Vendor or Assessor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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:

CIE Exploration

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03030 career planning
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

CIE Exploration is intended to help a member make informed choices about competitive integrated employment (CIE) or self-employment. CIE is defined at https://dwd.wisconsin.gov/dvr/partners/cie/definition.htm. CIE Exploration is appropriate for a member who is not employed in CIE and needs more information to make informed choices about employment goals, career interests, and whether to pursue CIE or self-employment. The outcome of CIE Exploration is member-specific knowledge and information that can be used to guide job development efforts.

CIE Exploration includes:
- Identification of member-specific interests, knowledge, and skills transferable to CIE or self-employment;
- Arrangement of career exploration opportunities and preparation of the member for participation in at least 3 business tours, informational interviews, and/or job shadows;
- Debriefing with the member after career exploration experiences;
- Introductory education on supported employment services;
- An initial conversation about work incentives available to minimize the impact of CIE on public benefits and identification of need for personalized, in-depth Work Incentives Benefits Analysis.
- Identifying the conditions necessary for CIE;
- Person-centered employment planning; and
- Sharing the member's completed assessment profile with their DVR counselor.

Members who are receiving CIE exploration services may not receive supported employment-individual support services or vocational futures planning and support services. This service does not include personalized in-depth Work Incentives Benefits Analysis, which is covered under Supported Employment- Individual Support Services.

CIE Exploration may not be provided in a small group format. The ratio is always 1:1 for this service.

CIE Exploration may only be provided in non-disability specific settings typically found in the community or the member's residence, which are not leased, owned, operated, or controlled by a service provider. The only exception is if the member lives in a residential setting that is leased, owned, operated, or controlled by a provider and this setting is the most appropriate setting for this service.

Prior to authorizing this service, the member's record documents this service is not otherwise available to the member through a program funded by Vocational Rehabilitation under section 110 of the Rehabilitation Act of 1973, as amended, and, for individuals ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

The cost of transportation from a member's residence and the for a member to get to and from a supported employment sites where the member starts and ends the service each day may be included in the reimbursement paid to the supported employment provider or may reimbursed under specialized (community) transportation, but not both.

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

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

CIE Exploration may only be authorized once in a 365-day period and only if the member is not currently engaged in CIE or receiving service(s) to obtain CIE.

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	CIE Exploration Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: CIE Exploration

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- A DVR contracted provider of Supported Employment or Customized Employment services; or
- Accreditation by a nationally recognized accreditation agency; or
- A minimum of two years of experience working with the target population providing employment-related services.

Additionally, if transportation is provided, the provider must meet the qualifications for Specialized Transportation-Community Transportation.

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: CIE Exploration

Provider Category:

Individual

Provider Type:

CIE Exploration Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- DVR contracted provider of supported employment or customized employment; or
- CESP certification from National APSE; or
- ACRE Basic Employment Certificate in Supported Employment, Community Employment or Customized Employment; or
- At least 2 years of experience working with the target population providing employment-related services.

Additionally, if transportation is provided, the provider must meet the qualifications for Specialized Transportation-Community Transportation.

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:

Communication Assistance

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:

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

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

Service Definition *(Scope):*

Communication assistance includes devices or services needed to assist members with hearing, speech, communication, or vision impairments. These items or services assist the member to effectively communicate with others, decrease reliance on paid staff, increase personal safety, enhance independence, increase community inclusion, and improve social and emotional well-being.

Communication assistance includes any device, software, or service that addresses these objectives, such as:
- Augmentative and alternative communication systems;
- Hearing or speech amplification devices, aids and assistive devices when not covered under the State Plan;
- Cognitive retraining aids;
- Electronic technology, such as tablets, mobile devices, and related software or mobile/tablet applications, when the use provides communication assistance for the member;
- Training and technical assistance for the member or, where appropriate, legal decision-maker, family members, employers, paid and unpaid caregivers, and other individuals substantially involved in major life functions of the member;
- Evaluation and assessment of communication assistance needs of the member, and;
- The repair, maintenance, and servicing of such systems.

Communication Assistance includes interpreter services, which are provided to members with hearing, speech, or vision impairments and who require interpretation to effectively communicate with people in the community, employees, or others.

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

This service does not supplant the responsibility of managed care organizations, contracted providers, or other health care professionals to take reasonable steps to provide meaningful access to their programs by persons with limited English proficiency (LEP). Providers must provide language assistance services in order to comply with Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

This waiver service is only provided to individuals ages 21 and over. All medically necessary Communication Assistance for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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

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	Qualified Health Professional Agency
Individual	Qualified Health Professional
Agency	Communication Aid Vendor or Assessor

Provider Category	Provider Type Title
Agency	Interpretation, Facilitation, or Translation Agency
Individual	Interpreter, Facilitator, or Translator
Agency	Interpretation Agency Employing Licensed Sign Language Interpreters
Individual	Licensed Sign Language Interpreter

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication Assistance

Provider Category:

Agency

Provider Type:

Qualified Health Professional Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication Assistance

Provider Category:

Individual

Provider Type:

Qualified Health Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Professionals with current state licensure or certification in their field of practice.

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: Communication Assistance

Provider Category:

Agency

Provider Type:

Communication Aid Vendor or Assessor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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: Provider Specifications for Service

Service Type: Other Service
Service Name: Communication Assistance

Provider Category:

Agency

Provider Type:

Interpretation, Facilitation, or Translation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Ability to interpret effectively, accurately, and impartially both receptively and expressively, using necessary specialized vocabulary.

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: Communication Assistance

Provider Category:

Individual

Provider Type:

Interpreter, Facilitator, or Translator

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Ability to interpret effectively, accurately, and impartially both receptively and expressively, using necessary specialized vocabulary.

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: Communication Assistance

Provider Category:

Agency

Provider Type:

Interpretation Agency Employing Licensed Sign Language Interpreters

Provider Qualifications

License *(specify):*

Employing or contracting with sign language interpreters licensed under Wis. Stat. 440.032.

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: Communication Assistance

Provider Category:

Individual

Provider Type:

Licensed Sign Language Interpreter

Provider Qualifications

License *(specify):*

Wis. Stat. 440.032

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:

Consultative Clinical and Therapeutic Services for Caregivers

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11030 medication assessment and/or management
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

The purpose of Consultative Clinical and Therapeutic Services for Caregivers 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 people with I/DD 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.

Services are provided by state licensed or certified professionals or agencies that deliver services limited to their areas of formal education and training and/or as directed by their professional code of ethics .

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.

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
Individual	Individual counselors or therapists
Agency	Counseling or therapy agencies

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 or therapists

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:

Annually

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 or therapy agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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:

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:

Consumer Education and Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training

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

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

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

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

Service Definition *(Scope):*

Consumer education and training services are designed to help members develop self-advocacy skills, support self-determination, exercise civil rights, and acquire skills needed to exercise control and responsibility over support services. Self-advocacy skills enable members to communicate wants and needs, make informed decisions, voice their choices, and develop trusted supports with whomever they can share concerns. The consumer education and training service includes education and training for members, their caregivers, and legal decision-makers that is directly related to developing self-advocacy skills. PIHPs assure that information about educational and/or training opportunities is available to members, 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.

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 payment for hotel and meal expenses.

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

Excludes education/training costs exceeding $3000 per member annually.

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	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 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:	Sub-Category 1:
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	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:**

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

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

Service Definition *(Scope):*

Counseling and Therapeutic Resources 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. The outcome of Counseling and Therapeutic Resources is maintenance or improvement of the member's mental, physical, or behavioral health, welfare, and functioning in the community. Counseling and Therapeutic Resources may be delivered in a member's home, natural (outdoor) setting, community setting, or a provider's office.

Counseling and Therapeutic Resources are provided by state licensed or certified professionals or agencies that deliver services limited to their areas of formal education and training, as directed by their professional code of ethics.

Counseling and Therapeutic Resources may include:
- Disability or aging adjustment and adaptation counseling;
- Interpersonal counseling;
- Recreational, music, art, equestrian (hippotherapy), or aquatic therapy;
- Nutritional counseling;
- Medical counseling and education provided by a registered nurse (RN);
- Weight counseling;
- Grief counseling;

Counseling and Therapeutic Resources must meet clearly defined outcomes, be effective for the member's condition or desired outcome, and be cost effective. Costs directly associated with counseling or therapies are included in this service. Expenses may not be primarily recreational or diversional in nature, as demonstrated in the member-centered plan.

This waiver service is only provided to individuals ages 21 and over. All medically necessary Counseling and Therapeutic Resources for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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

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

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
Individual	Individual counselors or therapists
Agency	Counseling or therapy agencies

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 or therapists

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:

Annually

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 or therapy agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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:

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:

Environmental Accessibility Adaptations (Home Modifications)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Home modifications are the provision of services and items to assess the need for, arrange for, and provide modifications and/or improvements to where a member lives in order to increase accessibility or safety. Modifications may provide for safe access to and within the home, reduce the risk of injury, facilitate independence and self-reliance, enable members to increase their abilities to perform ADLs or IADLs, and decrease reliance on paid providers. This service category includes the cost of materials, services, permits and inspections, and maintenance of home modifications.

Home modifications may include materials and services, such as:
- Adaptive door bells, locks, and/or security items, systems, or devices;
- Adaptive door knobs and door openers;
- Railings or transfer assist devices;
- Ramps;
- Surface protection/padding;
- Wheelchair-accessible or slip-resistant flooring;
- Widened doorways or hallways;
- Stair lifts, wheelchair lifts, ceiling lifts, or other mechanical devices to lift persons with impaired mobility from one vertical level to another;
- Kitchen and/or bathroom modifications;
- Specialized accessibility/safety adaptations;
- Voice-activated, light-activated, motion-activated, and other electronic devices, including automated, internet-connected, or remotely operated “smart home” technology that increases the member’s self-reliance and capacity to function independently.

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

Home Modifications excludes:
- Modifications or improvements that are of general home maintenance and upkeep;
- Modifications made to living arrangements that are owned or leased by agency providers of other waiver services;
- Modifications that do not meet standards of manufacture, design, and installation;
- Permanent or structural modifications to rented living arrangements; and
- Internet services. The member must have access to internet services before devices requiring internet connection are authorized.

All modifications are required to comply with applicable local and state housing or building codes and are subject to inspections required by the municipality responsible for administering the codes.
The services under the Environmental Accessibility Adaptations (Home Modifications) are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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	Carpenter, electrical contractor, plumber, electrician, elevator contractor, general/dwelling contractor, HVAC contractor, professional engineer
Individual	Individual carpenters, electrical contractors, electricians, elevator contractors, general/dwelling contractors, HVAC contractors, plumbers, professional engineers
Agency	Technology Vendor

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:

Carpenter, electrical contractor, plumber, electrician, elevator contractor, general/dwelling contractor, HVAC contractor, professional engineer

Provider Qualifications

License *(specify):*

Must obtain required state license

Certificate *(specify):*

Must obtain required state certification

Other Standard *(specify):*

Must obtain required state registration and adhere to industry set standards.

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: Environmental Accessibility Adaptations (Home Modifications)

Provider Category:

Individual

Provider Type:

Individual carpenters, electrical contractors, electricians, elevator contractors, general/dwelling contractors, HVAC contractors, plumbers, professional engineers

Provider Qualifications

License *(specify):*

Must obtain required state licensure

Certificate *(specify):*

Must obtain required state certification

Other Standard *(specify):*

Must obtain required state registration and adhere to industry set standards.

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:

Technology Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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:

Health and Wellness

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11040 nutrition consultation
Category 3:	**Sub-Category 3:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 4:	**Sub-Category 4:**
17 Other Services	17990 other

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**

◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Health and wellness services maintain or improve the health, well-being, socialization, or inclusion of the member in their community. Services support whole-person culturally appropriate wellness by promoting stress relief, non-pharmacologic pain management, self-determination, and community connections. Services prevent or delay higher cost institutional care through health and wellness activities that focus on healthy habits.

Health and Wellness includes:
1. Healthy lifestyle services, such as:
o Classes, lessons, events, or other educational opportunities, to address issues regarding living with a disability and having a healthy lifestyle, including nutrition, physical activity, and sensory regulation.
o Health and wellness web and mobile applications.
Healthy lifestyles services increase the capacity of the member to self-advocate, navigate community resources, and improve overall health and socialization skills. These skills keep members in the community and out of an institution.
2. Evidence-based or culturally appropriate complementary medicine and wellness services, such as: yoga, meditation, mindfulness, Tai Chi, Traditional African Based Holistic Services, Ayurveda, Chinese or Oriental medicine, Reiki, Native American healers (Treatments may include prayer, dance, ceremony and song, participation in sweat lodges, and the use of meaningful symbols of healing, such as the medicine wheel and/or other sacred objects), and
3. Sexuality Education and Training– including:
o A proactive educational program about the values and critical thinking skills needed to form and maintain meaningful relationships, healthy sexuality, and sexual expression.
o Learning objectives include positive self-image, communication skills, reproductive anatomy, conception and fetal development, safe sex, and health awareness.
o Positive outcomes include safety from negative consequences of being sexual, assertiveness about setting boundaries and reporting violations, expressing physical affection in a manner that is appropriate, and making informed choices about the relationships. Independent living skills are enhanced and improved work outcomes result from a better understanding of interpersonal boundaries, and improved communication, critical thinking, and self-reliance skills.
o Sexuality Education can be taught in a group classroom setting with the support of direct support professionals, family members, and natural supports.

Health and Wellness services must address a specific goal or outcome documented in the MCP. Services may not be primarily recreational or diversional in nature. This service excludes items or services that are harmful or contraindicated for the member, as determined by the member's interdisciplinary team (IDT).

This service excludes adaptations needed to participate in health and wellness activities. Adaptations are covered under Assistive Technology. This service excludes the purchase of food and any ingested herbs, treatments, or nutritional supplements.

Excludes physician services.

This service may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for members ages 18-21), or a responsible private or public entity. This service may not duplicate any service that is provided under another waiver service category.

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
Individual	Sexuality educator or trainer
Agency	Sexuality education and training provider
Agency	Wellness provider
Individual	Wellness provider
Individual	Personal Trainer
Agency	Fitness Center

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Health and Wellness

Provider Category:

Individual

Provider Type:

Sexuality educator or trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Sexuality Educator, Counselor, or Sex Therapist certified by the American Association of Sexuality Educators, Counselors, and Therapists (AASECT), or

Any of the following professionals with specialized training in sexuality education:
Psychologist;
Licensed Clinical Social Worker;
Licensed Professional Counselor;
Applied Behavior Analyst;
Other licensed or certified professionals approved by the SMA to provide the service.

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: Health and Wellness

Provider Category:

Agency

Provider Type:

Sexuality education and training provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agency staff providing the training and education must meet at least one of the following qualifications:

Sexuality Educator, Counselor, or Sex Therapist certified by the American Association of Sexuality Educators, Counselors, and Therapists (AASECT), or

Any of the following professionals with specialized training in sexuality education:
Psychologist;
Licensed Clinical Social Worker;
Licensed Professional Counselor;
Applied Behavior Analyst;
Other licensed or certified professionals approved by the SMA to provide the service.

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: Health and Wellness

Provider Category:

Agency

Provider Type:

Wellness provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Licensure, certification, registration, accreditation, experience, or training appropriate to the service being provided.

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: Health and Wellness

Provider Category:

Individual

Provider Type:

Wellness provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Licensure, certification, registration, accreditation, experience, or training appropriate to the service being provided.

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: Health and Wellness

Provider Category:

Individual

Provider Type:

Personal Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED) certification; National certification from an accredited agency

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: Health and Wellness

Provider Category:

Agency

Provider Type:

Fitness Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Stat. § 100.178 and Wis. Admin. Code Ch. DHS 174

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:

Home Delivered Meals

HCBS Taxonomy:

Category 1: 06 Home Delivered Meals

Sub-Category 1: 06010 home delivered meals

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

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

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

Service Definition *(Scope):*

Home delivered meals are meals provided to members 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 health care provider. 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.

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

Meals must align with USDA Dietary Guidelines for Americans standards, be medically appropriate for the member, and must provide a minimum of one-third of the estimated daily calorie needs for the member's age group.

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

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).

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	Nursing Homes
Agency	Aging network agencies

Provider Category	Provider Type Title
Agency	Restaurants
Agency	Home Health Agency
Individual	Indian Health Care Provider
Agency	Hospitals

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:

Nursing Homes

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. DHS 132 and Ch. 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. Stat. § 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: 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 Ch. ATCP 75

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:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code DHS 105.16

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:

Individual

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:

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:

Hospitals

Provider Qualifications

License *(specify):*

Wis. Admin. Code DHS 124

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:

Housing Counseling

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Housing counseling provides assistance to a member who is looking to acquire and maintain safe, affordable, and accessible housing in the community as set forth in the approved member-centered plan, where ownership or rental of housing is separate from service provision. The purpose of housing counseling is to promote consumer choice and control, increase access to affordable housing, and promote community inclusion. Housing counseling includes exploring home ownership and rental options and individual and shared housing options, including options where the member lives with their family.

Services may include:

- Conducting a community integration assessment to identify the member's preferences related to housing and needs for support to maintain community integration, including:
  - Type and location of housing desired;
  - Preference for living alone or with others;
  - Identification of a roommate, if applicable;
  - Accommodations and modifications needed;
  - Identification of the type of setting that works best for the individual;
  - Assistance in obtaining or accessing sources of income necessary for community living;
  - Assistance in establishing credit and meeting obligations of tenancy; and
  - Other important needs and preferences.
- Assistance with locating and securing available housing;
- Identifying and assisting the member in access to financing, securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings;
- 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;
- Supports to assist the member in communicating with the landlord and/or property manager regarding the member's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager; and
- Planning for ongoing management and maintenance of housing.

Housing counseling is not a one-time service and may be accessed by a member at any time.

This service provides supports to preserve the most independent living arrangement and/or assist the member in locating the most integrated option appropriate to the member.

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.

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

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	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:

Agency

Provider Type:

Housing counseling agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must have expertise in housing issues;
Must have housing counseling or assistance as a part of its mission or regular activities; and
Must not have a direct or indirect financial interest in the property or housing the participant selects.

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:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Personal emergency response system (PERS) is a service that provides a direct telephonic or other electronic communications link between a member 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.

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

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

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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	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:

Agency

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:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Relocation services are non-recurring start-up expenses needed to establish a community living arrangement for members who are relocating from an institution, certified adult family home, or other provider-operated living setting, to an independent living arrangement in a private residence where the member is directly responsible for their own living expenses. This service includes person-specific services, supports, or goods that are put in place to prepare 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 that the member relocates to the new community living arrangement.

Allowable expenses are those that are necessary to enable the member to establish a basic household excluding room and board.

Relocations services may include:
- Essential household furnishings, supplies, and appliances not included in the independent living arrangement;
- The payment of a security deposit;
- Utility connection costs, and telephone installation charges ;
- Payment for moving the member's personal belongings to the new community living arrangement; and
- General cleaning, and household organization needed to prepare the selected community living arrangement for occupancy.

Relocation services exclude home modifications necessary to address safety and accessibility in the member's living arrangement, which may be provided under the waiver's home modification service. This service 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.)

This service may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

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

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
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:

Remote Monitoring and Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
17 Other Services	17990 other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Remote monitoring and support enhances or increases a member's independence and ability to live, work, or meaningfully participate in the community by providing real-time support using two-way communication and non-invasive monitoring technology. Non-invasive monitoring technology includes devices, sensors, and communication systems that allow remote support staff to monitor and communicate with members without providing direct physical assistance. Services are provided by trained remote support professionals who deliver live support from a remote location, decreasing reliance on paid on-site staff and avoiding placement in a more restrictive environment.

Remote monitoring and support includes:

- An assessment of the member's remote support needs, including a discussion with the member and legal decision-maker, as applicable, about the types, locations, and required times of use of devices needed to ensure the member's health and welfare while maximizing the member's privacy and individual rights.
- Devices, equipment, software, or communication and monitoring technology used in the context of remote monitoring and support services, including:
  - Motion, pressure, or temperature sensors;
  - Radio frequency identification;
  - Live audio or video feed;
  - Web-based monitoring systems;
  - Automated medication dispenser systems; or
  - Other devices that facilitate remote monitoring or live two-way communication.
- Installation, repair, and maintenance of equipment, devices, and technology systems.
- Remote support services, including:
  - Oversight, monitoring, and support provided by remote support staff;
  - Communication with back-up supports when needed in the event of an equipment malfunction or when the member otherwise needs in-person assistance, or EMS in the event of an emergency;
- Training and technical assistance for the member or, where appropriate, legal decision-maker or family members, including:
  - Informing the member and legal decision-maker of the control they will have over the equipment, including how the member or legal decision-maker can turn off monitoring devices;
  - A description or tour of where devices or monitors will be placed, including the locations of monitors in bedrooms or bathrooms and scheduled times of use.

Before authorization of Remote Monitoring and Supports, the following must be documented in the MCP:
(A) Identification of a specific and individualized assessed need.
(B) Positive interventions and supports used prior to any modifications to the person-centered service plan.
(C) Less intrusive methods of meeting the need that have been tried but did not work.
(D) A clear description of the condition that is directly proportionate to the specific assessed need.
(E) Regular collection and review of data to measure the ongoing effectiveness of the modification.
(F) Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(G) Informed consent of the member.
(H) An assurance that interventions and supports will cause no harm to the member.

Cameras or monitors with audio or video feed may not be placed in bedrooms or bathrooms. Sensors or other devices without audio or video may be placed in bedrooms or bathrooms following the process described in A-H, above.

The member or legal decision-maker has a right to turn off monitoring devices or equipment and must be provided with instructions on how to turn off the devices.

The member, legal decision-maker, and any individuals living with the member must be fully informed of what remote monitoring entails, including whether recordings will be made, and must consent in writing to the use of remote monitoring and support systems, including for the types, locations, and schedule of use of remote monitoring devices, prior to use. The written consent forms are maintained in the member's record and updated at least every six (6) months or when necessitated by a change in the member's outcomes, preferences, situation, or condition.

The member, legal decision-maker, or individuals living with the member may retract their consent at any time. If consent is retracted, devices must be turned off and/or removed and back-up or necessary in-person supports

authorized as soon as possible.

Before authorizing Remote Monitoring and Support, the member, remote support provider, and PIHP interdisciplinary team (IDT) must develop and document a back-up support plan in the event of an emergency, equipment malfunction, or if the member otherwise needs in-person assistance.

Before authorizing Remote Monitoring and Support, the IDT shall evaluate how the service can help enhance the member's ability to live, work, and meaningfully participate in the community. Remote Monitoring and Support may be authorized to complement, but not replace, in-person services in meeting these goals.

Additionally, the IDT shall assess whether remote support is sufficient to ensure the member's health and welfare. Remote monitoring services shall not take the place of on-site staff monitoring that is necessary to ensure the member's health and welfare.
Remote Monitoring and Support excludes the purchase of internet services. The service may only be authorized for members who have access to necessary internet services.

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

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	Technology Vendor
Agency	Remote Support Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Monitoring and Support

Provider Category:

Agency

Provider Type:

Technology Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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: Provider Specifications for Service

Service Type: Other Service
Service Name: Remote Monitoring and Support

Provider Category:

Agency

Provider Type:

Remote Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- UL or FCC standards for electronic devices, if applicable.
- Use of a secure network system compliant with 45 CFR section 164.102 to section 164.534.
- Written policies and procedures that define emergency situations and detail how remote support staff will respond.
- Safeguards or emergency back-up systems, such as batteries or generators, at the remote support center and for use in the member's home.
- Provider trains staff on the ability to recognize and respond to emergencies, first-aid, member health, safety, and welfare, privacy and confidentiality, member rights, and member-specific information and individual needs.

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:

Residential Services (1-2 Bed AFH)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02013 group living, other
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 4:	**Sub-Category 4:**
02 Round-the-Clock Services	02031 in-home residential habilitation

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

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

Service Definition *(Scope):*

Residential services are a combination of treatment, support, or services above the level of room and board within a community-integrated residential setting that meets HCB setting requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable member needs. Services assist the member to reside in the most integrated setting appropriate to their needs and typically include supportive home care, personal care, and supervision. Services may also include include social and leisure skill development, behavior and social supports, daily living skills training, medication administration, and transportation if provided by the operator or designee of the operator. The service includes owner operated homes that are the primary domicile of the operator and corporate homes that are controlled and operated by a third party that hires staff to provide support and services.

Residential services also include coordination with other services and providers, including health care, vocational, or day services. Services may also include the provision of other waiver services as specified in the contract between the PIHP and residential provider.

Waiver funds are not used to pay for the cost of room and board, items of comfort or convenience, or costs related to building maintenance, upkeep or improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix I-5.

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

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	Certified 1-2 Bed Adulty Family Home
Individual	Certified 1-2 Bed Adult Family Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services (1-2 Bed AFH)

Provider Category:

Agency

Provider Type:

Certified 1-2 Bed Adulty Family Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wisconsin Medicaid Waiver Standards for Certified 1-2 Bed Adult Family Homes (AFH)

Other Standard *(specify):*

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

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: Residential Services (1-2 Bed AFH)

Provider Category:

Individual

Provider Type:

Certified 1-2 Bed Adult Family Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wisconsin Medicaid Waiver Standards for Certified 1-2 Bed Adult Family Homes (AFH)

Other Standard *(specify):*

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

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:

Residential Services (Other)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02013 group living, other
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 4:	**Sub-Category 4:**
02 Round-the-Clock Services	02023 shared living, other

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

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

Service Definition *(Scope):*

Residential services are a combination of treatment, supports, supervision, or care above the level of room and board provided to members residing in a community-integrated residential setting that meets HCB settings requirements and includes 24-hour on-site response capability to meet scheduled or unpredictable member needs. Services assist the member to reside in the most integrated setting appropriate to their needs and typically include supportive home care, personal care, and supervision. Other services provided may include social and recreational programming, daily living skills training, medication administration, intermittent skilled nursing services, and transportation. Payment is not made for 24-hour skilled nursing care.

Residential services also include coordination with other services and providers, including health care, vocational, or day services.

All services and activities previously covered under Adult Residential Services- 3-4 Bed Adult Family Homes, Adult Residential Services- Community-based Residential Facility, and Adult Residential Services- Residential Care Apartment Complex are now coverable under this service.

A member with an intellectual disability may only reside in a Community-based Residential Facility (CBRF) that is licensed for eight (8) or fewer residents, unless that member has been determined to require No Active Treatment (NAT) for their intellectual or developmental disability (IDD).

Waiver funds are not used to pay for the cost of room and board, items of comfort or convenience, or costs associated with building maintenance, upkeep, and improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix I-5.

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

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	Certified Residential Care Apartment Complex
Agency	Licensed Community Based Residential Facility
Agency	Licensed 3-4 Bed Adult Family Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Services (Other)

Provider Category:

Agency

Provider Type:

Certified Residential Care Apartment Complex

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code Ch DHS 89

Other Standard *(specify):*

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

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: Residential Services (Other)

Provider Category:

Agency

Provider Type:

Licensed Community Based Residential Facility

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch DHS 83

Certificate *(specify):*

Other Standard *(specify):*

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

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: Residential Services (Other)

Provider Category:

Agency

Provider Type:

Licensed 3-4 Bed Adult Family Home

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. DHS 88

Certificate *(specify):*

Other Standard *(specify):*

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

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:

Self-Directed Personal Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Self-directed personal care services 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 the member's 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; toileting; simple transfers; assistance with mobility and ambulation; 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 personal care needed 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 (IDT) 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 (MCP) developed jointly by the member and IDT staff including a registered nurse and the social service coordinator. The MCP shall specify delegated nursing tasks, if any. The member may use as a provider any individual who passes a background check and meets provider qualifications, including a legally responsible relative who qualifies under Appendix C-2 d. and e. of this waiver, or an agency or individual that is not barred from participating in the Medicaid or Medicare program. The MCP, including self-directed personal care and all other services received, is reviewed by the member and IDT at least every six months and 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 IDT will determine any additional 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 meets provider qualifications. 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/IID admission
• Receipt of medical or rehabilitative care entailing at least an overnight absence
• Participation in a therapeutic rehabilitative program as defined in Wis. Admin. § 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.

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 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.

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	Agency-employed, member-directed workers
Individual	Member-employed individual worker

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: 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

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:	**Sub-Category 1:**
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
05 Nursing	05010 private duty nursing
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Skilled nursing is “professional nursing” as defined in Wisconsin’s Nurse Practice Act, Wis. Stat. Ch. 441. Nursing services are 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 who is 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 not otherwise available to the member under the Medicaid state plan or through Medicare. However, the lack of coverage under the State plan or through Medicare does not preclude the coverage of skilled nursing as a waiver service when services are within the scope of the Wisconsin Nurse Practice Act.

This waiver service is only provided to individuals ages 21 and over. All medically necessary Skilled Nursing Services RN/LPN services for children under age 21 are covered in the state plan benefit pursuant to the EPSDT benefit.

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 of others, that requires substantial nursing skill, knowledge, 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. Stat. Ch. 448, dentist licensed under Wis. Stat. Ch. 447, or optometrist licensed under Wis. Stat. 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. Stat. Ch. 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 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 who has 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. Stat. Ch. 441, Wis. Admin. Code Ch. N 6, and the Wisconsin Nurses Association’s Guidelines for Registered Nurse Delegation to Unlicensed Assistive Personnel.

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, this excludes services that are available through the Medicare program except for payment of Medicare cost share.

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

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	Agency-directed registered nurse/LPN
Individual	Individual RN or 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:

Agency

Provider Type:

Agency-directed registered nurse/LPN

Provider Qualifications

License *(specify):*

Wis. Stats. Ch. 441

Certificate *(specify):*

Agency is certified by Medicare per Wis. Admin. DHS 105.16

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:

Individual

Provider Type:

Individual RN or LPN

Provider Qualifications

License *(specify):*

Wis. Stats. Ch. 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:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**

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

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

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

Service Definition *(Scope):*

Specialized medical equipment, items, devices, and supplies are those items necessary to maintain the member'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 member.

Allowable items, devices or supplies may include:
- Over the counter medications with a National Drug Code (NDC) if not covered under the State Plan drug benefit and when prescribed by any licensed and authorized prescriber;
- Medically necessary prescribed skin conditioning lotions/lubricants when not covered under the State Plan;
- Prescribed Vitamin D, a prescribed multivitamin, and prescribed calcium supplements;
- Books and other therapy aids that are designed to augment a professional therapy or treatment plan;
- Room air conditioners, humidifiers, and water treatment systems, when needed to support a member's health and safety outcomes; and
- Other items or devices as identified in the MCP and authorized by the PIHP.

This service also includes costs associated with routine maintenance for covered medical equipment and supplies.

This waiver service is only provided to individuals ages 21 and over. All medically necessary Specialized Medical Equipment and Supplies for children under age 21 are covered under the State Plan pursuant to the EPSDT benefit.

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.

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	Other Vendor
Agency	DME Vendors or Medical Supply Vendors
Individual	Licensed Pharmacy

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 Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable merchant that meets industry standards

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: Provider Specifications for Service

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

Provider Category:

Agency

Provider Type:

DME Vendors or Medical Supply Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin Code § DHS 105.40

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:

Individual

Provider Type:

Licensed Pharmacy

Provider Qualifications

License *(specify):*

Wis. Stat. Ch. 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: 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:	Sub-Category 1:
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**
03 Supported Employment	03010 job development
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Supported employment - small group employment support services provide a combination of person-centered career exploration, career planning, and employment training activities in integrated community settings. This service is provided in the general workforce in regular business or industry for groups of two to six workers. Small group employment support does not include services provided in facility-based work settings. Examples include mobile crews, enclaves, and other business-based workgroups who employ small groups of workers with disabilities in a community setting. 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.

Members must have a goal or outcome of at least part-time competitive integrated employment (CIE) in their member-centered plan to receive this service. The expected outcome of this service is gains in knowledge, skills, personal strengths, and experiences, which contribute to the member pursuing, achieving, or sustaining CIE. CIE is defined at https://dwd.wisconsin.gov/dvr/partners/cie/definition.htm.

Small group employment support services include:

- Career exploration and development leading to at least part-time participation in CIE. Career exploration activities must be provided in integrated community settings where such activities typically take place for individuals not receiving HCBS. Activities include:
  - Business tours and informational interviews;
  - Small group discovery;
  - Meeting with prospective employers;
  - Small group educational opportunities focused on key aspects of CIE;
  - Division of Vocational Rehabilitation orientation;
  - Soft skill education and training opportunities;
  - Developing transportation and mobility skills; and
  - Identification of need and referral for Work Incentive Benefits Analysis.
- Work experiences matched to a member's interest, strengths, skills, abilities, and conditions for success;
- Supports expected to maximize member independence and skill acquisition, utilizing systematic instruction based on job analysis, along with individualized assistive or adaptive devices/support; and
- Other workplace support services that are not specifically related to job skill training that enable the member to be successful in work and other community settings where this service is provided.

Small group employment support does not include payment for supervision, training, support, or adaptations that are typically available to workers without disabilities who fill similar positions in the business.

Supported employment-small group support services may only be provided in non-disability-specific settings in the community, which are not leased, owned, operated, or controlled by a service provider. Supported employment services- group employment support may not include volunteer work.

Members receiving small group employment support may also receive educational, pre-vocational, career planning, and day services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supported employment services, the member's record documents that the service is not otherwise available to the member through a program funded by Vocational Rehabilitation under § 110 of the Rehabilitation Act of 1973, as amended, and for members ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (20 U.S.C. § 1401 et seq).

This service does not include incentive payments, subsidies, or unrelated vocational training expenses, including the following:

1. Incentive payments 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.

Members participating in elements of this service that involve work shall be compensated in accordance with applicable Federal and State laws and regulations.

The cost of transportation from a member's residence to the site where the member starts and ends this service each day may be included in the reimbursement paid to the supported employment provider or may reimbursed under specialized (community) transportation, but not both.

Personal care may be a component part of supported employment- small group employment support, but may not comprise the entire service. Personal care 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 supportive home care or self-directed personal care, but not both.

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

Personal care may be a component part of supported employment- small group employment support, but may not comprise the entire service. Personal care 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 supportive home care or self-directed personal care, but not both.

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

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	Supported Employment Agency
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):*

Setting is HCBS compliant per 42 CFR 441.301(c)(4), and

At least one of the following:
o Accreditation by a nationally recognized accreditation agency, or
o Division of Vocational Rehabilitation (DVR) contracted provider of Supported Employment or Customized Employment, or
o A minimum two years of experience working with the target population providing employment-related services in the community.

Additionally:
If personal care services are provided, the provider must meet the Training and Documentation Standards for Supportive Home Care.
If transportation services are provided, the provider must meet the qualifications for Specialized Transportation- Community Transportation.

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):*

Setting is HCBS compliant per 42 CFR 441.301(c)(4), and

At least one of the following:
o Certified Employment Support Professional (CESP) certification, or
o ACRE Basic Employment certificate in Supported Employment, Community Employment, or Customized Employment, or
o A minimum of two years of experience working with the target population providing employment-related services.

Additionally:
If personal care services are provided, the provider must meet the Training and Documentation Standards for Supportive Home Care.
If transportation services are provided, the provider must meet the provider qualifications for Specialized Transportation-Community Transportation.

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:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08040 companion
Category 3:	**Sub-Category 3:**
08 Home-Based Services	08050 homemaker

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

08 Home-Based Services | 08060 chore

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

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

Service Definition *(Scope):*

Supportive home care is the provision of services to directly assist members with daily living activities and personal needs and to assure adequate functioning and safety in their home and community. Services include the following:
1. Providing support necessary for member safety at home and in the community, including observation or cueing of the member, to ensure that the member safely and appropriately completes activities of daily living and instrumental activities of daily living.
2. Routine housekeeping and cleaning activities performed for a member, consisting of tasks that take place on a daily, weekly, or other regular basis. These tasks may include washing dishes, doing laundry, dusting, vacuuming, cooking, shopping, cleaning, and similar activities that do not involve hands-on care of the member.
3. 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 tasks 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 bed bug inspection and extermination. This also may include assistance with packing/unpacking and household cleaning/organizing when a member moves.

This service also includes personal care services, including:

1. Hands-on assistance with activities of daily living, such as dressing/undressing; bathing; eating; toileting; assistance with mobility/ambulation/transferring (including the use of a walker, cane, etc.); and personal hygiene/grooming, such as care of hair, teeth, or dentures. This may also include preparation and cleaning of areas that are used during provision of personal assistance, such as the bathroom and kitchen.
2. Direct assistance with instrumental activities of daily living, such as meal preparation and serving, medication management and treatments that are normally self-administered, care of eyeglasses or hearing aids, money management, telephone/internet use, personal assistance on the job and in non-employment community activities, and using transportation.

Personal care may not comprise the entirety of this service.

This service also covers the cost of community involvement supports. Community involvement supports assist the member with engagement in community-integrated events and activities, through the coverage of associated expenses for support staff to accompany a participant, specifically when a member’s attendance is dependent on staff accompaniment. This is limited to the worker’s expense only; the member portion of the expense is the responsibility of the member.

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. This service excludes room and board (rent and food) costs for a live-in caregiver. 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 when 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/IID admission;
• Receipt of medical or rehabilitative care entailing at least an overnight absence; and
• Participation in a therapeutic rehabilitative program as defined in Wis. Admin. Code § 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 entailing at least an overnight absence and unaccompanied by the worker;

• Obtaining education, employment or job, habilitative, or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; and
• 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.

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.

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
Individual	Individual workers
Agency	Agency-directed workers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supportive Home Care

Provider Category:

Individual

Provider Type:

Individual workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Training and Documentation Standards for Supportive Home Care

Verification of Provider Qualifications

Entity Responsible for Verification:

PHIP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supportive Home Care

Provider Category:

Agency

Provider Type:

Agency-directed workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Training and Documentation Standards for Supportive Home Care

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:

Training Services for Unpaid Caregivers

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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 that are included in the member-centered plan (MCP), use of equipment specified in the MCP, and guidance 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 MCP and must directly relate to the individual's role in supporting the member.

This service includes, but is not limited to, on-line or in-person training; conferences; or resource materials on the specific disabilities, illnesses, or conditions that affect the member. 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 how to effectively care for a member with dementia.

Training includes registration costs and fees associated with formal instruction in areas that are relevant to the needs identified in the MCP.

This service may not be provided to train paid caregivers.

This service excludes payment for lodging, travel, 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.

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
Individual	Professional Services
Agency	Training/Service Agency

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 accredited professionals who maintain current credentials in their field of practice.

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:

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 accredited professionals who maintain current credentials in their field of practice.

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:	Sub-Category 1:
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Community transportation is the provision of transportation services or items that enable a member to engage with the community, including with the people, places and resources that are meaningful for the member's self-determination and that meet their goals and daily needs. This service allows the member to gain access to waiver services, a place of employment, and other community services, activities, and resources, as specified in the member-centered plan. This service may consist of items such as tickets, fare cards, or other fare media or services where the common carrier, transportation network company driver, specialized medical vehicle, or other provider directly conveys a member and the member's attendant, if any, to destinations.

Whenever possible, family, neighbors, friends or community agencies who can provide this service without charge will be utilized. Legally responsible persons, relatives, or legal guardians may be paid mileage reimbursement for providing this service if they meet the conditions under Appendix C-2 d and e of this waiver.

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.

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
Individual	Individual drivers
Agency	Transportation Network Company
Agency	Taxi or common carrier
Agency	Public mass transit
Agency	Specialized Transportation Agency

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:
Individual
Provider Type:

Individual drivers

Provider Qualifications

License *(specify):*

Operator’s license from the Department of Transportation

Certificate *(specify):*

Other Standard *(specify):*

Liability insurance, vehicle in good repair with all operating and safety systems functioning.

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: Transportation (Specialized Transportation) - Community Transportation

Provider Category:

Agency

Provider Type:

Transportation Network Company

Provider Qualifications

License *(specify):*

Wis. Admin Code § SPS 440.41

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: Transportation (Specialized Transportation) - Community Transportation

Provider Category:

Agency

Provider Type:

Taxi or common carrier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. Ch. 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):*

Other Standard *(specify):*

Wis. Stat. § 85.20

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:

Specialized Transportation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Stats. § 85.21 or Wis. Stats. § 85.22 or Wis. Stats. § 85.215
And
Wis. Admin. Code Ch. Trans 301

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) - Other Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Other Transportation consists of transportation to receive non-emergency, Medicaid-covered medical services for a member who elects to self-direct such 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, mass transit, transportation network company driver, 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 (1) are not limited to providers in the PIHP's network, although the PIHP must verify credentials of specialized medical vehicle providers, (2) are not required to obtain prior authorization to purchase any transportation service from a qualified provider to any Medicaid-covered medical service if the member's budget is sufficient to pay for the service, and (3) are not required to schedule routine trips in advance if the member can obtain transport. Legally responsible persons, relatives, or legal guardians may be paid for providing this service if they meet the conditions under Appendix C-2 d & e of this waiver.

This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the state plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan. This service excludes ambulance transportation, which is available through the Medicaid State Plan.

This service excludes non-emergency medical transportation when authorized by the PIHP as a State Plan service for members without budget authority. It also excludes nonmedical 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.

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	Specialized Transportation Agency
Individual	Individual drivers
Agency	Taxi or Common Carrier
Agency	Public Mass Transit
Agency	Transportation Network Company

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Transportation (Specialized Transportation) - Other Transportation

Provider Category:

Agency

Provider Type:

Specialized Transportation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Stats. § 85.21 or Wis. Stats. § 85.22 or Wis. Stats. § 85.215
And
Wis. Admin. Code Ch. Trans 301

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: Transportation (Specialized Transportation) - Other Transportation

Provider Category:

Individual

Provider Type:

Individual drivers

Provider Qualifications

License *(specify):*

Operator’s license from the Department of Transportation

Certificate *(specify):*

Other Standard *(specify):*

Liability insurance, vehicle in good repair with all operating and safety systems functioning.

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Taxi or Common Carrier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. Ch. 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) - Other Transportation

Provider Category:

Agency

Provider Type:

Public Mass Transit

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Stat. § 85.20

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) - Other Transportation

Provider Category:

Agency

Provider Type:

Transportation Network Company

Provider Qualifications

License *(specify):*

Wis. Admin Code § SPS 440.41

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:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Vehicle modifications are physical adaptations to the vehicle that is the member's primary means of transportation. Vehicle modifications accommodate the specialized needs of the member and enable the member to function with greater independence in the community. This service category also includes the cost of materials, services, inspections, and maintenance necessary for a vehicle modification.

Vehicle modifications and services may include:
- Customized devices necessary for the member to be transported safely in the community, including tie-downs and wheelchair docking systems;
- Driver control devices, including hand controls and pedal adjusters;
- Inspections required for a modification;
- Interior alterations to seats, head and leg rests, and belts;
- Modifications needed to accommodate a member's sensitivity to sound, light or other environmental conditions;
- Portable ramps when the sole purpose of the ramp is for the member to access the vehicle;
- Raising the roof or lowering the floor to accommodate wheelchairs; and
- Vehicular lifts, platforms, carriers, and curbsiders.

This service category excludes:
- Modifications to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual;
- Modifications to vehicles that are owned or leased by residential or agency providers of waiver services;
- Purchase or lease of a vehicle (however, this service category can be used to fund the portion of a new or used vehicle purchase that directly relates to the cost of accessibility adaptations); and
- Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

Vehicle modifications must meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

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

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	Motor Vehicle Modifier

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Motor Vehicle Modifier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

- Registered as a “vehicle modifier” with the National Highway Traffic Safety Administration (49 CFR 595.6);
- Meet requirements outlined in 49 CFR section 595.7; and
- Install equipment according to the manufacturer’s requirements and instructions.

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:

Vocational Futures Planning and Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	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:

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

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

Service Definition *(Scope):*

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 competitive integrated employment (CIE). CIE is defined at https://dwd.wisconsin.gov/dvr/partners/cie/definition.htm. This service assists a member in identifying a pathway to CIE and addresses barriers to employment due to the member's disability, benefits, or life circumstances. The expected outcome of this service is measurable gains in knowledge, skills, personal strengths, and experiences that contribute to the member obtaining and sustaining CIE with the highest possible wage.

This service includes seven (7) elements available as needed to the member:

1) Coordination of the VFPS process;
2) Development of a written employment plan based on an individualized determination of the member's strengths, assets, needs, interests, and barriers to CIE;
3) An assistive technology pre-screen or in-depth assessment;
4) Work incentive benefits analysis;
5) Career exploration;
6) Job seeking support, including customized job negotiation or business plan development and launch; and
7) Job coaching, including systematic instruction to stabilize in CIE or workplace personal assistance (WPA) support to maintain CIE.

VFPS must be provided by qualified professionals that include, for example, an employment specialist, a benefit 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.

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

This service may not be used to support volunteering, regardless of where the service takes place.

This service may not be provided in small group format. The ratio is always 1:1 for this service.

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.

This service may supplement but not duplicate any service that is provided to the member under an approved Individualized Plan for Employment (IPE) funded under the Rehabilitation Act of 1973, as amended, or, for members ages 18-22, under an approved Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA).
Prior to authorizing this service, the member's record documents that this service is not otherwise available to the member through a program funded by Vocational Rehabilitation under section 110 of the Rehabilitation Act of 1973, as amended, and for members ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

This service may not be authorized for a member who has already obtained CIE outside the VFPS process or does not have a goal to advance in CIE.

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

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	Vocational futures planning agency

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 agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The VFPS agency must offer all seven elements of the service, and

At least one of the following:
o A DVR contracted provider of Supported Employment and/or Customized Employment services, or
o Accreditation by a nationally recognized accreditation agency, or
o A minimum of two years of experience working with the target population providing employment-related services.

Additionally:
If personal care services are provided, the provider must meet the Training and Documentation Standards for Supportive Home Care.

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.*
  - ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a) The SMA-PIHP contract requires the PIHP to comply with Wis. Stat. § 50.065 and Wis. Admin. Code Chs. DHS 12 and 13, which govern caregiver background checks and the reporting and investigation of caregiver misconduct. This authority defines a caregiver as:
i. 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; or
ii. 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.

The terms “entity,” “direct contact,” “regular contact,” and “under the control of an entity” are defined in Wis. Stat. § 50.065 and Wis. Admin. Code Chs. DHS 12 and 13.

The SMA-PIHP contract additionally requires PIHPs to require contracted co-employment agencies and fiscal employment agents to perform background checks that are in accordance with those required to be conducted by entities under Wis. Stat. § 50.065 and Wis. Admin. Code Chs. DHS 12 and 13 on individuals providing services to self-directing members who have, or are expect to have, regular, direct contact with the member.

b) The scope of the required caregiver background checks is described under Wis. Stat. § 50.065(2). Caregivers are barred from participation in WI Medicaid when they have been convicted of crimes referenced in Wis. Stat. § 50.065(1)(e)(1) or Wis. Admin. Code § DHS 106.06(8).

c) Each PIHP is required by the SMA-PIHP contract to ensure that all persons working as caregivers as described above have had required background checks completed. The PIHP must perform, or ensure that its providers perform, these checks at the time of caregiver employment or contracting and at least every four years thereafter or as required by WI Medicaid provider enrollment standards. During annual quality reviews and annual PIHP provider network reviews, the SMA and EQRO review a sample of member records and contracted provider agency records to verify that the required background checks have been completed.

Additionally, individuals providing support broker services are subject to criminal background checks as described above.

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 Wis. Stat. § 146.40 and Wis. Admin. Code Ch. DHS 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 by, certified by, or registered with the SMA to provide direct care or treatment services to clients, are required to report to the SMA any allegation of abuse, neglect, or misappropriation committed by any person who is 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 as defined in C.2.a.

c. Each PIHP is required by the SMA-PIHP contract to ensure that all persons working as caregivers, as described under C.2.a, have had the background checks described under Wis. Stat. § 50.065(2) completed. These background checks include screening the individual against the SMA's caregiver misconduct registry. The PIHP must perform, or ensure that its providers perform, these checks at the time of caregiver employment or contracting and at least every four years thereafter or as required by WI Medicaid provider enrollment standards. During annual quality reviews and annual PIHP provider network care management reviews, the SMA and EQRO review a sample of member records and contracted provider agency records to verify that the required screens have been completed as a part of the background checking process.

Appendix C: Participant Services

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

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

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law 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 spouse of a member may be paid to provide self-directed personal care, supportive home care, and personal care provided as a component of daily living skills training, supported employment-individual employment support, supported employment- group employment support, respite, or skilled nursing services.

b. Payment may be made to spouses for extraordinary care under the following circumstances:

i. The member's interdisciplinary team (IDT) identifies the service as necessary and it is included in the member's member-centered plan (MCP);

ii. The member's preference is for the spouse to provide the service;

iii. The spouse meets the provider qualifications and standards for the service to be provided and there is a properly executed provider agreement between the PIHP and the spouse ; and

iv. The spouse will provide extraordinary as opposed to ordinary care, as defined below:

1. Ordinary care includes activities that a spouse would ordinarily perform in the household on behalf of a person without a disability, including household activities that directly benefit the spouse residing in the household with the member (for example, lawn mowing, snow shoveling, family meal preparation, grocery shopping, emptying trash cans).

2. Extraordinary care may indirectly benefit the spouse, but is clearly intended to support the health and welfare of the member and avoid institutionalization; is provided in an amount that exceeds the normal spousal care-giving responsibilities for a spouse who does not have a disability; or the spouse forgoes paid employment to provide the service.

The IDT 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 spouse is in the best interest of the member:

i. The service to be provided meets identified needs and outcomes in the MCP and assures the health, safety, and welfare of the member;

ii. Purchase of services from the spouse is cost-effective in comparison to purchase of services from another provider; and

iii. Real or potential conflicts of interest for the provider are identified and monitored by the IDT.

c. The IDT is responsible to monitor and document that the services purchased from the spouse are delivered in accordance with the MCP. 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 legally responsible 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.*

a. Specific circumstances under which payment is made:
1) service is identified in the member-centered plan (MCP);
2) the individual providing the service meets the provider qualifications and standards for the service;
3) there is a properly executed provider agreement between the PIHP and the individual;
4) for spouses, the individual will either provide an amount of service that exceeds the normal spousal caregiving responsibilities for a spouse who does not have a disability or finds it necessary to forego paid employment in order to provide the service; and
5) the member's preference is for the individual to provide the service.

b. Relative is defined as any relative of the member. Legal guardian is defined in state statute.

c. Services for which payment may be made: self-directed personal care, supportive home care, specialized transportation-community transportation, specialized transportation-other transportation, residential services (1-2 Bed AFH), daily living skills training, respite services, skilled nursing services, supported employment- small group employment support, and supported employment-individual employment support services.

d. Controls employed are: The IDT must ensure that: 1) the service meets identified needs and outcomes in the MCP and assures the health, safety, and welfare of the member; 2) purchase of services from the individual is cost-effective in comparison to purchase of services from another provider; and 3) real or potential conflicts of interest for the individual, including the potential for self-referral, are identified and monitored by the IDT.

The IDT monitors and documents that the services purchased from the individual are delivered in accordance with the MCP. 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.

○ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

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 § 1915(b) waiver that allows for the restriction of free choice of providers. To assure that the PIHP maintains a network of providers sufficient in number, mix, and geographic distribution, the SMA-PIHP contract requires the PIHP to demonstrate that its provider network complies with SMA network adequacy standards.

For services that involve intimate personal care needs or require a provider to frequently enter a member's home, the PIHP must, upon a member's request, purchase services from any qualified provider who will accept and meet the provisions of the provider agreement.

Wis. Stat. § 46.284(2)(c) requires that PIHPs must contract with any community-based residential facility (CBRF), residential care apartment complex, nursing home, intermediate care facility for individuals with intellectual disabilities, community rehabilitation program, home health agency, day service, or personal care provider that (1) agrees to accept the PIHP's reimbursement rate for similar providers and (2) meets quality, utilization, or other standards.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
The SMA verifies that PIHPs ensure 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 *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☒ **Other** Specify: PIHP / EQRO data validation	☒ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 ensure 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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☒ **Other**	☒ **Annually**	☐ **Stratified**

Specify: PIHP / EQRO data validation		Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95% with +/- 5% margin of error
☒ **Other** Specify: PIHP / EQRO data validation	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

The SMA Oversight team is the primary resource for the discovery of problems/issues within the waiver program. However, other monitoring, quality improvement, and quality assurance processes may result in the discovery of problems/issues. The processes that could result in such discovery include the Annual Quality Review, conducted by the external quality review organization and the SMA; the review of PIHP or State level grievances and appeals, Family Care Ombudsman program reports, and critical incident reports; the evaluation of requests for the use of isolation, seclusion, or restrictive measures; and the provision of technical assistance or policy clarification.

b. Methods for Remediation/Fixing Individual Problems

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

EQRO reviewers are focused on confirming that PIHPs demonstrate 100% compliance with all applicable licensure and certification standards for providers, and that supportive home care and/or in-home respite workers have completed training per SMA standards. If a deficiency is identified with regard to either provider licensure/certification standards, or training per SMA standards for non-licensed or certified staff, the SMA contacts the PIHP to work toward immediate remediation of the issue.

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 external quality review organization (EQRO) related to individual member concerns; review of Family Care Ombudsman program reports, grievances and appeals, and member incident reports; assessment of requests for use of isolation, seclusion, and restrictive measures; discovery of problems or issues when providing policy clarification to PIHPs; complaints to the SMA; and from other sources. The team also regularly interacts with the PIHP and may identify concerns through these interactions. The oversight team directs remediation of individual member concerns as well as isolated operational concerns, on an as-needed basis. Teams may also use information gathered through direct interaction with the PIHP, or other sources, to identify, document, and direct remediation of individual and systemic problems or issues within the PIHP. Oversight teams have the ability to respond quickly to any issue that affects member health or safety that are identified through routine discovery activities, and can respond quickly to other issues as they are identified. The SMA has also developed policies and procedures for the EQRO and oversight teams to report and document issues that require the SMA's attention and the resolution or remediation of such issues.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

(1) Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future:

The SMA reviewed setting types that each waiver service are typically provided in and grouped the settings into two categories following the process used in the SMA's State Transition Plan.

1.The first category of settings are settings that typically have HCBS characteristics. These settings are natural community settings that are not specific to people receiving HCBS services. The SMA has determined that the settings are typically integrated in the greater community or, in the case of residences in rural settings, are the member's choice and are consistent with the character of such communities; do not segregate or isolate members, except with respect to private residences in rural areas where such is the member's preference; provide opportunities for regular interaction in daily activities with non-members; facilitate member choice in services, daily activities, and assumption of typical, age appropriate social roles; and support rights to dignity, respect, autonomy, and freedom from coercion. More details regarding means by which the state Medicaid agency ascertains that these waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing are included in the answer to #2 below.

a. Settings where the individual will reside:

i. 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.

b. Settings where the individual will receive services:

i. Places of integrated, competitive employment: Per the SMA-DWD joint definition of Competitive Integrated Employment (CIE) (https://dwd.wisconsin.gov/dvr/partners/cie/definition.htm), a CIE location must be "a location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons" and "must typically found in the community. To be "typically found in the community", an employment setting location should be found in the competitive labor market and not formed for the purposes of employment for individuals with disabilities.

ii. Community sites predominantly used by the general public for typical community activities, unless specifically prohibited by 42 CFR § 441.301(c)(5): These sites include, but are 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. These sites cannot be provider owned, leased, or controlled.

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

a. Settings where the individual will reside:

i. Licensed Community-based residential facilities: Residences where five or more adults not related to the operator or administrator of the facility live together in a community setting.

ii. Licensed 3-4 bed adult family homes: Residences where three or four adults not related to the operator or administrator of the facility live together in a community setting.

iii. Certified 1-2 bed adult family homes: Residences where up one or two adults live together in a community setting.

iv. Certified Residential Care Apartment Complexes: Homelike, community-based setting where 5 or more adults reside in their own living units that are separate and distinct from each other.

b. Settings where the individual will receive services:

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

ii. Day habilitation- facility based service settings: A non-residential setting, separate from the member's private residence or other residential living arrangement, that provides activities and supports to foster the acquisition of generalized skills and opportunities for the member to participate in integrated community-based activities. Day habilitation settings are considered facility-based (as opposed to community-based) when the provider uses a provider owned or controlled setting for any portion of the service delivery.

iii. Prevocational- facility based service settings: A center-based site where individuals receive pre-vocational services

intended to enable progression to competitive integrated employment. Prevocational services are considered facility-based (as opposed to community-based) when the provider uses a provider owned or controlled setting for any portion of the service delivery.

iv. Group-supported employment settings: A setting where a small group of workers receives a combination of person-centered career exploration, career planning, and employment training activities in integrated community settings. Small group employment support does not include services provided in facility-based work settings, but sites are reviewed to ensure compliance.

(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:

The state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing through the following means:

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

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

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

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

4. Compliance for Non-residential settings (Day habilitation- facility based service settings, Prevocational- facility based service settings, adult day care centers, and group supported employment settings):

Contracted staff under the direction and supervision of the SMA completed reviews of consisting of desk review of materials submitted and a validiation visit to ensure that all HCBS Settings requirements were in place. For current and future adult day care center settings requesting review, the responsibility for conducting the reviews will has transition to DQA. DQA follows the same process followed by the contracted staff under the direction and supervision of the SMA. If during the review for a non-residential setting, a setting is found to not meet requirements, the provider is required to submit verification of remediation before an HCBS Settings Compliance determination is made. Settings that meet all compliance criteria, both with and without remediation, receive a letter from the SMA. A list of nonresidential settings that have been found compliant with the HCBS settings rule is on the HCBS Nonresidential Settings Compliance List found on the SMA HCBS webpage (https://www.dhs.wisconsin.gov/hcbs/nonres-compliance-list.xlsx) for all non-residential providers other than adult day care centers. The compliance status for adult day care centers is included on the Division of Quality Assurance (DQA)'s public-facing Provider Search (https://www.dhs.wisconsin.gov/guide/provider-search.htm). To ensure ongoing compliance, these settings will have their compliance status verified at least once every three years. The ongoing verification process includes verification of the HCBS Settings Requirements and remediation of any items not successfully remediated. The review process for all new and existing providers will include an off-site review of provider documents and an onsite visit. Settings that are not found to be compliant with the HCBS settings rule, are required to submit acceptable remediation plans. If the non-residential provider fails to achieve compliance with the HCBS settings rule within the designated timeframe, the provider is no longer eligible to serve as an HCBS waiver provider.

5.Additional steps taken by the SMA to ascertain initial and ongoing compliance for all settings include:
a. including requirements in the SMA-PIHP contract to ensure
settings in which waiver services are provided have been determined to be compliant with the HCBS Settings Rule; and
b. Informing members, through the Member Handbook, of the settings requirements and how to report any concerns in regard to the settings in which they receive services.
c. Adding review of HCBS Settings Rule related person centered planning requirements to the External Quality Review Organizations care management reviews.

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 member-centered plan development may not provide other direct waiver services to the member, with the exception of Indian Health Care Providers (IHCPs) and providers contracted by the PIHP and approved by the SMA to provide culturally appropriate services. The SMA only approves these exceptions when the IHCP or culturally appropriate provider is the only willing and qualified entity in the geographic area able to provide culturally appropriate member-centered plan development or services and the IHCP or provider administratively separates its care management functions from its service provider functions. For these exceptions, several additional safeguards have been put in place:

During enrollment and options counseling, the Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist is responsible to inform the potential member and/or the member's 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 Tribal Aging and Disability Resource Specialist informs the potential member and/or the member's 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.

If a PIHP contracts with a provider of culturally appropriate services and the member identifies with the culture of which the provider provides culturally appropriate services, the ADRC informs the potential member and the member's legal representative of 1) the option to choose between the culturally appropriate provider (if the selected PIHP has a care management contract with the provider) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either the culturally appropriate provider (if available) or other PIHP network providers.

IHCPs and providers of culturally appropriate services who also provide care management are required to educate members about not only the services provided by the IHCP or provider of culturally appropriate services but also the full range of waiver services available to the members. The IHCP is required to educate members that they have a right to free choice of providers and can access services through the IHCP (if the IHCP has the capacity) or a PIHP network provider. Additionally, the IHCP or culturally appropriate care management provider must provide the member with an opportunity to challenge the assertion that the provider is the only willing and qualified provider able to provide culturally appropriate care management to the member. If the member chooses to challenge this assertion, they are provided with information about how to file a grievance with the PIHP, using the PIHPs internal grievance and appeal system as described in Appendix F-2. If the member is dissatisfied with the PIHP's response to their grievance, they may request a DHS (SMA) grievance review, described in F-3. To document that this process has occurred, the IHCP or culturally appropriate provider is required to ask the member to sign an attestation which will be attached to the member care plan (MCP) indicating that the provider has provided the member with this information every twelve (12) months as part of the annual comprehensive assessment. If the member refuses to sign the attestation, the IHCP or culturally appropriate provider will document that refusal in the MCP. The State's EQRO will, as part of its annual review, sample the MCPs of Indian members receiving care management from an IHCP and members receiving care management from other culturally appropriate providers to assure this process has occurred.

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. Upon enrollment, members are provided with an SMA-approved member handbook specific to the PIHP. For Indian members who choose to receive Indian Health Care Provider (IHCP) care management, the member handbook includes an insert specific to the IHCP.

The handbook describes each of the following topics related to service plan development:
- the care planning process
- the care management process
- the service authorization process that the PIHP is required to use;
- the role members and their families play in the processes on this list
- the grievance and appeal rights and procedures
- the member's rights, including the option to self-direct supports and services,
- the member's responsibilities as a PIHP member

As with all aspects of the member-centered planning process, the MCO must communicate this information and support to the member:
- in plain language
- in a manner that respects the diverse cultural considerations that the member holds
- in a manner that is accessible to members with disabilities through the provision of auxiliary aids and services at no cost to the member
- in a manner that is accessible to members who have limited English language proficiency through the provision of language services at no cost to the member.

This process provides the necessary information and support to ensure that members lead and direct the member-centered care planning process to the maximum extent possible and empowers members to make informed choices and decisions.

In addition to the PIHP handbook, the consumer education and training service is available to members. The intent of this service is to help members acquire the skills needed to exercise control and responsibility over support services and enable members to communicate wants and needs, make informed decisions, voice their choices, and develop trusted supports with whomever they can share concerns.

Information specific to Indian members receiving care management from an IHCP can be found in the SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf).

b. Each member has the right to include anyone of their choice in the care planning process. This right is explained 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. The member and interdisciplinary team (IDT) staff develop the plan and participate in the service plan development process. At a minimum, the IDT consists of the member, the member's legal decision maker, any other persons requested by the member, a registered nurse, and a social service coordinator assigned by the PIHP. The IDT may also include any other appropriate professionals (e.g., therapist, behavioral specialist). The term "IDT staff" refers to the social service coordinator, registered nurse, and any other staff who are assigned or contracted by the PIHP to participate in the IDT and distinguishes those staff from the full IDT. The assessment and member-centered plan (MCP) are developed by the IDT.

The service plan development process includes the following events:

- Beginning on the member's enrollment date, the PIHP must provide the member with necessary services in the benefit package, as well as any services that the member is receiving at the time of enrollment and that in the absence of, the member would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
- Within three calendar days of the member's enrollment date, the PIHP must contact the member by phone or in-person to complete the items listed in the next subsection, (b).
- Within five calendar days of enrollment, the IDT staff must develop and implement an initial service authorization, which must be signed by the member within 10 calendar days of enrollment.
- Within 10 calendar days of enrollment, the IDT must complete an initial assessment.
- Within 30 calendar days of enrollment, the IDT must complete a comprehensive assessment.
- Within 60 calendar days of enrollment, the IDT must finalize a fully developed member-centered plan (MCP) and have the member sign the MCP.
- The IDT must routinely reassess and update all sections of the member's comprehensive assessment and MCP. The IDT must complete a reassessment at the member's current residence at least every twelve (12) months, or every six (6) months for vulnerable or high-risk members.

The Indian Health Care Provider (IHCP) has the same requirements as the PIHP. Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf).

b. Initial and comprehensive assessments provide the basis for the initial service authorization and MCP, respectively.

Within 3 days of enrollment, the PIHP must contact the member in-person or by telephone to complete the following tasks that provide a foundation for service plan development:

- Welcome the member to the PIHP
- Review the stability of supports the member currently has in place
- Identify those services the member needs to sustain their living arrangement
- 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
- Schedule an in-person meeting at a time and location convenient to the member

Within 10 days of enrollment, the IDT staff must meet in-person and complete an initial assessment, which includes an initial brief nursing and social assessment and at a minimum addresses:

- Whether the member is an imminent physical or behavioral danger to themselves or others
- Whether the member requires assistance with medication administration
- Whether there is a support system change or concern (i.e. loss of spouse, caregiver, no support available, etc.)
- Whether the member demonstrates severe impairment of cognition or orientation
- Whether the member has had a recent transition of care (i.e. hospital to home) or recent emergency room or urgent needs visits
- Whether the member has current supports necessary to sustain the member in the member's current living arrangement

Within 30 days of enrollment, the IDT staff must meet in-person and complete a comprehensive assessment of the member's needs and strengths, preferences, natural supports, personal experience outcomes, long-term care outcomes, and any ongoing member conditions that require a course of treatment or regular care monitoring. The comprehensive assessment must include a review of the member's functional screen, available member medical records, any other available background information, and documentation of the following:

- A full nursing assessment, including but not limited to:
    - Risk assessments for falls, skin integrity, nutrition, pain, and an evaluation of the member's ability to set up, administer, and monitor their own medication(s)

- The member's medications and their understanding of the desired responses, potential benefits, and side effects, and rationale for use; a detailed description of the behaviors indicating the need for any complex medication regime or behavior modifying medication; and any examples of inappropriate use of, side effects caused by, or any use contrary to the intended use of any complex medication regime or behavior-modifying medication
- Clarification and correction of any discrepancies between medications prescribed and taken.
- An exploration of self-directed supports and the member's desire to self-direct.
- The member's preferences regarding privacy, services, caregivers, and daily routine.
- Mental health, alcohol, and substance use issues.
- The availability and stability of existing natural and community supports, and assessing how the existing supports can be sustained, maintained, and/or enhanced.
- The member's preferred living situation, including the stability of the member's current housing situation and their financial ability to sustain it.
- The member's preferences for educational and vocational activities, including supported employment.
- The member's available financial resources.
- The member's understanding of his or her rights, preferences for executing advance directives and whether the member has a guardian, durable power of attorney, activated power of attorney for health care, or a supported decision-making agreement.
- The member's understanding of abuse, neglect and exploitation. This includes an assessment of the member's potential vulnerability to and risk factors for abuse or neglect in the their personal life or finances.

The IDT staff must routinely reassess the comprehensive assessment and MCP as the member's long-term care outcomes change, and at a minimum, every 6 months.

The IHCP is required to use the PIHP's assessment protocol.

c. Upon enrollment, the PIHP provides the member with an SMA-approved member handbook, which describes the services available. The PIHP also informs the member of the full range of services in the benefit package that are appropriate for the member's level of care. As the IDT staff work with the member to develop outcomes and goals, the IDT staff explore available services and supports that may help the member meet their goals. Information specific to Indian members receiving care management from an IHCP can be found in the SMA-IHCP-PIHP Agreement.

d. The plan development process ensures that the services plan addresses participant goals, needs, and preferences, by being member-centered and identifying and documenting the member's long-term personal experience outcomes throughout the process. The IDT must encourage the active involvement of the member and the member's support contacts to ensure that the process addresses the member's goals, needs, and preferences. Also, each step of the plan development process has assessment and documentation requirements to ensure that the member's goals, needs, and preferences are addressed in a way that will satisfactorily support the member's outcomes.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf).

e. The PIHP must implement procedures outlined in the SMA-PIHP Contract to ensure service coordination. The IDT staff must coordinate the member's waiver services with other services and service providers that support the member. The IDT staff also serve as the primary coordinators for the member's Medicare and Medicaid acute and primary health care services. Most acute and primary health care services coordination efforts are conducted by the registered nurse on the IDT.

f. During the service plan development process, PIHPs must obtain the signatures of all individuals and essential providers responsible for MCP implementation. The MCP includes the assignment of responsibilities for each provider. Essential providers are defined under the SMA-PIHP contract. For non-essential providers, the PIHP must attach a copy of the provider's signed service contract, agreement, or authorization to the MCP. The PIHP must distribute a copy of the MCP to the member and essential provider(s) that are responsible for the MCP's implementation.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf).

g. The member and IDT staff must review and update the MCP no later than the sixth month after the month in which the

previous comprehensive assessment was completed. MCPs must also be reviewed and updated whenever the member's preferences change; there is a significant change in the member's situation or condition; the MCP fails to meet the member's needs or support the planned outcomes; or at the member's, the member's legal decision maker's, or the member's primary medical provider's request. The IDT are required to have monthly phone contact and quarterly in-person contact with the member. During these contacts, the IDT staff review the MCP to see if any changes are needed. The MCP can be updated at any time.

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 it must implement a policy that expressly prohibits all forms of abuse, neglect, exploitation, and mistreatment of members by PIHP employees and providers. Each PIHP is required to create a safety and risk policy that must be approved by the SMA.

The safety and risk policy must include the following:
- guidelines for how interdisciplinary teams (IDT) assess and respond to risk factors;
- directions for identifying abuse and neglect;
- procedures for reporting suspected abuse or neglect;
- 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
- identification of members' right to freedom from unnecessary physical 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.

Indian Health Care Providers (IHCPs) providing care management are required to comply with the PIHP's safety and risk policy.

The safety and risk policy must also include identifying vulnerable/high risk members. A vulnerable/high risk member is a member who is dependent on a single caregiver, or two or more caregivers all of whom are related, to provide or arrange for the provision of nutrition, fluids, or medical treatment that is necessary to sustain life and to whom at least one of the following applies: a) is nonverbal and unable to communicate feelings or preferences; b) is unable to make decisions independently; c) is clinically complex, requiring a variety of skilled services or high utilization of medical equipment; or d) is medically frail.

The PIHP's safety and risk policy reduces risk to members by making the IDT staff responsible for preventing unnecessary risk. PIHP procedures provide the IDT staff with appropriate tools for working with each member to identify risks, to assess the level of risk that the member is willing to accept, and to balance the member's needs for safety, protection, good physical health, and freedom from accidents with overall quality of life and individual choice and freedom.

Each member's member-centered plan (MCP) must include paid and unpaid supports, services, strategies, and backup plans to mitigate risk. The IDT staff monitors the effectiveness of backup plans. It ensures that provider contracts include arrangements for backup direct care providers or that a member's self-directed supports plan includes backup arrangements. Specific arrangements vary 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 a regularly scheduled provider is unable to furnish services.

Each PIHP is required to have a mechanism to monitor, evaluate, and improve the PIHP's performance in addressing safety and risk issues to ensure that individualized supports are in place to facilitate a safe environment for each member and that desired member outcomes and preferences are understood and respected. When the member prefers, the PIHP must include family members and other informal supports when addressing safety concerns.

The PIHP and its subcontracted providers must comply with Wis. Stat. § 51.61(1)(i) and Wis. Admin. Code § DHS 94.10 in the use of isolation, seclusion, and restrictive measures, which require specific case-by-case approval from the SMA.

The PIHP is responsible for providing members with access to services in the benefit package, coordinating services outside the benefit package, and linking to adult protective services 24 hours a day, seven days a week. This responsibility includes maintaining a 24-hour, seven 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.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf).

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 generally restricted under the companion s. 1915 (b) waiver to the PIHP's network providers.

For services involving 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.

Member handbooks are provided to every member and describe the process for requesting an out-of-network provider if the PIHP's network providers are unable to meet the member's needs or support the member's outcomes. PIHPs must develop and maintain up-to-date provider directories which are provided to members upon enrollment and upon request. When significant changes occur in their provider network, PIHPs must provide members with an updated directory, an addendum to the directory, or other written notification of the change. PIHPs must also make provider directories available on the PIHP's website and provide them to each Aging and Disability Resource Center (ADRC) in the PIHP's service area.

Prior to enrollment, if an applicant is an Indian, the ADRC or Tribal Aging and Disability Resource Specialist (TADRS) informs the potential member 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 SMA-IHCP-PIHP Agreement, to educate members 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 (IDT) up to two times per calendar year if additional IDTs are available. If 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 twelve (12) months period, within the same PIHP), or accessing care management through an Indian Health Care Provider (IHCP)(if available).

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):

To verify that services are furnished using a written member-centered service plan (MCP) that is based on a person-centered approach and is subject to approval by the SMA, the SMA's EQRO conducts a retrospective review of MCPs. To conduct its review, the EQRO selects and reviews a sample of at least 30 existing MCPs from each PIHP at least annually. Wisconsin's long-term care functional screen data and the PIHP's encounter data are used to effectively identify populations of members for review based on pre-established targeting criteria. Systematic, random sampling techniques are employed to ensure that the MCP review provides valid and reliable information on the quality of care provided. For large PIHPs with many service locations or programs, the SMA may direct the EQRO to obtain larger sample sizes to ensure adequate records are sampled for each service location and program.

MCPs are reviewed by EQRO individuals who are knowledgeable about waiver target groups, services, eligibility requirements, and the service delivery system. The EQRO-designated reviewers may consult with other professionals within the SMA, including nurse consultants, therapy consultants, and others who have knowledge of services and member needs.

EQRO-designated reviewers evaluate whether services in an MCP are sufficient to assure the member's health, safety, and well-being, consistent with the nature and severity of the member's disability or frailty, or satisfactory to the member in supporting the member's long-term care outcomes. Each review includes the following 1) an examination of the functional screen, 2) review of the comprehensive assessment, 3) the member centered plan (service plan) and 4) case notes. Reviewers may also examine other available information related to services, supports, or time periods, and may interview care management staff, staff responsible for service provision, and members or legal decision-makers. The EQRO is required to review a minimum of six months of historical records, but the SMA may extend this review to one year. The reviewers will approve an MCP that identifies and sufficiently addresses each of a member's long-term care and personal experience outcomes.

If the reviewer finds that the MCP is not sufficient and there is an identified health and safety concern, the member is complex and challenging, or if the member is using personal resources without proper counseling, then the reviewer will make an immediate referral to the SMA. If, after further investigation, the SMA determines that the effect on the member is serious, the PIHP will be directed to take immediate corrective action to ensure that the member's essential long-term care and personal experience outcomes are adequately addressed. In this circumstance, the SMA will not approve the MCP at issue until the identified problems are corrected. The SMA will track and review findings, identify trends, and provide a periodic report to the PIHP.

For all other insufficiencies, the reviewer will inform the PIHP, who will complete follow-up on those insufficiencies and report the insufficiencies to the SMA. If a PIHP is found to have an unfavorable trend towards non-approved MCPs, the SMA may increase its frequency of review and require the PIHP to submit a remediation plan for SMA approval.

In addition to the review of a statistical sample of MCPs, the SMA establishes criteria for and implements targeted reviews of additional MCPs, based on the results of the sample reviews and other quality monitoring activities. Targeted MCP reviews may focus on specific PIHPs, specific interdisciplinary teams, specific target populations, or members with specific conditions, as needed for the SMA to implement effective quality improvement in the targeted areas.

These procedures also apply to MCPs developed by an IHCP providing case management. A statistical sample of those MCPs is also reviewed.

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 (IDT) is responsible for monitoring the implementation of the member-centered plan (MCP) and the member's health and welfare.

b. As required by the SMA-PIHP contract, IDT staff regularly contact the member, legal decision maker, or individual authorized by the member to speak with IDT staff in-person and by telephone, to monitor and follow up on the implementation of the MCP as well as the member's health and welfare. Further, IDT staff may consult with natural or paid supports or review provider timesheets, provider agency reports, or member contact records.

When IDT staff contact the member, IDT staff must document all aspects of service monitoring to ensure that the member receives services and supports as authorized and that the natural and community services and supports are being provided as identified in the MCP to meet the member's outcomes. IDT staff must also document and ensure that the services and supports are sufficient to assure the member's health, safety, and well-being, are consistent with the nature and severity of the member's disability or frailty, and are satisfactory to the member in supporting the member's long-term care outcomes. Finally, IDT staff must document and ensure that the member exercises free choice of providers and has effective back-up plans.

The member-centered planning process includes ongoing monitoring and follow-up. The MCP is a dynamic document that reflects significant changes in member's outcomes, health status and life. IDT staff capture changes through ongoing re-assessments. All aspects of the member-centered planning and comprehensive assessment process occur at times and locations consistent with the requirements within the SMA-PIHP contract.

The SMA's external equality review organization (EQRO) completes care management reviews (CMR) annually with each PIHP. Through a reliable sample, the EQRO reviews whether:

- Services are furnished in accordance with the MCP;
- The member has access to services identified in MCP;
- The member has exercised choice of provider;
- Services meet member's outcomes and needs;
- The member has effective back-up plans;
- The member's health and welfare are assured; and
- The member has access to non-waiver services in MCP, including health services and natural supports.

The CMR results are included in the entire Annual Quality Review (AQR) report and submitted to both the SMA and PIHPs by the EQRO. The PIHP is required to submit for SMA approval a remediation plan for any CMR performance measure that scores lower than 90%. The SMA will monitor the PIHP's progress of the remediation plan until complete. If the EQRO identifies an instance where the PIHP is not addressing a member's health and welfare needs, the EQRO makes an immediate referral to the SMA. Upon receiving such a referral, the SMA will contact the PHIP to request an individual remediation plan for the identified member.

In addition, the SMA assigns a designated Member Care Quality Specialist (MCQS) for each PIHP. The MCQS continually monitors their assigned PIHP(s) to help ensure member health and welfare and identify any PIHP issues that need remediation. The MCQS addresses individual member issues promptly with the PHIP when a need for such remediation is identified. If an MCQS identifies a need for systemic remediation within a PIHP, the PHIP is required to develop a remediation plan and submit it to the SMA for approval. The SMA monitors the PHIPs remediation plan until such time as it is successfully completed.

c. The frequency with which monitoring is performed is established by the SMA-PIHP contract. The contract indicates that the IDT must establish a schedule of in-person contacts based on the complexity of the member's needs and the member's potential vulnerability/risk. This may include an increase in in-person visits and contact with the member and legal decision maker to ensure health and welfare.

The SMA-PIHP contract requires, at a minimum:
- Monthly contact, either in-person or by telephone, by an IDT staff member with the member;
- In-person contact every three months by the social services coordinator and registered nurse, either together or separately, with the member; and
- In-person contact at the member's residence every twelve months by the social services coordinator and registered nurse, either together or separately, with the member as part of the annual comprehensive assessment.

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 member-centered plan monitoring and implementation may not provide other direct waiver services to the member, with the exception of Indian Health Care Providers (IHCPs) providing services to Indian members and providers contracted by the PIHP and approved by the SMA to provide culturally appropriate services. The SMA approves these exceptions only when the IHCP or culturally appropriate provider is the only willing and qualified entity in the geographic area able to provide culturally appropriate member-centered plan monitoring or services and the IHCP or provider administratively separates its care management functions from its service provider functions. For these exceptions, the following safeguards have been put in place:

The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist is responsible to inform the potential member and/or the potential member's legal decision maker about the available service and enrollment options. If the individual is an Indian, the ADRC or Tribal Aging and Disability Resource Specialist informs the potential member and/or the potential member's legal decision maker of 1) the option to choose between IHCP, if available, and the PIHP for care management services and 2) the option to choose to receive benefit package services from the IHCP, if available, or PIHP network providers.

If a PIHP contracts with a provider of culturally appropriate services and the member identifies with the culture of which the provider provides culturally appropriate services, the ADRC informs the potential member and the member's legal representative of 1) the option to choose between the culturally appropriate provider (if the selected PIHP has a care management contract with the provider) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either the culturally appropriate provider (if available) or other PIHP network providers.

IHCPs and providers of culturally appropriate services who also provide care management are required to educate members about not only the services provided by the IHCP or provider of culturally appropriate services but also the full range of waiver services available to the members. The IHCP is required to educate members about accessing services through the IHCP, assuming the IHCP has the capacity to provide, or a PIHP network provider. Additionally, the IHCP or culturally appropriate care management provider must provide the member with an opportunity to challenge the assertion that the provider is the only willing and qualified provider able to provide culturally appropriate care management to the member. If the member chooses to challenge this assertion, they are provided with information about how to file a grievance with the PIHP, using the PIHPs internal grievance and appeal system as described in Appendix F-2. If the member is dissatisfied with the PIHP's response to their grievance, they may request a DHS (SMA) grievance review, described in F-3. To document that this process has occurred, the IHCP or culturally appropriate provider is required to ask the member to sign an attestation which will be attached to the member centered plan (MCP) indicating that the provider has provided the member with this information every twelve (12) months as part of the annual comprehensive assessment. If the member refuses to sign the attestation, the IHCP or culturally appropriate provider will document that refusal in the MCP. The State's EQRO will, as part of its annual review, sample the MCPs of Indian members receiving care management from an IHCP and members receiving care management from other culturally appropriate providers to assure this process has occurred.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Member-centered 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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = Confidence Interval = 95% with +/- 5% margin of error
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
Member-centered 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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% with +/- 5% margin of error
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

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 reviewed by the EQRO 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:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = 95% with +/- 5% margin of error
☒ **Other** Specify: EQRO	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

For a member-centered plan to be comprehensive, all needs that are identified in the health and care management assessment by the PIHP as needing some level of assistance (not independent) must have a related intervention or identification of how the need is being met. For members who choose not to receive an outside intervention for an assessed need, this could be identified in the assessment or the plan. DME and DMS utilized by the member is expected to be on the MCP.
Additional components of comprehensive assessment include:

- The frequency of IDT face-to-face visits; and
- LTC outcomes are identified in the record

In December 2023, CMS found the SMA deficient in its compliance with sub-assurances a. and e. The SMA is currently working with the EQRO to ensure future demonstrable, improved compliance with these sub-assurances.

Sub-assurance a:
The SMA and the EQRO have determined that the EQRO is currently using a protocol to evaluate compliance with the performance measure for this sub-assurance that is more restrictive than those used successfully by peer states. The SMA and EQRO are working together to evaluate this issue and determine next steps, such as aligning the evaluation protocols for this performance measure more closely with methods used by peer states, in order to demonstrate future compliance with sub-assurance a.

Sub-assurance e:
The SMA has identified an inconsistency between the frequency with which the SMA evaluates member assessments for compliance with this sub-assurance (currently every 6 months) and that used to measure compliance with this sub-assurance for waiver reporting purposes (annually). This difference has, at times, inadvertently resulted in the wrong data field being used to evaluate compliance with the performance measure for this sub-assurance. The SMA is working internally to implement new protocols that will help to ensure that data gathered on an annual basis is consistently used to evaluate compliance with the performance measure for this sub-assurance as required under the Waiver.

b. Methods for Remediation/Fixing Individual Problems

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

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 external quality review organization (EQRO) related to individual member concerns; review of Family Care Ombudsman program reports, grievances and appeals, and member incident reports; assessment of requests for use of isolation, seclusion, and restrictive measures; discovery of problems or issues when providing policy clarification to PIHPs; complaints to the SMA; and from other sources. The team also regularly interacts with the PIHP and may identify concerns through these interactions. The oversight team directs remediation of individual member concerns as well as isolated operational concerns, on an as-needed basis. Teams may also use information gathered through direct interaction with the PIHP, or other sources, to identify, document, 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 that are identified through routine discovery activities, and can respond quickly to other issues as they are identified. The SMA has also developed policies and procedures for the EQRO and oversight teams to report and document issues that require the SMA's attention and the resolution or remediation of such issues.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a. Members can self-direct all waiver services except care management and community residential care services. PIHPs and Indian Health Care Providers (IHCPs) present self-directed supports (SDS) as a choice to all members as required by Wis. Admin Code § DHS 10.44(6). Interdisciplinary teams work with members during the comprehensive assessment and member-centered planning process to explain the SDS option so that members may choose which services and supports they want to self-direct.

b. Members may exercise employer authority, budget authority or both. Members may choose to employ a support broker or financial management services to assist in exercising SDS options.

c. IDT staff identify the support an individual member may need to exercise the SDS option and provide training opportunities or other assistance as needed.

Members may choose to employ a financial management service provider or support broker to assist in exercising SDS options. Fiscal intermediaries or fiscal agents are available to members to pay member-selected providers using funds that the PIHP or IHCP authorized for the member's use. Fiscal agents withhold 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 directs the worker. The cost of co-employment services is provided and reported as part of the individual service for which the co-employment agency hired the provider, 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 entitled consumer-directed services – support broker.

d. Each PIHP must have a SMA-approved SDS plan, which the IHCP must also use. An approved SDS plan will ensure that SDS is implemented through processes characterized by the following:

- Support for the member and those who are 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;
- Planning 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;
- Emphasis on identifying and strengthening networks of informal supports and on making use of community resources to the extent possible; and
- Identification of how members will be supported in service planning and 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 member’s needs and preferences.

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 cannot be member directed, but other waiver services received may be directed by the member.

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 self-direction services (SDS) opportunities (e.g. the benefits of SDS, member responsibilities, and potential liabilities) is provided
- in the PIHP member handbooks.
- as part of the comprehensive assessment and member–centered care planning process.

The IDT staff explain that SDS is voluntary and the member's choice, the choices available within SDS, the supports and resources available to assist members with SDS, and an overview of the conditions in which the PIHP or IHCP may limit or terminate SDS for a member. The IDT addresses which specific services a member chooses to self-direct, what level of participation a member chooses to exercise, whether the member will need assistance or support to participate in SDS, resources (including natural supports) available to assist members to participate in SDS, whether any potential health or safety issues exist related to SDS and how to address them, development of a budget and the extent to which the member has chosen to participate in the budgeting and payment, the manner in which payroll and benefits will be administered, and the need for training legal decision makers or self-advocacy training. The IDT ensures mechanisms are in place to ensure the member's expenditures are consistent with their budget, identifies any changes needed to the member's budget or related supports, exercises oversight over potential health and safety issues, exercises oversight regarding potential conflicts of interest, and validates the completion of appropriate provider training.

Annually, members must affirm their IDT explained the SDS option to them and affirmatively accept or deny the SDS option by choosing the appropriate option on their member-centered plan.

b. PIHPs or IHCPs are responsible for providing the information described above.

c. PIHPs and IHCPs must distribute member handbooks to members within ten (10) business days of their initial enrollment notification, within five (5) business days of a member's request, and an addendum or other written notification at least thirty (30) calendar days in advance of the effective date when significant changes occur. Additional information is provided by the IDT to members on an ongoing basis throughout the member-centered planning process.

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
Prevocational Services	☐	☒
Communication Assistance	☐	☒
Vocational Futures Planning and Support	☐	☒
Consumer Directed Supports (Self-Directed Supports) Broker	☒	☒
Specialized Medical Equipment and Supplies	☐	☒
Transportation (Specialized Transportation) - Other Transportation	☒	☒
Self-Directed Personal Care	☒	☒
Consumer Education and Training	☐	☒
Transportation (Specialized Transportation) - Community Transportation	☒	☒
Health and Wellness	☐	☒
Supported Employment - Individual Employment Support	☒	☒
Supported Employment - Small Group Employment Support	☐	☒
Respite	☒	☒
Daily Living Skills Training	☒	☒
Relocation services	☐	☒
Consultative Clinical and Therapeutic Services for Caregivers	☐	☒
Day Habilitation Services	☐	☒
Environmental Accessibility Adaptations (Home Modifications)	☐	☒
Assistive Technology	☐	☒
Housing Counseling	☐	☒
Adult Day Care Services	☐	☒
Home Delivered Meals	☐	☒
Financial Management Services	☐	☒
Personal Emergency Response Systems (PERS)	☐	☒
Skilled Nursing Services RN/LPN	☒	☒
CIE Exploration	☐	☒
Training Services for Unpaid Caregivers	☐	☒
Counseling and Therapeutic Resources	☐	☒
Remote Monitoring and Support	☐	☒
Vehicle Modifications	☐	☒
Supportive Home Care	☒	☒

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 PIHP and completing a Provider Agreement with the SMA.

There may be more than one FMS providing services to members under contract with any PIHP. 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 PIHPs according to the terms specified in the contract between the PIHP 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:

☒ **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:

☒ **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.

To monitor and assess the performance for the FMS entities, including ensuring the integrity of the financial transactions,

1. The FMS will issue monthly statements to the member, PIHP, or IHCP, and support broker, indicating all disbursements made on the member's behalf and balances remaining in the member's account. The member, PIHP or IHCP, and support broker review the monthly payments for accuracy. Any inconsistencies are reported to the FMS to address.

2. The PIHP or IHCP will ensure that all paid claims, including FMS, are for authorized services provided to eligible and enrolled members, from contracted providers, and at the contracted rate. The PHIP or IHCP have an ongoing claim audit function to identify fraudulent claims, payments to Medicaid suspended providers, or claims processing errors.

3. The SMA ensures claims are paid correctly by requiring PIHP to submit the claims testing audit results to SMA with their annual independent financial audit. Claims testing is performed by an independent certified public accounting firm and specifically includes a statistically significant sample of member self-directed support claims paid by an FMS.

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 (IDT) is responsible to assess the needs of each member who elects self-direction and to provide support to the member. Examples of support provided include training, sharing information, and assistance in locating resources. The IDT has access to the SMA's best practice guide, Self-Directed Supports in Family Care, Family Care Partnership, and PACE: A Best Practice Manual of Interdisciplinary Team Staff, which has 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
Prevocational Services	☐
Communication Assistance	☐
Vocational Futures Planning and Support	☐
Consumer Directed Supports (Self-Directed Supports) Broker	☒
Specialized Medical	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Equipment and Supplies	
Transportation (Specialized Transportation) - Other Transportation	☐
Self-Directed Personal Care	☐
Consumer Education and Training	☐
Transportation (Specialized Transportation) - Community Transportation	☐
Health and Wellness	☐
Supported Employment - Individual Employment Support	☐
Supported Employment - Small Group Employment Support	☐
Respite	☐
Daily Living Skills Training	☐
Relocation services	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Day Habilitation Services	☐
Environmental Accessibility Adaptations (Home Modifications)	☐
Assistive Technology	☐
Housing Counseling	☐
Adult Day Care Services	☐
Care Management	☒
Home Delivered Meals	☐
Residential Services (1-2 Bed AFH)	☐
Financial Management Services	☒
Personal Emergency Response Systems (PERS)	☐
Residential Services (Other)	☐
Skilled Nursing Services RN/LPN	☐
CIE Exploration	☐
Training Services for Unpaid Caregivers	☐
Counseling and Therapeutic Resources	☐
Remote Monitoring and Support	☐
Vehicle Modifications	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supportive Home Care	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The ombudsman programs offer independent advocacy to members or potential members. The ombudsman program for individuals under age 60 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.

Advocacy services provided by these ombudsman agencies vary and are tailored to members' individual needs and preferences. The scope of assistance ranges from a single information and assistance discussion with a member to individualized, step-by-step advocacy through the appeals process including representation at fair hearings and judicial proceedings.

PIHPs are required to inform members of the existence of these agencies and how to contact them via the member handbook that is provided to members upon enrollment. Template notices also include contact information for the ombudsman agencies and describe the services they provide. PIHPs are required to assist members to obtain access to ombudsman services upon member request.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A member transitioning from self-direction to an alternate service delivery method is not terminating services or disenrolling from the program; the member is only changing how the member obtains their services.

When the member decides that they no longer want to self-direct services, the member notifies the interdisciplinary team (IDT). This notification can occur at any time, or the member may communicate the decision during a member-centered plan (MCP) review. As part of the MCP review, the IDT is required to ask the member whether the member prefers to continue self-directing services. Based on the member's MCP, the IDT is aware of the types and amounts of services that the member receives. The IDT meets with the member to select network providers to replace the self-directed providers. The IDT ensures that there will be 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 or Indian Health Care Provider (IHCP) transmits this information to the network providers and sends written notice along with a revised MCP to the member. Further, the PIHP or IHCP informs the financial management services (FMS) provider that the member will no longer receive fiscal agent services. The member is advised to inform the IDT of any problems during the transition. Reported gaps in essential services will trigger PIHP or IHCP contingency plans for the use of backup providers.

The member may use any of the external member resources available for advocacy, including, but not limited to, the Ombudsman Program, the external quality review organization, and the benefit specialist programs available through Aging and Disability Resource Centers. See Appendix A:3.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The PIHP or IHCP is authorized to involuntarily terminate member self 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 or IHCP to adequately monitor the situation. This action is appealable. If member direction is involuntarily terminated for a member, the member's IDT resumes full responsibility for authorization of services and for assuring continuity of services and, as appropriate, providers.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		12257
Year 2		12587
Year 3		12917
Year 4		13247

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 5		13577

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.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Method does not vary from Appendix C-2-a.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

- ☒ **Determine staff wages and benefits subject to state limits**
- ☒ **Schedule staff**
- ☒ **Orient and instruct staff in duties**
- ☒ **Supervise staff**
- ☒ **Evaluate staff performance**
- ☒ **Verify time worked by staff and approve time sheets**
- ☒ **Discharge staff (common law employer)**
- ☒ **Discharge staff from providing services (co-employer)**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☒ **Reallocate funds among services included in the budget**
- ☒ **Determine the amount paid for services within the state's established limits**
- ☒ **Substitute service providers**
- ☒ **Schedule the provision of services**
- ☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☒ **Identify service providers and refer for provider enrollment**
- ☒ **Authorize payment for waiver goods and services**
- ☒ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

To determine budgets for self-directed services (SDS), PIHPs and the Indian Health Care Providers (IHCP) estimate what it would cost the PIHP to fund the member-centered plan (MCP), or the part of the MCP to be self-directed, in the absence of self-direction. The estimated cost is the basis for the self-directed budget. Usually, the estimate involves determining what the same services and supports, in the authorized amounts, would cost if the PIHP purchased them for the member or for a similarly situated member who does not self-direct. In all circumstances, the member selects the needs and outcomes for which the member wants to self-direct supports. Within this overall approach, PIHPs have some flexibility in the methods that they use. IHCPs providing case management to Indian members use the PIHP's SMA-approved policy and procedure for setting budgets.

These variations can be categorized as follows:
• Establishing an Overall Rate
This approach starts with an established rate that is determined by the PIHP for the cost of the authorized goods or services the member chooses 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 authorized amount. Using the established rate, the PIHP creates the member's overall budget. Within that budget, the member has some flexibility to determine wages.

• Zero-based Budget
In this variation, the process starts with the amount of services needed and the cost of goods or services to purchase through a Fiscal Management Services provider (e.g., special medical equipment, assistive technology, or home modification). For direct care services, the IDT then works with the member to establish possible employee wage levels for the amount of services authorized. The PIHP adds additional costs to the wage baseline for fringe benefit costs. The budget is set for a specific time period, such as one month, six months, or one year.

Members experience flexibility in their care plan when their needs or outcomes change or when they choose to self-direct additional allowable services using the member-centered planning process. The Resource Allocation Decision (RAD) is the consistent tool used by IDTs to authorize services that are within the Family Care benefit package. The RAD process always includes the member and is a collaborative process facilitated by the IDT staff, clarifies the identified long-term care need and outcome, assists in determining the most effective and cost-effective way to support the outcome, and includes specific documentation by the MCO.

The budget methodology is publicly available in the Self-Directed Supports Best Practice Manual, and the IDT staff discuss with the member and document in the member plan.

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 their member-centered 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 (IDT) must oversee the member's implementation of the member-centered plan (MCP) and use of the member's self-directed supports (SDS) budget. PIHPs' contracts for fiscal management agent services (FMS) require regular budget authority utilization reports provided to the IDT. If there is significant under-utilization or over-utilization of services and budget authority, the IDT reviews the MCP, budget, and member's circumstances. The SMA does not require the PIHP to follow any specific protocol for these reviews.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Before requesting a state fair hearing, the member must first exhaust their appeal rights at the PIHP level (Please see the most recently approved 1915(b) waiver (WI.0007.R07.01 - https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83636)). If the PIHP denies their initial appeal, or the PIHP fails to issue a decision within the timeframes established in the SMA-PIHP contract and required by federal regulation and/or Wisconsin administrative code provisions, the member may request a state fair hearing on the matter.

Members are informed of the right to a fair hearing prior to enrollment, at the time of enrollment, and while enrolled. Prior to enrollment, the Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialists inform potential members of the right to a fair hearing prior to enrollment. Also, the regional income maintenance (IM) consortiums that determine eligibility for Medicaid and all managed long-term care programs and process enrollments send enrollees standardized eligibility notification forms that include information about the right to a fair hearing.

Once a member is enrolled, the PIHP interdisciplinary team (IDT) gives the member handbook to the member. The member handbook contains information about the right to a fair hearing and how to request one, including information about the member's right to have services continued while their appeal or fair hearing is pending.

While enrolled, a member will receive information about the right to a fair hearing and how to request one any time when the PIHP issues an adverse benefit determination. An adverse benefit determination includes the following:

- The denial of functional eligibility
- The denial or limited authorization of a requested service that falls within the benefit package
- The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount of time or duration and that amount or duration has been completed
- The denial, in whole or in part, of payment for a service that falls within the benefit package
- The denial of a member's request to dispute a financial liability
- The denial of a member's request to obtain services outside the MCO's network when the member is a resident of a rural area with only one managed care entity
- The failure to provide services and support items included in the member's care plan in a timely manner, as defined by the SMA
- The development of a member-centered plan that is unacceptable to the member because (a) the plan is contrary to the member's wishes insofar as it requires the member to live in a place that is unacceptable to the member; (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 involuntary disenrollment of the member from the PIHP at the PIHP's request
- The failure of the MCO to act within the timeframes for resolution of grievances or appeals established in the SMA-PIHP contract

The member also receives written notice of the right to fair hearing and how to request one from the PIHP when a member's level of care changes from the nursing home level of care to non-nursing home level of care, and from the SMA when the SMA issues a notice of disenrollment.

To issue an adverse benefit determination to the member, the PIHP must mail or hand-deliver written notice to the member. The PIHP must use the SMA template letters for notice of adverse benefit determination.

Adverse benefit determinations, notices of a change in level of care, and notices of disenrollment are hand-delivered or mailed to members in accordance with timelines required for each type of appeal under the Code of Federal Regulations and/or Wisconsin administrative code provisions.

Copies of adverse benefit determinations, notice of change in level of care, and notice of disenrollment are maintained in the member-centered plan (MCP). The member handbook/evidence of coverage and the above referenced notices describe the member's right to continuation of services pending the outcome of an appeal at the PIHP and State fair hearing levels.

The SMA requires PIHPs to assist members in filing a request for fair hearing. Both the member's IDT and the PIHP's member rights specialist (a position required by the SMA) are available to assist the member. In addition, the ombudsman programs the SMA contracts with or has an MOU for are available to assist members in filing a request for fair hearing and to assist the member at the hearing.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf).

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The SMA has checked "Yes" to this item because PIHPs operate a grievance and appeal system as required by 42 CFR §438 subpart H. Members are required to grieve or appeal to the PIHP before using the DHS grievance review process (described in F-3) or requesting a State Fair Hearing (described in F-1), respectively.

The PIHP internal appeal process applies to disputes related to an adverse benefit determination as defined in F-1 of the waiver application, with the exception of loss of financial eligibility or cost share (Members can directly request State Fair Hearing for these adverse benefit determinations). The PIHP internal grievance process applies to expressions of dissatisfaction about any matter other than an adverse benefit determination.

For appeals (disputes related to an adverse benefit determination), members are required to request an appeal orally or in writing within sixty (60) days of the date on the notice of adverse benefit determination sent to the member. Once the member has requested an appeal, the PIHP must acknowledge the appeal within five (5) business days. Members may request an expedited resolution if the standard resolution timeframe could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. In the case of an expedited appeal, the PIHP must make reasonable efforts to give the member prompt oral notice of approval or denial of the request for expedited resolution and a written notice within two (2) calendar days. PIHPs are required to attempt to resolve the appeal through negotiation, mediation, or internal review, but if the appeal cannot be resolved informally, the appeal must be reviewed by the PIHP's grievance and appeal committee. The member has a right to appear in person before the grievance and appeal committee. The committee is required to make a decision on the appeal no later than thirty (30) days after the receipt of the appeal or within seventy-two (72) hours for an expedited appeal. These timeframes may be extended up by up to fourteen (14) days after the appeal request is received (total of 44 days for a standard appeal, 17 days for an expedited appeal) if the member requests the extension or the PIHP demonstrates that there is need for additional information and the delay is in the member's interest. If the grievance and appeal committee's decision is adverse to the member, the written notice of appeal decision includes information and instructions for requesting a state fair hearing.

Members may file a grievance (expression of dissatisfaction other than those related to an adverse benefit determination) orally or in writing at any time. The PIHP is required to acknowledge the receipt of the grievance in writing within five (5) business days of receiving the grievance. The PIHP is required to attempt to resolve the grievance informally through mediation and negotiation whenever possible, but if the grievance cannot be resolved informally, the grievance must be reviewed by the PIHP's grievance and appeal committee. Members have a right to appear in person in front of the PIHP's grievance and appeal committee. The committee is required to mail or deliver a written decision on the grievance as expeditiously as the situation requires, but no later than ninety (90) calendar days (thirty (30) days for FIDE SNP members) after the date of receipt of the grievance. This timeframe may be extended by up to fourteen (14) days (up to a total of 104 days or 44 for FIDE SNP members) if the member requests the extension or the PIHP demonstrates that more information is needed and the extension is in the member's interest. FIDE SNP members may request an expedited grievance review, which requires the PIHP to mail or hand deliver a decision within twenty-four (24) hours if the grievance involves a decision to invoke an extension relating to an adverse benefit determination or appeal, or refusal to grant the member's request for an expedited adverse benefit determination or appeal. The written grievance decision must include information about how the member can request DHS grievance review if the member is dissatisfied with the grievance resolution. Grievance decisions sent to FIDE SNP members must include a description of the member's right to file a written complaint with the Quality Improvement Organization (QIO).

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf).

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 SMA operates a grievance resolution process called Department of Health Services (DHS) review. The SMA contracts with the external quality review organization (EQRO) to administer the process. 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 for consistency.

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. A grievance is an expression of a member's dissatisfaction about any matter other than an adverse benefit determination. Adverse benefit determinations are defined in F-1 and the SMA-PIHP contract. Common examples of issues that can be grieved include changes in providers, concerns about the quality of care or services, and personal care workers arriving late.

b. Members must first file a grievance with their PIHP (see the concurrent 1915(b) waiver (WI.0007.R07.01 - https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/83636)). The PIHP must issue a written decision on the grievance within 90 calendar days of the date of receipt. For FIDE SNP members, a written grievance decision must be issued within 30 calendar days of the date of receipt. If the PIHP decision does not resolve the grievance to the member's satisfaction, the member can then request an SMA review to resolve the grievance. A request for SMA review must be made within 45 calendar days of the date of receipt of the PIHP's written grievance decision. The SMA contracts with the EQRO to perform the review. The EQRO must complete its review of the grievance within 30 calendar days of receipt of the member's request for SMA review. The EQRO must mail or hand deliver to the member and the PIHP its written binding decision within seven calendar days of the completion of the review.

c. The EQRO reviews, investigates, and analyzes the facts related to the member's grievance and the PIHP's decision in response to the grievance. This includes obtaining and reviewing all relevant materials (documents, records, files) from the PIHP and the member. The EQRO reviews the matter with the member and the PIHP and facilitates discussion to try to informally resolve the grievance. If the EQRO is unable to informally resolve the grievance to the satisfaction of both parties, it will issue a binding written decision to resolve the grievance. The SMA review is the final level of the grievance process. This grievance process is separate from and does not have any impact on the state fair hearing process when the member has a right to a fair hearing. DHS grievance review is not a pre-requisite or substitute for a State Fair Hearing.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf).

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 include the following:

i. Abuse, including physical abuse, sexual abuse, emotional abuse, treatment without consent, and unreasonable confinement or restraint;
ii. Exploitation ;
iii. Neglect;
iv. Self-Neglect;
v. Financial exploitation;
vi. Medication error;
vii. Missing person;
viii. Fall;
ix. Emergency use or unapproved use of restrictive measures;
x. Death due to any of the member incidents (i. through ix.) in this list, as well as death due to accident, suicide, psychotropic medication(s), or unexplained, unusual, or suspicious circumstances; and
xi. Any other type of accident, injury, illness, death, or unplanned law enforcement involvement that is unexplained, unusual, or around which suspicious circumstances exist and resulted in a moderate or severe illness/injury.

Incidents must be reported by contracted providers or by PIHP staff immediately, but not more than three (3) business days after PIHP staff discover or learn of the incident to the PIHP's designated member care quality specialist through the SMA's adult incident reporting system (AIRS). The SMA's AIRS is a critical incident system that enables electronic collection, tracking (status and resolution of investigations) and trending of data on critical incidents.

The PIHP and contracted providers also must report the following incidents to local law enforcement authorities:
- incidents where the member is a victim of a potential violation of the law; and
- incidents where the member is suspected of violating the law, to the extent required by law.

The requirements described above also apply to Indian Health Care Providers (IHCP) performing case management for Indian members. Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf).

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, the Interdisciplinary Team (IDT) must inform the member about abuse, neglect, and exploitation protections at the initial assessment upon member enrollment or at the initial comprehensive assessment and at each annual comprehensive assessment thereafter. The IDT staff must also assess the member's understanding of abuse, neglect, and exploitation. Completion of these tasks must be documented in the member record. The IDT must also inform members and/or the members' legal decision makers, and involved family and other unpaid caregivers, as appropriate, about how to report member abuse, neglect, or exploitation.

This information is provided to members at the time of the initial face-to-face assessment, which takes place within 10 days of enrollment, or at the time of the initial comprehensive assessment, which takes place within 30 days of enrollment, and, again, at each annual reassessment. The requirements described for PIHP IDTs also apply to Indian Health Care Providers (IHCP) performing case management for Indian members.

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.

After discovering an incident, PIHPs and contracted providers must immediately take effective steps to prevent further harm to or by the affected member(s). Within three (3) business days of learning of the incident, the PIHP must notify the member or member's legal decision maker of a member incident, unless the member or member's legal decision maker reported the incident to the PIHP or the legal decision maker is a subject of the investigation. PIHPs must also report critical incidents to the PIHP's designated SMA member care quality specialist through the SMA's adult incident reporting system (AIRS).

PIHPs must also require their providers to report critical incidents to the PIHP. Each PIHP is responsible for evaluating reports of critical incidents. PIHP managers evaluate the reports. Also, 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 and is weekly, biweekly, monthly, or quarterly.

PIHP managers initiate incident investigations. The PIHP designates staff to conduct incident investigations who are not directly responsible for authorizing or providing the member's care, have sufficient authority to obtain information from those involved, and have clinical expertise to evaluate the adequacy of the care provided relevant to the member incident. The PIHP also must designate staff to provide oversight of PIHP incident investigation staff or the provider.

The incident investigation staff must investigate member incidents in a manner consistent with the relative scope, severity, and implications of the incident; and determine and document, at a minimum, the following information:
1. 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;
2. The cause(s) of the incident;
3. The outcome of the incident;
4. Whether reasonable actions by the provider or others with responsibility for the health, safety and welfare of the member would have prevented the incident; and
5. Interventions and/or preventative strategies, like changes in the MCO's or provider's policies or practices to help prevent occurrence of similar incidents in the future.

The PIHP must complete an investigation of each reported member incident within thirty (30) calendar days of the date that the PIHP learned about or discovered the incident. If the PIHP cannot obtain information or findings necessary for completion of the investigation within 30 days for reasons beyond the PIHP's control, the PIHP must the complete the investigation as soon as possible.

Within five (5) business days of completion of the investigation, the PIHP must notify the member or member's legal decision maker (and/or the member's family, as appropriate) of the results or outcomes of the investigation. The PIHP must document this notice in the member's record.
Indian Health Care Providers (IHCP) performing case management are required to complete incident reports and send them to the PIHP who proceeds with the above process.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The SMA is responsible for overseeing the integrity of the incident management system that is operated by the PIHPs. The PIHPs must report all specified incident types immediately, but not more than three (3) business days after discovering or learning of an incident in the SMA's online Adult Incident Reporting System (AIRS). The PIHP has thirty (30) days to complete their investigation of each incident.

Even though all incidents are entered into the AIRS immediately by the PIHP, the PIHP may not have all necessary information for a full investigation to report an outcome of the incident at the time of the initial submission. As the PIHP continues to investigate a reported incident, the PIHP adds necessary information to the incident report in AIRS. The SMA Member Care Quality Specialist (MCQS) assigned to the PIHP has access to all information that the PIHP enters in the AIRS in real time.

The AIRS provides logic in determining which incidents require more urgent review and follow up by the SMA. If an incident is reported as a "level one" incident, the MCQS is required to review the submitted documentation by the PIHP immediately and can ask questions or make comments to the PIHP in real time, during the PIHP's investigation process. Level one incidents also require the PIHP to submit the member's chart so the MCQS can review as necessary. If an incident is entered into the AIRS and the logic determines the incident is a "level two", these incidents are reviewed by the MCQS on a weekly basis, after the PIHP determines the incident as closed. If the MCQS determines that more information is needed on a level two incident, the MCQS can request that information, including the chart, of the PIHP within the AIRS.

The AIRS can run multiple reports at any time. The SMA may schedule reoccurring reports to review on a regular basis (daily, weekly, monthly, quarterly, annually) or run a unique report that is needed at any time. These reports will allow the SMA to follow up on individual issues with one PIHP or systematic issues that affect all PIHPs. Since incident reporting is in real time by the PIHP to the SMA, the SMA can run reports and obtain current data, making SMA oversight of incident reporting more valuable.

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, the information provided in the Restrictive Measures Guidelines and Standards applies to all restrictive measures, including all types of restraints.

The Restrictive Measures Guidelines and Standards are available at:
https://www.dhs.wisconsin.gov/publications/p02572.pdf

Any unauthorized use of a restrictive measure or use of a restrictive measure that is not within the scope of the state Restrictive Measures Guidelines and Standards is prohibited under any circumstance. All prohibited practices are outlined within the SMA's Restrictive Measures Guidelines and Standards.

Unauthorized use of a restrictive measure must be reported to the PIHP as an incident by any person who observes or any person to whom a member reports such unauthorized use. Members can also self-report to the PIHP, and PIHP staff assess whether any unauthorized use of restrictive interventions may be occurring during in-person meetings with the member. The PIHP must investigate and report unauthorized use of a restrictive measure to the SMA through the Adult Incident Reporting System (AIRS).

Actions taken with provider deficiencies may include, but are not limited to, mandated training or re-training and additional monitoring by the member's interdisciplinary team (IDT) and/or the PIHP's Provider Network (IHCP's if applicable) staff. In egregious situations, provider suspension may occur. Further, the Restrictive Measures Guidelines and Standards specify that if the same or similar emergency use occurs more than twice in a six-month period, it is no longer considered an emergency and the restrictive measures planning process for an approved restrictive measure must be initiated.

Prior to using a restrictive measure with a member, providers must submit a restrictive measure request to the PIHP. Each restrictive measure request must include a list of any support strategies, interventions, and evidence-based methods or approaches attempted prior to the request. The PIHP's restrictive measures committee reviews and approves each request prior to submission for SMA review and approval.

Review and approval of each request is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. Restrictive measures may be approved for less than but no more than one year; a renewal request, review for use and effectiveness, and approval is required prior to expiration of the previous approval.

Each restrictive measure on a member's behavior support plan, including restraints, are reviewed and discussed during the member-centered assessment and planning process, which is directed by the member or the member's legal decision-maker. Each restrictive measure must be approved by the interdisciplinary team, including a medical professional's determination that there are no medical contraindications to the use of each restrictive measure. The interdisciplinary team must also identify the specific need and justification for each restrictive measure, which other less restrictive options were tried first, how each restrictive measure will be monitored, how each restrictive measure is only used when imminent risk of harm to self or others is evident, and the reduction and elimination plan for each restrictive measure. The member or legal decision-maker, PIHP interdisciplinary team, and provider must consent in writing to each restrictive measure annually during the planning process.

Documentation requirements related to restrictive measure use are specified in the Restrictive Measures Guidelines and Standards. Each restrictive measures application must specify the monitoring and documentation plan as well as the reduction/elimination plan.

Providers must report the use of each approved restrictive measure to the PIHP as specified in the Restrictive Measures Guidelines and Standards publication.

Quarterly, each PIHP and IHCP reports restrictive measures member utilization data to the SMA.

All individuals involved in the administration of restrictive measures must be trained by a restrictive measures training expert and/or designated competent PIHP/IHCP staff annually and when there are changes to members' needed behavior supports. Providers are required to keep all training records in the personnel files for each staff person and the records must be available to PIHPs or the SMA upon request. Assurance of

training of all individuals involved in the administration of restrictive measures is the responsibility of the PIHP/IHCP within their contracts/care coordination agreement with respective providers in accordance with SMA-PIHP Contract or SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf) as applicable.

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:

Quarterly, the SMA collects data on approved restrictive measures from each PIHP in a standardized file format via the Restrictive Measures database. This data is loaded into a data warehouse environment. The SMA extracts aggregated data from the warehouse environment for analysis, tracking, and trending to identify potential patterns and outcomes for monitoring and possible quality improvement efforts.

Additionally, when a PIHP requests renewal of a restrictive measures approval, the SMA reviews the data utilization summary from the prior approval period to monitor trends and verify the use and effectiveness of approved restrictive measures. The SMA's Restrictive Measures Lead may determine that more information is necessary before the SMA can approve the renewal request. All follow-up by the SMA Restrictive Measures Lead is documented.

Use of approved restrictive measures is monitored and accounted for by each PIHP’s restrictive measures lead. Thus, whether restrictive measures have been approved can be readily assessed. In the context of member-centered care, PIHP IDT oversight includes ongoing risk assessment and harm reduction management. If there are any concerns, the IDT will increase monitoring of the member or situation, which can result in daily member contact.

The SMA is also responsible for reviewing each PIHP’s reports of incidents of emergency or unapproved use of restrictive measures submitted in the Adult Incident Reporting System (AIRS). The SMA may determine that follow-up is necessary and review the member’s report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data as provided in AIRS or individual member record reviews, depending on the trends or concerns identified. All follow-up by the SMA is documented.

Potential patterns concerning the unauthorized or emergency use of restrictive measures associated with certain providers are obtainable via analysis of the AIRS data. Unauthorized use of any restrictive measure is captured as a member incident within AIRS.

During the annual external quality organization (EQRO) review process, the individual PIHP’s restrictive measures tracking tool is reviewed to ensure timeliness of initial approval and annual renewal. If EQRO discovery indicates out-of-compliance timelines for initial or annual renewal approval, remediation of the identified individual or systems issues takes place with follow-up from the SMA’s PIHP Oversight Team. It may or may not need a corrective action plan, but the SMA’s PIHP Oversight Team would follow-up in its 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, the information in the Restrictive Measures Guidelines and Standards applies to all restrictive measures, including all types of restrictive interventions.

Any unauthorized use of a restrictive measure or use of a restrictive measure that is not within the scope of the SMA's Restrictive Measures Guidelines and Standards is prohibited under any circumstance. All prohibited practices are outlined within the SMA's Restrictive Measures Guidelines and Standards.

Unauthorized use of a restrictive measure must be reported to the PIHP as an incident by any person who observes or any person to whom a member reports such unauthorized use. Members can also self-report to the PIHP, and PIHP staff assess whether any unauthorized use of restrictive interventions may be occurring during in-person meetings with the member. The PIHP must investigate and report unauthorized use of a restrictive measure to the SMA through the Adult Incident Reporting System (AIRS).

Actions taken with provider deficiencies may include, but are not limited to, mandated training or re-training and additional monitoring by the member's interdisciplinary team (IDT) and/or the PIHP's Provider Network (IHCP's if applicable) staff. In egregious situations, provider suspension may occur. Further, the Restrictive Measures Guidelines and Standards specify that if the same or similar emergency use occurs more than twice in a six-month period, it is no longer considered an emergency and the restrictive measures planning process for an approved restrictive measure must be initiated.

Prior to using a restrictive measure with a member, providers must submit a restrictive measure request to the PIHP. Each restrictive measure request must include a list of support strategies, interventions, or evidence-based methods or approaches attempted prior to the request. The PIHP's restrictive measures committee reviews and approves the restrictive measures request prior to submission for SMA review and approval. Review and approval of each request is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. A restrictive measure may be approved for less than but no more than one year; a renewal request and review and approval is required prior to the expiration of the previous approval.

Each restrictive measure on a member's behavior support plan, including restrictive interventions, are reviewed and discussed during the member-centered assessment and planning process, which is directed by the member or the member's legal decision-maker. Each restrictive measure must be approved by the interdisciplinary team, including a medical professional's determination that there are no medical contraindications to the use of each restrictive measure. The interdisciplinary team must also identify the specific need and justification for each restrictive measure, which other less restrictive options were tried first, how each restrictive measure will be monitored, how each restrictive measure is only used when imminent risk of harm to self or others is evident, and the reduction and elimination plan for each restrictive measure. The member or legal decision-maker, PIHP interdisciplinary team, and provider must consent in writing to each restrictive measure annually during the planning process.

Documentation requirements related to restrictive measures are specified in the SMA's Restrictive Measures Guidelines and Standards. Each restrictive measure application must specify the monitoring and documentation plan.

Providers must report the use of each approved restrictive measure to the PIHP as required by the SMA's Restrictive Measures Guidelines and Standards. Quarterly, each PIHP and IHCP must report member data to the SMA.

All individuals involved in the administration of restrictive interventions must be trained by a restrictive measures training expert and/or designated competent PIHP/IHCP staff annually and when there are changes to members' needed behavior supports. Providers are required to keep all training records in the personnel files for each staff person and the records must be available to PIHPs or the SMA upon request. Assurance of training of all individuals involved in the administration of restrictive measures is the responsibility of the PIHP/IHCP within their contracts/care coordination agreement with respective providers in accordance with SMA-PIHP Contract or SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf) as applicable.

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:

Quarterly, the SMA collects data on approved restrictive measures from each PIHP in a standardized file format via the Restrictive Measures database. This data is loaded into a data warehouse environment. The SMA extracts aggregated data from the warehouse environment for analysis, tracking, and trending to identify potential patterns and outcomes for monitoring and possible quality improvement efforts.

Additionally, when a PIHP requests renewal of a restrictive measures approval, the SMA reviews the data utilization summary from the prior approval period to monitor trends and verify the use and effectiveness of approved restrictive measures. The SMA's Restrictive Measures Lead may determine that more information is necessary before the SMA can approve the renewal request. All follow-up by the SMA Restrictive Measures Lead is documented.

The SMA is also responsible for reviewing the PIHP's reports of incidents of emergency or unapproved use of restrictive measures submitted in the Adult Incident Reporting System (AIRS) on an ongoing basis. The SMA may determine that follow-up is necessary and review the member's report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data as provided in AIRS or individual member record reviews, depending on the trends or concerns identified. All follow-up by the SMA is documented.

Potential patterns concerning the unauthorized or emergency use of restrictive measures associated with certain providers are obtainable via analysis of the AIRS data. Unauthorized use of any restrictive measure is captured as a member incident within AIRS.

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, the information provided applies to all restrictive measures, including seclusion.

Any unauthorized use of seclusion, or use of seclusion that is not within the scope of the Restrictive Measures Guidelines and Standards, is prohibited under any circumstance.

Unauthorized use of seclusion must be reported to the PIHP as an incident by any person who observes such use or any person to whom a member reports such use. The PIHP must investigate and report any unauthorized use of seclusion to the SMA through the Adult Incident Reporting System (AIRS). Such a member incident is identified in the AIRS as abuse-unreasonable confinement and restraint.

Actions taken with provider deficiencies may include, but are not limited to, mandated training or re-training and additional monitoring by the member's interdisciplinary team (IDT) and/or the PIHP's Provider Network (IHCP's if applicable) staff. In egregious situations, provider suspension may occur.

Prior to using seclusion with a member, providers must submit a restrictive measures request to the PIHP. Each request for seclusion must include a list of support strategies, interventions, or evidence-based methods or approaches attempted prior to the request. The PIHP's restrictive measures committee reviews and approves each restrictive measures request prior to submission for SMA review and approval. Review and approval of each seclusion request is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. Seclusion may be approved for less than but no more than one year; a renewal request and review and approval is required prior to the expiration of the previous approval.

Documentation requirements related to seclusion are specified in the Restrictive Measures Guidelines and Standards. Each seclusion application must specify the monitoring and documentation plan.

Providers must report the use of each approved use of seclusion to the applicable PIHP as indicated in the Restrictive Measures Guidelines and Standards. Quarterly, each PIHP and IHCP reports member data to the SMA.

All individuals involved in the administration of seclusion must be trained by a restrictive measures training expert and/or designated competent PIHP/IHCP staff annually and when there are changes to members' needed behavior supports. Providers are required to keep all training records in the personnel files for each staff person and the records must be available to PIHPs or the SMA upon request. Assurance of training of all individuals involved in the administration of restrictive measures, including seclusion, is the responsibility of the PIHP/IHCP within their contracts/care coordination agreement with respective providers in accordance with SMA-PIHP Contract or SMA-IHCP-PIHP Agreement (https://www.dhs.wisconsin.gov/familycare/tribal-three-party-agreement.pdf) as applicable.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Quarterly, the SMA collects data on approved restrictive measures, including seclusion, from each PIHP in a standardized file format via the Restrictive Measures database. This data is loaded into a data warehouse environment. The SMA extracts aggregated data from the warehouse environment for analysis, tracking, and trending to identify potential patterns and outcomes for monitoring and possible quality improvement efforts.

Additionally, when a PIHP requests renewal of a restrictive measures approval, the SMA reviews the data utilization summary from the prior approval period to monitor trends and verify the use and effectiveness of approved restrictive measures. The SMA's Restrictive Measures Lead may determine that more information is necessary before the SMA can approve the renewal request. All follow-up by the SMA Restrictive Measures Lead is documented.

The SMA is also responsible for reviewing the PIHP's reports of incidents of unapproved use of restrictive measures, including seclusion, on an ongoing basis. The SMA may determine that follow-up is necessary and review the member's report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data as provided in AIRS or individual member record reviews, depending on the trends or concerns identified. All follow-up by the SMA is documented.

Potential patterns concerning the unauthorized use of restrictive measures, including seclusion, associated with certain providers are obtainable via analysis of the AIRS data. Unauthorized use of any restrictive measure is captured as a member incident within AIRS.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The PIHP interdisciplinary team (IDT) staff is responsible for monitoring members' medication regimens. The IDT assesses the medication regimens of all members, regardless of residential setting, as part of routine reassessments completed 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 nurse is responsible, in accordance with state and professional nursing standards, for clarifying and reinforcing with the member the correct medication regimen.

When a complex medication regimen and /or behavior modifying medication is/are prescribed for a member, the IDT nurse or other appropriately licensed medical professional ensures the member is reassessed, as needed, but at least every six months for the desired responses and possible side effects of the medication, and ensures 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 assessment.

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.

PIHP interdisciplinary team (IDT) nursing staff or other appropriately licensed medical professionals are responsible for monitoring the member's medication regimens as part of a regular reassessment, at least every six months or more often when there is a significant change in health or functional status. This activity is part of the member's nursing assessment. It includes needed education on medication administration, identifying 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.

The PIHP must review, document, and report any medication errors that come to its attention and meet the definition of "medication error" established by the SMA to the SMA in the Adult Incident Reporting System. The SMA reviews PIHP-reported incidents for trends and/or concerns on an ongoing basis. The SMA identifies insufficient responses to medication errors that require review and if necessary, remediation or a corrective action plan.

Follow-up methodology varies and is determined by the PIHP and SMA's findings. Methods may include but are not limited to the following:

- IDT consultation with medical providers
- IDT consultation with a residential provider who administers medication
- IDT increasing supports with medication management
- IDT completing medication management education with the member and/or a service provider
- IDT completing and reviewing risk agreements with the member
- PIHP reporting harmful practices to the SMA's Division of Quality Assurance, law enforcement, adult protective services, or any other appropriate authority

When medication errors are the result of nurse error, the Department of Safety and Professional Services (DSPS) completes the oversight and any sanctions. The DSPS communicates its oversight activities related to errors made by nurses to PIHPs by a letter to the nurse's employer(s) or posting of Board of Nursing disciplinary actions in the Wisconsin Board of Nursing newsletter.

When medication errors are the result of provider error, the PIHP's staff nurse provides education and methods to ensure medication compliance when a member has natural supports. The PIHP may also put a provider found responsible for a medication error on a corrective action plan and report the provider to the SMA's Division of Quality Assurance.
When directed by the SMA, the EQRO will evaluate PIHP performance related to medication management.

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).

Most waiver providers who administer medications are subject to state regulations. Adult Day Care Centers, Community Based Residential Facilities (CBRFs), licensed 3-4 Bed Adult Family Homes, and Residential Care Apartment Complexes (RCACs) all have facility-specific regulations for medication administration in the state's administrative code. 1-2 Bed Adult Family Homes are certified by the SMA and are required to comply with policies for medication administration described in the Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes.

Providers that are not regulated facilities must train their employees on both administering medication and observing member administration of medication and document the training. For self-directed supports, members who self-direct medication administration and who make training decisions must document training of a self-directed support employee. If the member receiving self-directed medication administration support does not make training decisions, then the fiscal employer agent, the PIHP, or the PIHP's contractor must train the employee and maintain documentation of the training. Policies in this paragraph are maintained in the SMA-PIHP contract and the PIHP's Training and Documentation Standards for Supportive Home Care document.

Waiver providers must assess medications that a member takes and the member's ability to control and self-administer medications. Providers administer medications to members who have been determined by the member's physician incompetent or lack capacity to self-administer, or members who request in writing that the provider manage and administer medication.

Waiver providers responsible for the administration of medications to a member must have 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.

When a member is determined by their physician to be competent to self-administer medications, the PIHP informs waiver providers through the member-centered plan of the self-administration. This information in the member-centered plan may include that the member is responsible for all medication management, including set up and administration, as well as where the member keeps the medication.

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:

Service providers are required to report medication errors to the PIHP. The PIHP must report medication errors listed in (b) to the SMA.

Service providers licensed by the Department of Health Services, Division of Quality Assurance (DQA) (https://www.dhs.wisconsin.gov/dqa/index.htm) have reporting requirements related to the terms of their licensure and report to DQA.

Providers in a licensed profession may also have license-related reporting requirements enforced by and reported to the Department of Safety and Professional Services (DSPS).

(b) Specify the types of medication errors that providers are required to *record:*

All medication errors (medication omission, wrong medication, wrong dose, wrong time, wrong technique, 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:

Providers must report all medication errors, including medication omission, wrong medication, wrong dose, wrong time, wrong technique, and wrong route, to the PIHP at the time of incident discovery. Providers do not report medication errors directly to the SMA. The PIHP reports member incidents, including medication errors, to the SMA through the Adult Incident Reporting System.

○ **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 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. 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 type of provider. In addition, the SMA's Division of Quality Assurance provides ongoing oversight of provider medication administration practices in regulated facilities and takes appropriate regulatory actions if a pattern of errors is discovered.

The SMA reviews incident data related to the administration of medications reported by the PIHP on an ongoing basis to identify trends and patterns and support quality improvement strategies.

The external quality review organization (EQRO) evaluates the performance of PIHPs for appropriate medication management as part of annual quality reviews.

The state's Department of Safety and Professional Services regulates licensed professional nurses, such as LPN, RN, APNP, as well as investigation of complaints for professional misconduct.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
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:

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

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

Data Aggregation and Analysis:

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

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

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:

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

Specify: PIHP		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Data Aggregation and Analysis:

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

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

PIHP		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

PIHP staff and providers must be trained in identifying, responding to, documenting, and reporting member incidents, including abuse, neglect, exploitation, medication errors, and unapproved use of restrictive measures. PIHPs must document PIHP staff's completion of training in the staff member's file. Completion of training for providers must be documented and provided upon request to the SMA.

Additionally, the PIHP's internal incident management system must integrate with the SMA's Adult Incident Reporting System (AIRS). AIRS has multiple reporting features that allow SMA staff to track and aggregate member incidents by PIHP, by service provider (individually or by provider type), by member, by incident type, region, etc. (PIHPs will also be able to run similar reports for their individual organization). Because the system is new, the SMA is currently engaged in the process of developing new methods for identifying potential systemic issues above and beyond those already required for CMS reporting. Once any such systemic issues are identified, the SMA will identify which system actor(s) are responsible for implementing any remediation steps that may be required and ensuring that follow-through occurs. (For instance, a PIHP may be required to implement a provider corrective action plan).

The SMA also reviews incidents discovered by the EQRO during the Quality Compliance Review (QCR) process, individual issues discovered during the Care Management Review (CMR) process, problems identified during the annual restrictive measures policy review and approval process, and observations made by other potential reporters.

b. Methods for Remediation/Fixing Individual Problems

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

The PIHP must develop and maintain an internal incident management system, which manages incidents occurring at the member and provider levels, to assure member health and safety, reduce member incident risks, and enable the development of strategies to prevent future incident occurrences.

After discovering a member incident, PIHPs and providers must immediately take effective steps to prevent further harm to or by the affected member(s). The process used by PIHPs for investigating and responding to individual incidents is described in G-1-d.

The PIHP's internal incident management system must integrate with the SMA's Adult Incident Reporting System (AIRS). Using AIRS, SMA staff can review individual incidents and aggregate reports and provide oversight of PIHP incident investigations and remediation in real-time. If the substance or timeliness of remediation of individual problems is determined to be deficient, the SMA will review requirements and procedures with the PIHP and may request corrective action for the PIHP if warranted.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The SMA's 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. Issues at the Individual Issue Level

PIHPs are charged with the day-to-day identification and remediation of individual issues. When the SMA identifies single issues that require remediation, additional action, or oversight, SMA oversight teams review those issues with PIHP staff and managers and develop plans for remediation. If quality concerns are identified, those are addressed with the PIHP and may be elevated to SMA section managers. Individual issues may be identified through the review of member incident or other reports submitted by PIHPs, the findings of the external quality review organization (EQRO), and other sources. This process occurs on a continuous basis. 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 the PIHP Level

When systemic issues are identified within a PIHP, the SMA oversight teams work with the PIHP to develop systemic plans for system improvements at the PIHP. These issues may be identified through the review of reports submitted by PIHPs, the findings of the EQRO as identified above, member incident reporting, 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.

3. Systemic Issues at the Statewide or Regional Level or Among Multiple PIHPs

When issues that cross multiple PIHPs are identified, the systems improvement activities described above are 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 may issue contract changes to address issues identified among multiple PIHPs.

4. Systemic Issues within a PIHP: Prioritization

Systemic issues that could affect member health and safety or that involve members with high risk due to complex needs are given priority. Issues that address service gaps, affect financial accountability and SMA compliance with waiver assurances are also prioritized for remediation. Significant issues of concern are 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, such as additional staff and provider training or the implementation of performance improvement projects.

a. Oversight

i. SMA PIHP oversight process

The SMA oversight teams for PIHPs are supervised by section managers who can identify trends across the PIHPs. The SMA oversight teams meet on a periodic basis to share information about PIHP performance and best practices in relation to oversight. The SMA section managers meet regularly with other SMA section managers and discuss issues they are seeing that may cross PIHPs or suggest changes to SMA policies and procedures. SMA oversight teams meet regularly with the SMA's fiscal teams and information systems staff to share information about issues identified in those areas.

ii. 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 waiver systems and recommend potential quality improvement strategies. Strategies 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 quality priorities.

b. Policy

SMA policy staff work with 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 and brought to management as appropriate. Issues that require an immediate response may be addressed through written policy clarifications or contract amendments.

c. Quality

i. Trending and analysis of performance metrics

a. The SMA has identified a number of performance metrics that it tracks and trends over time. Those metrics are available to PIHPs for 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 may be modified over time. The performance metrics are not specified in the SMA-PIHP contract although many of them are based on reporting requirements found in the contract, such as member incident reporting, influenza and pneumococcal vaccination rates, member survey results and financial reporting. Another group of 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.

ii. Analysis of waiver performance measures

a. Trends and opportunities to improve CMS-reported measures are identified annually when preparing the 372 report and the waiver renewal evidence-based report. Performance indicators yielding below-standard outcomes are identified for process improvement.

iii. Implementation of Medicaid Managed Care Quality Strategy

a. The SMA submits and updates the Medicaid Managed Care Quality Strategy to CMS. The strategy includes a three year plan for overall quality improvement efforts that prioritizes projects to address long term care opportunities including and beyond CMS-reported measures. The strategy outlines goals with corresponding quality measures. Measures in the strategy include and extend beyond regulatory requirements and are operationally defined and collected through the appropriate measurement mechanisms.

5. Methods of Implementing Quality Improvement Strategies

Quality improvement strategies can be implemented in a variety of ways including:

a. Oversight

i. Oversight processes for implementation of quality improvement strategies are substantially similar to those described above in 4.a.i and ii.
ii. Additionally, the SMA utilizes its review process for certification and business plan: Some issues may be addressed by modifying SMA criteria for the annual review of certification documentation or the annual PIHP business plans.
iii. 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.
iv. 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.

b. Policy

i. Modifications to the contract between the SMA and PIHP: The contract reflects the requirements and

expectations of the SMA for the operation of the waiver. 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.

ii. Modification of RFP criteria: The SMA must periodically re-procure for PIHPs. The request for proposal (RFP) process allows the SMA to establish criteria that reinforce quality standards.

c. Quality

i. 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.

ii. Specialized reporting requirements: The SMA can require the PIHPs to submit materials to monitor progress related to a quality issues.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the State-IHCP-PIHP Agreement. The State will utilize corrective action procedures specified in that Agreement for any systems issues identified.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

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 the processes or policies they are replacing. The SMA staff that monitors and assesses a particular system design change varies with the nature of the change. Fiscal oversight staff monitor and assess changes related to fiscal policies or practices. Contract specialists monitor compliance with contract requirements. Clinical staff monitor changes within their scope of practice and expertise. Member care quality specialists 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 staff work within a team 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 receives updates on results of any changes. The processes for monitoring and assessing systems improvement are standardized, with each indicator being reviewed every other year. The EQRO annual quality reviews routinely evaluate all indicators on a regular cycle.

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 contract 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. The SMA maintains a website that provides information about the program to the general public, including families, providers, agencies and other interested parties.

The results of changes are communicated in many of the same ways. The communication method and frequency depend on the change. Some changes, although precipitated by discovery, are relatively routine (e.g., a change in elements in a fiscal report). The contract between the SMA and PIHPs may include changes, in conjunction with contract review processes. The SMA shares results of such a change internally and with the PIHPs to determine if the change had the desired results. As necessary, the results of more significant changes are communicated more broadly. For example, results are presented to the Wisconsin Long Term Care Advisory Council and other interested stakeholder groups.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The SMA evaluates the Quality Improvement Strategy (QIS) annually, in conjunction with the External Quality Review Organization (EQRO), focusing on continuous improvement and operationalization of processes to measure, analyze, and improve outcomes. The SMA evaluates progress on meeting performance goals, decides a course of action to meet goals not met, and monitors high-level effects of system-wide changes. Additional evaluation is completed every 3 years as part of the revision of the Medicaid Managed Care Quality Strategy.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

The SMA has conducted both the NCI-AD and the NCI-IDD in the past 12 months. The SMA also conducts an internally developed statewide survey called the Member Satisfaction Survey. The Member Satisfaction Survey is meant to capture overall member satisfaction with their PIHP. The SMA may also use additional internally-developed satisfaction surveys.

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).*

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. 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 member 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 require system walkthroughs, 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.

i. At least every five years, each PIHP has an on-site comprehensive financial audit conducted by SMA independent auditors with health care and waiver program expertise staffed by the Wisconsin Office of the Commissioner of Insurance. 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.

ii. PIHP annual independent CPA audits include a requirement for sample and testing of claims payments to ensure systems are in place to accurately pay only contracted providers for waiver services for eligible, enrollment members. Annual audit report submissions by PIHPs to the SMA must include a report of the claim audit results against the SMA defined criteria. Follow up on failure to satisfy the criteria is conducted by the SMA fiscal oversight CPAs to ensure corrective action plans are identified and implemented.

iii. The need for off-cycle audit is identified through comprehensive SMA fiscal oversight and includes review of PIHP 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 PIHP 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 may be followed up on by the SMA through an audit to evidence correction of the finding prior to the next audit if warranted.

iv. Fiscal corrective action plans are developed by the Division of Medicaid Services 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.

v. 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, waste, 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 SMA independent audits; 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: 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, 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 and the required template for the claims audit reporting and completion for external independent CPAs are outlined in the SMA Managed Long-Term Care Audit Guide available on the SMA's website: http://www.dhs.wisconsin.gov/LTCare/ProgramOps/fiscal/index.htm

The SMA has CPA auditors with specific industry and program expertise to conduct off-cycle and targeted audits.

For services provided by IHCPs, IHCPs submit claims to PIHPs that are 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 monitors the costs for waiver services, including 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 submit a comprehensive annual financial audit conducted by an independent CPA firm. IHCPs are required to submit a cost allocation methodology for the SMA's approval prior to the submission of cost reporting. IHCPs 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 the SMA fiscal oversight CPAs 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 requests additional information and/or conducts additional audit sampling and testing work as required to evaluate cost allocation and to further establish compliance with the requirements. Annually, the SMA contracts for an external quality review organization (EQRO) which includes review of a sample of IHCP care plans. The SMA provides a sample of encounter reporting records for the IHCP care plans selected for validation against services rendered and documented in the IHCP care plan notes.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
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 *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☐ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% with +/- 5% margin of error*
☒ ***Other*** *Specify:* *Independent Auditor*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
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):*
Other
If 'Other' is selected, specify:
Monthly Capitation Payment Data

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☒ ***Other*** *Specify:* *Biannually (twice per year)*

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

The 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 Managed Long Term Care Audit Guide.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***Other*** *Specify:* *PIHP*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The 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. The rate methodology submitted is approved by CMS. The 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 subject to CMS approved directed managed care payments 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. The SMA contract with the PIHP 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 are conducted. This analysis, 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. 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 these contract provisions. 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. Self-directed services encounters are included in the full set of encounter data submitted by the PIHPs and used in the annual capitation rate development process by the contracted actuarial firm.

Analyses are carried out to ensure that the Medicaid fee schedule is being employed where required, per the SMA contract.

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 and includes 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 include benchmarking against other PIHP rates and program experience over time 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.

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 or, If there is no negotiated rate, at a rate not less than the level and amount of payment that would be made to an in-network provider that is not an 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 directly contracted or through self-direction 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:*

All waiver services are furnished by the PIHP. PIHP billings to the SMA are made in accordance with the SMA's concurrent 1915(b) waiver (WI.0007). Provider billings to the PIHP are made in accordance with the terms of the provider's contract with the PIHP.

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:*

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 members. The PIHPs authorize services through a member-centered plan 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.

If a capitation payment is found to have been made inappropriately, the SMA's Fiscal Agent will update the participant's enrollment record with the correct information. The enrollment record update will cause the MMIS to create a negative version of the original payment record. If necessary, the MMIS will also create a new record with the corrected payment amount based on the updated enrollment record. A receivable record is then generated in the MMIS for the difference between the reversed original amount and the corrected payment amount. The receivable amount will be recouped against future payments made to the PIHP. When the FFP claim is prepared, the reversal records created through the recoupment process are identified and grouped according to the quarter in which the original payment was made. The total reversal amount for each quarter is entered on a separate CMS-64 form prepared for each quarter to align with the FMAP claimed for the original payments.

Wraparound payments the SMA makes to Indian Health Care Providers (IHCPs) are eligible for 100% federal financial participation. The wraparound payments/recoupments are 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.
Annually, the SMA contracts for an external quality review organization (EQRO) review which includes review of a sample of IHCP care plans. Outcome-based care plans identify the service needs that result in service authorizations and encounter records for billed services. The SMA provides a sample of rendered and billed services from the SMA encounter reporting records for validation against individual IHCP service plans.

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 member who is enrolled in a PIHP. A capitation payment is made each month by the SMA's Fiscal Agent to the PIHP for each member. 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:

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:

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

- ( ) ***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.

○ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***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 are required to report the waiver member's room and board obligation separate from the service costs when waiver services are provided in a residential setting that is not the member's own home or family home. The member's room and board obligation is excluded from the cost of allowable waiver services when calculating capitation rates. The member pays the room and board obligation using the member's own resources.

The waiver member's room and board obligation is the lesser of:
- *HUD FMR rental amounts based on residential type plus the maximum Supplemental Nutrition Assistance Allocation for one person; or*
- *The member's available income for room and board using procedures specified by the SMA.*

Room and board obligations will be determined at time of service plan creation or renewal.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***

○ ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: 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	*41414.55*	*12779.03*	*54193.58*	*156726.73*	*5935.94*	*162662.67*	*108469.09*
2	*42719.14*	*13141.82*	*55860.96*	*161489.76*	*6104.46*	*167594.22*	*111733.26*
3	*44015.70*	*13514.84*	*57530.54*	*166396.56*	*6277.73*	*172674.29*	*115143.75*
4	*45472.31*	*13936.08*	*59408.39*	*171916.78*	*6473.40*	*178390.18*	*118981.79*
5	*46728.18*	*14292.34*	*61020.52*	*176654.66*	*6638.89*	*183293.55*	*122273.03*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*	
		Level of Care:	*Level of Care:*
		Nursing Facility	*ICF/IID*
Year 1	*70974*	*51406*	*19568*

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 2	*72886*	*52730*	*20156*
Year 3	*74797*	*54051*	*20746*
Year 4	*76707*	*55370*	*21337*
Year 5	*78618*	*56687*	*21931*

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.

Projected enrollment is generally based on actual enrollment as of February 2024 and historical enrollment growth experience for each PIHP/MCO and geographic service region in the Family Care and Partnership programs. This amounts to net enrollment growth of 123 participants per month, which is the same growth assumed in the State budget. Additional growth capacity of 10 participants per month (1% of the roughly 60,000 average monthly participants spread over the 60 months in the waiver period) is added to ensure Factor C is not exceeded in the event of unforeseen enrollment spikes. The monthly 133 or annual 1,599 net enrollment growth amounts to trends of 2.8% in CY2025 (Year 1), 2.7% in CY2026 (Year 2), 2.6% in CY2027 (Year3), 2.6% in CY2028 (Year 4), and 2.5% in CY2029 (Year 5) or a 2.6% average annual enrollment growth trend during the waiver period.

The number of unduplicated participants served during the waiver year, which includes both actively enrolled and disenrolled participants, is calculated by adding the number of members expected to disenroll during the year to the projected participant count at the end of the year. A churn factor of roughly 1.7% per month based on the waiver's historical monthly disenrollment rate is applied to the projected monthly member count to calculate the number of members projected to disenroll each month. The sum of the monthly disenrollments is then added to the projected member count at year end to arrive at the total number of unduplicated participants served during the year. Including the churn factor each month results in the annual unduplicated participant counts being roughly 19.8% higher than the point in time year-end participant counts.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

The Factor D estimate is generally based on actual 10/1/2022 - 9/30/2023 Family Care service costs from encounter data for members at the Nursing Home level of care, which includes costs for both the ICF-IID and Nursing Facility populations. This is the most recent 12-month period of complete encounter data. The term "Nursing Home level of care" used here is defined as a broader term referring to waiver eligibility determined by the State's Long-Term Care Functional Screen. It does not refer to a specific type of facility or target group. This is a different definition than the term used to describe "level of care" in the 1915(c) waiver. Alternate data sources were used for the following services:

Competitive Integrated Employment (CIE) Exploration is a new service. Utilization is based participant survey data. Cost is assumed to be similar to Supported Employment - Individual.

Health and Wellness services are expanded. Utilization is based on implementation of the service in a different long term care program. Services are not expected to be fully utilized until CY2026 (Year 2) due to slower uptake experienced when the service was added. Unit cost is assumed to be similar to the health classes covered in the existing waiver.

Remote Monitoring and Support is a new service. Utilization and cost for both equipment (Each) and ongoing monitoring (Hours) are based on similar services provided in other states.

Supportive Home Care is based mostly on encounter data, but also includes direct care workforce funding provided in the State budget.

Residential Care (1-2 Bed Adult Family Home), Residential Care (Other), and Supportive Home Care costs are increased to meet minimum payment rates established for these service providers effective 10/1/2024.

All service costs are trended forward at average annual rates of -0.007% in CY2023, 4.1% in CY2024, 4.0% in CY2025 (Year 1), and 3.0% in CY2026 (Year 2) - CY2029 (Year 5) using trends in the rate setting reports prepared by the State's contracted actuaries and the State budget. CY2023 and CY2024 trends are included to allow projections to be tracked back to the source data. The unduplicated participant count in the derivation is projected using the same method to derive Average Length of Stay as described above. The Family Care benefit package also includes services covered under the State Medicaid plan. These State plan costs are included in the calculation of Factor D'.

The number of users for each service is calculated by multiplying the user percentage for each service by the projected unduplicated participants for each waiver year. The user percentages for existing services are based on the number of users for each service in the 10/1/2022 - 9/30/2023 base period encounter data divided by the number of unduplicated participants in the base period. User percentages for new or expanded services are based on the alternative data sources listed above. Other than the expanded Health and Wellness benefit ramping up over the first two years, user percentages are held constant for the projected waiver years as utilization patterns are not expected to change.

Total costs and total units are pulled from the 10/1/2022 - 9/30/2023 base period encounter data and grouped by service. The total costs and units for each service are divided by member days in the base period to arrive at the baseline average service cost per member per day and average units per member per day.

To calculate projected total cost for each waiver year, the base period daily service costs per member are trended forward using the trend factors in the rate setting reports prepared by the State's contracted actuaries and the State budget and then multiplied by the projected member days for each waiver year.

Average cost per unit is calculated by dividing projected total costs for each waiver year as described above by the projected total units each year for each service. To calculate total units, the average units per member per day for each service from the base data are multiplied by the projected member days for each year. No trend factors are applied to average units per member per day as utilization patterns are assumed to remain constant.

Average units per user for each service is calculated by dividing the projected units for each service by the number of users for each service. Derivations for total units and number of service users are described above.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these*

estimates is as follows:

Factor D' is based on actual 10/1/2022 - 9/30/2023 Medicaid State Plan service costs for Family Care members at the Nursing Home Level of Care. The portion of Factor D' related to State plan services included in the capitation payment is from certified encounter data. State plan service costs in Factor D' not included in the capitation payment are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. The cost of prescribed drugs furnished to Medicare / Medicaid dual eligible members under the provisions of Part D are not included in the estimate. Costs for both the ICF-IID and Nursing Facility populations are included.

The term "Nursing Home level of care" used here is defined as a broader term which refers to waiver eligibility determined by the State's Long-Term Care Functional Screen. It does not refer to a specific type of facility or target group. This is a different definition than the term used to describe "level of care" in the 1915(c) waiver.

Base period average cost per member is trended forward at average annual rates of -0.1% in CY2023, 2.8% in CY2024, and 2.8% in CY2025 (Year 1) - CY2029 (Year 5) using the Consumer Price Index for Medical Care. CY2023 and CY2024 trends are included to allow projections to be tracked back to the source data.

The unduplicated participant count used in the derivation is projected using the same method to derive Average Length of Stay as described above.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is based on a blend of 10/1/2022 - 9/30/2023 Medicaid institutional costs for individuals residing in ICFs-IID, State Centers, and Nursing Facilities to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS.

Base period costs are trended 4.5% in CY2023, 10.4% in CY2024, and 3.0% in the CY2025 (Year 1) – CY2029 (Year 5) waiver period using rate increases in the State budget and the Consumer Price Index for All Items. CY2023 and CY2024 trends are included to allow projections to be tracked back to the source data.

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay between the institutional populations versus the Family Care waiver population. The average length of stay (ALOS) in the institutional population base data is 237 days. The ALOS for the wavier population is 301.0 days in CY2025 (Year 1), 301.1 days in CY2026 (Year 2), 301.2 days in CY2027 (Year 3), 302.2 days in CY2028 (Year 4), and 301.4 in CY2029 (Year 5). With the institutional population having a lower ALOS, it follows the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the cost of the institutional population is adjusted by the ratio of the institutional ALOS to the wavier ALOS. This has the effect of increasing Factors G and G' by roughly 27% depending on the ALOS in the waiver population for the year. Factor G is higher by $33,241 in Year 1; $34,300 in Year 2; $35,391 in Year 3; $36,981 in Year 4; and $37,671 in Year 5 than it would be without the adjustment for ALOS.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is based on a blend of 10/1/2022 - 9/30/2023 Medicaid non-institutional costs for individuals residing in ICFs-IID, State Centers, and Nursing Facilities to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS.

Base period average cost per member is trended forward at average annual rates of -0.1% in CY2023, 2.8% in CY2024, and 2.8% in CY2025 (Year 1) - CY2029 (Year 5) using the Consumer Price Index for Medical Care. CY2023 and CY2024 trends are included to allow projections to be tracked back to the source data.

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay between the institutional populations versus the Family Care waiver population. The average length of stay (ALOS) in the institutional population base data is 237 days. The ALOS for the wavier population is 301.0 days in CY2025 (Year 1), 301.1 days in CY2026 (Year 2), 301.2 days in CY2027 (Year 3), 302.2 days in CY2028 (Year 4), and 301.4 in CY2029 (Year 5). With the institutional population having a lower ALOS, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional population are adjusted by the ratio of the institutional ALOS to the wavier ALOS. This has the effect of increasing Factors G and G' by roughly 27% depending on the ALOS in the waiver population for the year. Factor G' is higher by $1,259 in Year 1, $1,297 in Year 2, $1,335 in Year 3, $1,392 in Year 4, and $1,416 in Year 5 than it would be without the adjustment for ALOS.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Care Services	
Care Management	
Daily Living Skills Training	
Day Habilitation Services	
Prevocational Services	
Respite	
Supported Employment - Individual Employment Support	
Consumer Directed Supports (Self-Directed Supports) Broker	
Financial Management Services	
Assistive Technology	
CIE Exploration	
Communication Assistance	
Consultative Clinical and Therapeutic Services for Caregivers	
Consumer Education and Training	
Counseling and Therapeutic Resources	
Environmental Accessibility Adaptations (Home Modifications)	
Health and Wellness	
Home Delivered Meals	
Housing Counseling	
Personal Emergency Response Systems (PERS)	
Relocation services	
Remote Monitoring and Support	
Residential Services (1-2 Bed AFH)	
Residential Services (Other)	
Self-Directed Personal Care	

Waiver Services	
Skilled Nursing Services RN/LPN	
Specialized Medical Equipment and Supplies	
Supported Employment - Small Group Employment Support	
Supportive Home Care	
Training Services for Unpaid Caregivers	
Transportation (Specialized Transportation) - Community Transportation	
Transportation (Specialized Transportation) - Other Transportation	
Vehicle Modifications	
Vocational Futures Planning and Support	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Services Total:							**13173465.80**
Adult Day Care Services	☒	Hours	1564	602.93	13.97	**13173465.80**	
Care Management Total:							**294329297.53**
Care Management	☒	Hours	70567	42.31	98.58	**294329297.53**	
Daily Living Skills Training Total:							**6980057.73**
Daily Living Skills Training	☒	Hours	814	287.27	29.85	**6980057.73**	
Day Habilitation Services Total:							**64513384.63**
Day Habilitation Services	☒	Hours	5559	756.04	15.35	**64513384.63**	
Prevocational Services Total:							**25018633.11**
Prevocational Services	☒	Hours	3318	693.04	10.88	**25018633.11**	
Respite Total:							**12069013.90**

GRAND TOTAL:		**2939356021.66**
Total: Services included in capitation:		2939356021.66
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**70974**
Factor D (Divide total by number of participants):		**41414.55**
Services included in capitation:		41414.55
Services not included in capitation:		
Average Length of Stay on the Waiver:	301	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	☒	*Hours*	*1877*	*394.96*	*16.28*	***12069013.90***	
Supported Employment - Individual Employment Support Total:							***12414826.23***
Supported Employment - Individual Employment Support	☒	*Hours*	*2239*	*275.45*	*20.13*	***12414826.23***	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							***1633996.13***
Consumer Directed Supports (Self-Directed Supports) Broker	☒	*Hours*	*613*	*51.34*	*51.92*	***1633996.13***	
Financial Management Services Total:							***17401529.37***
Financial Management Services	☒	*Hours*	*23785*	*11.02*	*66.39*	***17401529.37***	
Assistive Technology Total:							***1012358.66***
Assistive Technology	☒	*Items*	*6010*	*2.93*	*57.49*	***1012358.66***	
CIE Exploration Total:							***1476251.67***
CIE Exploration	☒	*Hours*	*1065*	*68.86*	*20.13*	***1476251.67***	
Communication Assistance Total:							***110644.67***
Communication Assistance	☒	*Each*	*307*	*20.63*	*17.47*	***110644.67***	
Consultative Clinical and Therapeutic Services for Caregivers Total:							***817544.25***
Consultative Clinical and Therapeutic Services for Caregivers	☒	*Hours*	*251*	*22.66*	*143.74*	***817544.25***	
Consumer Education and Training Total:							***532810.97***

GRAND TOTAL:	***2939356021.66***
Total: Services included in capitation:	*2939356021.66*
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	***70974***
Factor D (Divide total by number of participants):	***41414.55***
Services included in capitation:	*41414.55*
Services not included in capitation:	
Average Length of Stay on the Waiver:	*301*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Education and Training	☒	Hours	196	66.19	41.07	532810.97	
Counseling and Therapeutic Resources Total:							2133534.67
Counseling and Therapeutic Resources	☒	Hours	1049	27.77	73.24	2133534.67	
Environmental Accessibility Adaptations (Home Modifications) Total:							2607989.93
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	777	2.36	1422.24	2607989.93	
Health and Wellness Total:							3372372.58
Health and Wellness	☒	Hours	3818	16.65	53.05	3372372.58	
Home Delivered Meals Total:							7817170.23
Home Delivered Meals	☒	Meals	4974	152.88	10.28	7817170.23	
Housing Counseling Total:							696883.92
Housing Counseling	☒	Hours	669	44.90	23.20	696883.92	
Personal Emergency Response Systems (PERS) Total:							1993697.25
Personal Emergency Response Systems (PERS)	☒	Month	8092	8.29	29.72	1993697.25	
Relocation services Total:							396915.38
Relocation services	☒	Projects	357	5.22	212.99	396915.38	
Remote Monitoring and Support Total:							15680085.00
Remote Monitoring and Support - Each	☒	Each	2129	1.00	500.00	1064500.00	
Remote Monitoring and	☒	Hours	2129	686.50	10.00	14615585.00	

GRAND TOTAL:	2939356021.66
Total: Services included in capitation:	2939356021.66
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	70974
Factor D (Divide total by number of participants):	41414.55
Services included in capitation:	41414.55
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support - Hours							
Residential Services (1-2 Bed AFH) Total:							**360089294.43**
Residential Services (1-2 Bed AFH)	☒	Days	2776	290.21	446.97	**360089294.43**	
Residential Services (Other) Total:							**1413414637.38**
Residential Services (Other)	☒	Days	26566	281.86	188.76	**1413414637.38**	
Self-Directed Personal Care Total:							**323053.05**
Self-Directed Personal Care	☒	Hours	10	1673.85	19.30	**323053.05**	
Skilled Nursing Services RN/LPN Total:							**4290966.23**
Skilled Nursing Services RN/LPN	☒	Hours	103	1167.27	35.69	**4290966.23**	
Specialized Medical Equipment and Supplies Total:							**1567139.56**
Specialized Medical Equipment and Supplies	☒	Items	9472	209.43	0.79	**1567139.56**	
Supported Employment - Small Group Employment Support Total:							**3201390.26**
Supported Employment - Small Group Employment Support	☒	Hours	509	382.81	16.43	**3201390.26**	
Supportive Home Care Total:							**616883776.94**
Supportive Home Care	☒	Hours	27293	806.36	28.03	**616883776.94**	
Training Services for Unpaid Caregivers Total:							**69583.96**
Training Services for Unpaid Caregivers	☒	Hours	158	4.56	96.58	**69583.96**	

GRAND TOTAL:	**2939356021.66**
Total: Services included in capitation:	2939356021.66
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**70974**
Factor D (Divide total by number of participants):	**41414.55**
Services included in capitation:	41414.55
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation (Specialized Transportation) - Community Transportation Total:							**52020518.13**
Transportation (Specialized Transportation) - Community Transportation	☒	Trips	18550	155.97	17.98	**52020518.13**	
Transportation (Specialized Transportation) - Other Transportation Total:							**571644.38**
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	918	32.93	18.91	**571644.38**	
Vehicle Modifications Total:							**644119.76**
Vehicle Modifications	☒	Each	96	1.28	5241.86	**644119.76**	
Vocational Futures Planning and Support Total:							**97433.96**
Vocational Futures Planning and Support	☒	Each	94	1.55	668.73	**97433.96**	

GRAND TOTAL:	**2939356021.66**
Total: Services included in capitation:	2939356021.66
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**70974**
Factor D (Divide total by number of participants):	**41414.55**
Services included in capitation:	41414.55
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Services Total:							**13929545.92**
Adult Day Care Services	☒	Hours	1606	603.16	14.38	**13929545.92**	
Care Management Total:							**311407518.47**
Care Management	☒	Hours	72468	42.32	101.54	**311407518.47**	
Daily Living Skills Training Total:							**7387677.66**
Daily Living Skills Training	☒	Hours	836	287.38	30.75	**7387677.66**	
Day Habilitation Services Total:							**68264906.21**
Day Habilitation Services	☒	Hours	5709	756.32	15.81	**68264906.21**	
Prevocational Services Total:							**26486611.34**
Prevocational Services	☒	Hours	3408	693.30	11.21	**26486611.34**	
Respite Total:							**12760678.02**
Respite	☒	Hours	1927	395.11	16.76	**12760678.02**	
Supported Employment - Individual Employment Support Total:							**13144286.10**
Supported Employment - Individual Employment Support	☒	Hours	2300	275.55	20.74	**13144286.10**	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							**1730441.66**
Consumer Directed Supports (Self-Directed Supports) Broker	☒	Hours	630	51.36	53.48	**1730441.66**	
Financial Management Services Total:							**18422856.18**
Financial Management Services	☒	Hours	24426	11.03	68.38	**18422856.18**	
Assistive							**1070932.11**

GRAND TOTAL:	**3113627178.04**
Total: Services included in capitation:	3113627178.04
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**72886**
Factor D (Divide total by number of participants):	**42719.14**
Services included in capitation:	42719.14
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology Total:							
Assistive Technology	☒	Items	6172	2.93	59.22	**1070932.11**	
CIE Exploration Total:							**1561655.01**
CIE Exploration	☒	Hours	1093	68.89	20.74	**1561655.01**	
Communication Assistance Total:							**116972.10**
Communication Assistance	☒	Each	315	20.63	18.00	**116972.10**	
Consultative Clinical and Therapeutic Services for Caregivers Total:							**862567.43**
Consultative Clinical and Therapeutic Services for Caregivers	☒	Hours	257	22.67	148.05	**862567.43**	
Consumer Education and Training Total:							**563155.41**
Consumer Education and Training	☒	Hours	201	66.22	42.31	**563155.41**	
Counseling and Therapeutic Resources Total:							**2258890.14**
Counseling and Therapeutic Resources	☒	Hours	1078	27.78	75.43	**2258890.14**	
Environmental Accessibility Adaptations (Home Modifications) Total:							**2770525.69**
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	798	2.37	1464.91	**2770525.69**	
Health and Wellness Total:							**6886437.66**
Health and Wellness	☒	Hours	7565	16.66	54.64	**6886437.66**	
Home Delivered Meals Total:							**8272552.60**
Home Delivered Meals	☒	Meals	5108	152.93	10.59	**8272552.60**	

	GRAND TOTAL:	**3113627178.04**
	Total: Services included in capitation:	3113627178.04
	Total: Services not included in capitation:	
	Total Estimated Unduplicated Participants:	**72886**
	Factor D (Divide total by number of participants):	**42719.14**
	Services included in capitation:	42719.14
	Services not included in capitation:	
	Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Counseling Total:							**737246.36**
Housing Counseling	☒	Hours	687	44.92	23.89	**737246.36**	
Personal Emergency Response Systems (PERS) Total:							**2111953.26**
Personal Emergency Response Systems (PERS)	☒	Month	8310	8.30	30.62	**2111953.26**	
Relocation services Total:							**420275.04**
Relocation services	☒	Projects	367	5.22	219.38	**420275.04**	
Remote Monitoring and Support Total:							**16596329.44**
Remote Monitoring and Support - Each	☒	Each	2187	1.00	515.00	**1126305.00**	
Remote Monitoring and Support - Hours	☒	Hours	2187	686.76	10.30	**15470024.44**	
Residential Services (1-2 Bed AFH) Total:							**381057594.08**
Residential Services (1-2 Bed AFH)	☒	Days	2851	290.32	460.38	**381057594.08**	
Residential Services (Other) Total:							**1495560990.48**
Residential Services (Other)	☒	Days	27281	281.97	194.42	**1495560990.48**	
Self-Directed Personal Care Total:							**366177.47**
Self-Directed Personal Care	☒	Hours	11	1674.49	19.88	**366177.47**	
Skilled Nursing Services RN/LPN Total:							**4550052.08**
Skilled Nursing Services RN/LPN	☒	Hours	106	1167.71	36.76	**4550052.08**	
Specialized Medical Equipment and Supplies Total:							**1671252.89**

GRAND TOTAL:	**3113627178.04**
Total: Services included in capitation:	3113627178.04
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**72886**
Factor D (Divide total by number of participants):	**42719.14**
Services included in capitation:	42719.14
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies	☒	Items	9728	209.51	0.82	**1671252.89**	
Supported Employment - Small Group Employment Support Total:							**3388874.31**
Supported Employment - Small Group Employment Support	☒	Hours	523	382.96	16.92	**3388874.31**	
Supportive Home Care Total:							**652755129.52**
Supportive Home Care	☒	Hours	28029	806.67	28.87	**652755129.52**	
Training Services for Unpaid Caregivers Total:							**73649.02**
Training Services for Unpaid Caregivers	☒	Hours	162	4.57	99.48	**73649.02**	
Transportation (Specialized Transportation) - Community Transportation Total:							**55048320.18**
Transportation (Specialized Transportation) - Community Transportation	☒	Trips	19050	156.03	18.52	**55048320.18**	
Transportation (Specialized Transportation) - Other Transportation Total:							**604454.27**
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	942	32.94	19.48	**604454.27**	
Vehicle Modifications Total:							**684176.49**
Vehicle Modifications	☒	Each	99	1.28	5399.12	**684176.49**	
Vocational Futures Planning and Support Total:							**102493.44**
Vocational	☒					**102493.44**	

GRAND TOTAL:	**3113627178.04**
Total: Services included in capitation:	3113627178.04
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**72886**
Factor D (Divide total by number of participants):	**42719.14**
Services included in capitation:	42719.14
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Futures Planning and Support		Each	96	1.55	688.80		

GRAND TOTAL:	**3113627178.04**
Total: Services included in capitation:	3113627178.04
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**72886**
Factor D (Divide total by number of participants):	**42719.14**
Services included in capitation:	42719.14
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Services Total:							**14736566.96**
Adult Day Care Services	☒	Hours	1648	603.38	14.82	**14736566.96**	
Care Management Total:							**329295346.33**
Care Management	☒	Hours	74368	42.34	104.58	**329295346.33**	
Daily Living Skills Training Total:							**7802820.71**
Daily Living Skills Training	☒	Hours	857	287.49	31.67	**7802820.71**	
Day Habilitation Services Total:							**72200886.28**
Day Habilitation Services	☒	Hours	5858	756.61	16.29	**72200886.28**	
Prevocational Services Total:							**28013131.15**
Prevocational Services	☒	Hours	3497	693.56	11.55	**28013131.15**	
Respite Total:							**13501763.71**

GRAND TOTAL:	**3292242234.63**
Total: Services included in capitation:	3292242234.63
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**74797**
Factor D (Divide total by number of participants):	**44015.70**
Services included in capitation:	44015.70
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	☒	Hours	1978	395.25	17.27	13501763.72	
Supported Employment - Individual Employment Support Total:							13895910.34
Supported Employment - Individual Employment Support	☒	Hours	2360	275.66	21.36	13895910.34	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							1828186.72
Consumer Directed Supports (Self-Directed Supports) Broker	☒	Hours	646	51.38	55.08	1828186.72	
Financial Management Services Total:							19472344.13
Financial Management Services	☒	Hours	25066	11.03	70.43	19472344.13	
Assistive Technology Total:							1131711.53
Assistive Technology	☒	Items	6333	2.93	60.99	1131711.53	
CIE Exploration Total:							1651491.55
CIE Exploration	☒	Hours	1122	68.91	21.36	1651491.55	
Communication Assistance Total:							123600.99
Communication Assistance	☒	Each	323	20.64	18.54	123600.99	
Consultative Clinical and Therapeutic Services for Caregivers Total:							913036.92
Consultative Clinical and Therapeutic Services for Caregivers	☒	Hours	264	22.68	152.49	913036.92	
Consumer Education and Training Total:							594531.82

GRAND TOTAL:	**3292242234.63**
Total: Services included in capitation:	3292242234.63
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**74797**
Factor D (Divide total by number of participants):	**44015.70**
Services included in capitation:	44015.70
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Education and Training	☒	Hours	206	66.24	43.57	594531.82	
Counseling and Therapeutic Resources Total:							2388167.00
Counseling and Therapeutic Resources	☒	Hours	1106	27.79	77.70	2388167.00	
Environmental Accessibility Adaptations (Home Modifications) Total:							2928742.53
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	819	2.37	1508.86	2928742.53	
Health and Wellness Total:							7283150.34
Health and Wellness	☒	Hours	7763	16.67	56.28	7283150.34	
Home Delivered Meals Total:							8749531.76
Home Delivered Meals	☒	Meals	5242	152.99	10.91	8749531.76	
Housing Counseling Total:							779537.75
Housing Counseling	☒	Hours	705	44.93	24.61	779537.75	
Personal Emergency Response Systems (PERS) Total:							2231769.07
Personal Emergency Response Systems (PERS)	☒	Month	8528	8.30	31.53	2231769.07	
Relocation services Total:							444345.82
Relocation services	☒	Projects	376	5.23	225.96	444345.82	
Remote Monitoring and Support Total:							17547479.06
Remote Monitoring and Support - Each	☒	Each	2244	1.00	530.45	1190329.80	
Remote Monitoring and	☒	Hours	2244	687.02	10.61	16357149.26	

GRAND TOTAL:	**3292242234.63**
Total: Services included in capitation:	3292242234.63
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**74797**
Factor D (Divide total by number of participants):	**44015.70**
Services included in capitation:	44015.70
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support - Hours							
Residential Services (1-2 Bed AFH) Total:							**402965798.97**
Residential Services (1-2 Bed AFH)	☒	Days	2926	290.43	474.19	**402965798.97**	
Residential Services (Other) Total:							**1581397036.45**
Residential Services (Other)	☒	Days	27997	282.07	200.25	**1581397036.45**	
Self-Directed Personal Care Total:							**377368.78**
Self-Directed Personal Care	☒	Hours	11	1675.11	20.48	**377368.78**	
Skilled Nursing Services RN/LPN Total:							**4820651.33**
Skilled Nursing Services RN/LPN	☒	Hours	109	1168.15	37.86	**4820651.33**	
Specialized Medical Equipment and Supplies Total:							**1757563.05**
Specialized Medical Equipment and Supplies	☒	Items	9983	209.59	0.84	**1757563.05**	
Supported Employment - Small Group Employment Support Total:							**3585781.52**
Supported Employment - Small Group Employment Support	☒	Hours	537	383.10	17.43	**3585781.52**	
Supportive Home Care Total:							**690083397.43**
Supportive Home Care	☒	Hours	28764	806.97	29.73	**690083397.43**	
Training Services for Unpaid Caregivers Total:							**77735.79**
Training Services for Unpaid Caregivers	☒	Hours	166	4.57	102.47	**77735.79**	

GRAND TOTAL:	**3292242234.63**
Total: Services included in capitation:	3292242234.63
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**74797**
Factor D (Divide total by number of participants):	**44015.70**
Services included in capitation:	44015.70
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation (Specialized Transportation) - Community Transportation Total:							**58190263.03**
Transportation (Specialized Transportation) - Community Transportation	☒	Trips	19549	156.09	19.07	**58190263.03**	
Transportation (Specialized Transportation) - Other Transportation Total:							**639164.76**
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	967	32.95	20.06	**639164.76**	
Vehicle Modifications Total:							**724554.42**
Vehicle Modifications	☒	Each	101	1.29	5561.09	**724554.42**	
Vocational Futures Planning and Support Total:							**108866.64**
Vocational Futures Planning and Support	☒	Each	99	1.55	709.46	**108866.64**	

GRAND TOTAL:	**3292242234.63**
Total: Services included in capitation:	3292242234.63
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**74797**
Factor D (Divide total by number of participants):	**44015.70**
Services included in capitation:	44015.70
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Services Total:							**15618012.42**
Adult Day Care Services	☒	Hours	1691	605.24	15.26	**15618012.42**	
Care Management Total:							**348911488.26**
Care Management	☒	Hours	76267	42.47	107.72	**348911488.26**	
Daily Living Skills Training Total:							**8268427.24**
Daily Living Skills Training	☒	Hours	879	288.37	32.62	**8268427.24**	
Day Habilitation Services Total:							**76466362.19**
Day Habilitation Services	☒	Hours	6008	758.94	16.77	**76466362.19**	
Prevocational Services Total:							**29662936.58**
Prevocational Services	☒	Hours	3586	695.70	11.89	**29662936.58**	
Respite Total:							**14295851.82**
Respite	☒	Hours	2028	396.47	17.78	**14295851.82**	
Supported Employment - Individual Employment Support Total:							**14721392.40**
Supported Employment - Individual Employment Support	☒	Hours	2420	276.51	22.00	**14721392.40**	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							**1938863.67**
Consumer Directed Supports (Self-Directed Supports) Broker	☒	Hours	663	51.54	56.74	**1938863.67**	
Financial Management Services Total:							**20645221.22**
Financial Management Services	☒	Hours	25706	11.07	72.55	**20645221.22**	
Assistive							**1199566.75**

GRAND TOTAL:	**3488044764.80**
Total: Services included in capitation:	3488044764.80
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**76707**
Factor D (Divide total by number of participants):	**45472.31**
Services included in capitation:	45472.31
Services not included in capitation:	
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Technology Total:							
Assistive Technology	☒	Items	6495	2.94	62.82	**1199566.75**	
CIE Exploration Total:							**1750509.86**
CIE Exploration	☒	Hours	1151	69.13	22.00	**1750509.86**	
Communication Assistance Total:							**130862.14**
Communication Assistance	☒	Each	331	20.71	19.09	**130862.14**	
Consultative Clinical and Therapeutic Services for Caregivers Total:							**968375.82**
Consultative Clinical and Therapeutic Services for Caregivers	☒	Hours	271	22.75	157.07	**968375.82**	
Consumer Education and Training Total:							**629260.24**
Consumer Education and Training	☒	Hours	211	66.45	44.88	**629260.24**	
Counseling and Therapeutic Resources Total:							**2530222.08**
Counseling and Therapeutic Resources	☒	Hours	1134	27.88	80.03	**2530222.08**	
Environmental Accessibility Adaptations (Home Modifications) Total:							**3093962.00**
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	840	2.37	1554.13	**3093962.00**	
Health and Wellness Total:							**7716266.12**
Health and Wellness	☒	Hours	7961	16.72	57.97	**7716266.12**	
Home Delivered Meals Total:							**9264760.78**
Home Delivered Meals	☒	Meals	5376	153.46	11.23	**9264760.78**	

GRAND TOTAL:	**3488044764.80**
Total: Services included in capitation:	3488044764.80
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**76707**
Factor D (Divide total by number of participants):	**45472.31**
Services included in capitation:	45472.31
Services not included in capitation:	
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Housing Counseling Total:							**826045.21**
Housing Counseling	☒	Hours	723	45.07	25.35	**826045.21**	
Personal Emergency Response Systems (PERS) Total:							**2366303.77**
Personal Emergency Response Systems (PERS)	☒	Month	8746	8.33	32.48	**2366303.77**	
Relocation services Total:							**470749.23**
Relocation services	☒	Projects	386	5.24	232.74	**470749.23**	
Remote Monitoring and Support Total:							**18588745.62**
Remote Monitoring and Support - Each	☒	Each	2301	1.00	546.36	**1257174.36**	
Remote Monitoring and Support - Hours	☒	Hours	2301	689.13	10.93	**17331571.26**	
Residential Services (1-2 Bed AFH) Total:							**426850803.60**
Residential Services (1-2 Bed AFH)	☒	Days	3000	291.32	488.41	**426850803.60**	
Residential Services (Other) Total:							**1675551117.53**
Residential Services (Other)	☒	Days	28711	282.94	206.26	**1675551117.53**	
Self-Directed Personal Care Total:							**389808.16**
Self-Directed Personal Care	☒	Hours	11	1680.28	21.09	**389808.16**	
Skilled Nursing Services RN/LPN Total:							**5072505.75**
Skilled Nursing Services RN/LPN	☒	Hours	111	1171.75	39.00	**5072505.75**	
Specialized Medical Equipment and Supplies Total:							**1872437.39**

GRAND TOTAL:	**3488044764.80**
Total: Services included in capitation:	3488044764.80
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**76707**
Factor D (Divide total by number of participants):	**45472.31**
Services included in capitation:	45472.31
Services not included in capitation:	
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies	☒	Items	10237	210.24	0.87	**1872437.39**	
Supported Employment - Small Group Employment Support Total:							**3793804.30**
Supported Employment - Small Group Employment Support	☒	Hours	550	384.28	17.95	**3793804.30**	
Supportive Home Care Total:							**731127552.07**
Supportive Home Care	☒	Hours	29498	809.46	30.62	**731127552.07**	
Training Services for Unpaid Caregivers Total:							**82656.82**
Training Services for Unpaid Caregivers	☒	Hours	171	4.58	105.54	**82656.82**	
Transportation (Specialized Transportation) - Community Transportation Total:							**61679686.82**
Transportation (Specialized Transportation) - Community Transportation	☒	Trips	20048	156.57	19.65	**61679686.82**	
Transportation (Specialized Transportation) - Other Transportation Total:							**677350.50**
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	992	33.05	20.66	**677350.50**	
Vehicle Modifications Total:							**768459.09**
Vehicle Modifications	☒	Each	104	1.29	5727.93	**768459.09**	
Vocational Futures Planning and Support Total:							**114397.35**
Vocational	☒					**114397.35**	

GRAND TOTAL:	**3488044764.80**
Total: Services included in capitation:	3488044764.80
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**76707**
Factor D (Divide total by number of participants):	**45472.31**
Services included in capitation:	45472.31
Services not included in capitation:	
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Futures Planning and Support		Each	101	1.55	730.74		

GRAND TOTAL:		**3488044764.80**
Total: Services included in capitation:		3488044764.80
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**76707**
Factor D (Divide total by number of participants):		**45472.31**
Services included in capitation:		45472.31
Services not included in capitation:		
Average Length of Stay on the Waiver:	302	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Services Total:							**16449450.92**
Adult Day Care Services	☒	Hours	1733	603.81	15.72	**16449450.92**	
Care Management Total:							**367459275.90**
Care Management	☒	Hours	78167	42.37	110.95	**367459275.90**	
Daily Living Skills Training Total:							**8709411.98**
Daily Living Skills Training	☒	Hours	901	287.69	33.60	**8709411.98**	
Day Habilitation Services Total:							**80567449.11**
Day Habilitation Services	☒	Hours	6158	757.14	17.28	**80567449.11**	
Prevocational Services Total:							**31253765.55**
Prevocational Services	☒	Hours	3676	694.05	12.25	**31253765.55**	
Respite Total:							**15064661.86**

GRAND TOTAL:		**3673675857.15**
Total: Services included in capitation:		3673675857.15
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		**78618**
Factor D (Divide total by number of participants):		**46728.18**
Services included in capitation:		46728.18
Services not included in capitation:		
Average Length of Stay on the Waiver:	301	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite	☒	*Hours*	*2079*	*395.53*	*18.32*	***15064661.86***	
Supported Employment - Individual Employment Support Total:							***15508138.04***
Supported Employment - Individual Employment Support	☒	*Hours*	*2481*	*275.85*	*22.66*	***15508138.04***	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							***2040384.68***
Consumer Directed Supports (Self-Directed Supports) Broker	☒	*Hours*	*679*	*51.42*	*58.44*	***2040384.68***	
Financial Management Services Total:							***21733872.15***
Financial Management Services	☒	*Hours*	*26347*	*11.04*	*74.72*	***21733872.15***	
Assistive Technology Total:							***1266476.94***
Assistive Technology	☒	*Items*	*6657*	*2.94*	*64.71*	***1266476.94***	
CIE Exploration Total:							***1842345.01***
CIE Exploration	☒	*Hours*	*1179*	*68.96*	*22.66*	***1842345.01***	
Communication Assistance Total:							***138169.95***
Communication Assistance	☒	*Each*	*340*	*20.66*	*19.67*	***138169.95***	
Consultative Clinical and Therapeutic Services for Caregivers Total:							***1020928.87***
Consultative Clinical and Therapeutic Services for Caregivers	☒	*Hours*	*278*	*22.70*	*161.78*	***1020928.87***	
Consumer Education and Training Total:							***665015.31***

GRAND TOTAL:	***3673675857.15***
Total: Services included in capitation:	*3673675857.15*
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	***78618***
Factor D (Divide total by number of participants):	***46728.18***
Services included in capitation:	*46728.18*
Services not included in capitation:	
Average Length of Stay on the Waiver:	*301*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Education and Training	☒	Hours	217	66.29	46.23	665015.31	
Counseling and Therapeutic Resources Total:							2663743.58
Counseling and Therapeutic Resources	☒	Hours	1162	27.81	82.43	2663743.58	
Environmental Accessibility Adaptations (Home Modifications) Total:							3266442.43
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	861	2.37	1600.75	3266442.43	
Health and Wellness Total:							8125695.36
Health and Wellness	☒	Hours	8160	16.68	59.70	8125695.36	
Home Delivered Meals Total:							9760232.17
Home Delivered Meals	☒	Meals	5510	153.10	11.57	9760232.17	
Housing Counseling Total:							869864.05
Housing Counseling	☒	Hours	741	44.96	26.11	869864.05	
Personal Emergency Response Systems (PERS) Total:							2491718.60
Personal Emergency Response Systems (PERS)	☒	Month	8964	8.31	33.45	2491718.60	
Relocation services Total:							495225.56
Relocation services	☒	Projects	395	5.23	239.72	495225.56	
Remote Monitoring and Support Total:							19589136.00
Remote Monitoring and Support - Each	☒	Each	2359	1.00	562.75	1327527.25	
Remote Monitoring and	☒	Hours	2359	687.50	11.26	18261608.75	

GRAND TOTAL:	3673675857.15
Total: Services included in capitation:	3673675857.15
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	78618
Factor D (Divide total by number of participants):	46728.18
Services included in capitation:	46728.18
Services not included in capitation:	
Average Length of Stay on the Waiver:	301

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support - Hours							
Residential Services (1-2 Bed AFH) Total:							***449578307.99***
Residential Services (1-2 Bed AFH)	☒	*Days*	*3075*	*290.63*	*503.06*	***449578307.98***	
Residential Services (Other) Total:							***1764686031.16***
Residential Services (Other)	☒	*Days*	*29427*	*282.27*	*212.45*	***1764686031.16***	
Self-Directed Personal Care Total:							***400501.60***
Self-Directed Personal Care	☒	*Hours*	*11*	*1676.30*	*21.72*	***400501.60***	
Skilled Nursing Services RN/LPN Total:							***5353157.84***
Skilled Nursing Services RN/LPN	☒	*Hours*	*114*	*1168.97*	*40.17*	***5353157.84***	
Specialized Medical Equipment and Supplies Total:							***1958713.62***
Specialized Medical Equipment and Supplies	☒	*Items*	*10493*	*209.74*	*0.89*	***1958713.62***	
Supported Employment - Small Group Employment Support Total:							***3997920.37***
Supported Employment - Small Group Employment Support	☒	*Hours*	*564*	*383.37*	*18.49*	***3997920.37***	
Supportive Home Care Total:							***770028814.10***
Supportive Home Care	☒	*Hours*	*30233*	*807.54*	*31.54*	***770028814.10***	
Training Services for Unpaid Caregivers Total:							***86940.82***
Training Services for Unpaid Caregivers	☒	*Hours*	*175*	*4.57*	*108.71*	***86940.82***	

GRAND TOTAL:	***3673675857.15***
Total: Services included in capitation:	*3673675857.15*
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	***78618***
Factor D (Divide total by number of participants):	***46728.18***
Services included in capitation:	*46728.18*
Services not included in capitation:	
Average Length of Stay on the Waiver:	*301*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation (Specialized Transportation) - Community Transportation Total:							**64962255.42**
Transportation (Specialized Transportation) - Community Transportation	☒	Trips	20548	156.20	20.24	**64962255.42**	
Transportation (Specialized Transportation) - Other Transportation Total:							**713745.24**
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	1017	32.98	21.28	**713745.24**	
Vehicle Modifications Total:							**806734.55**
Vehicle Modifications	☒	Each	106	1.29	5899.77	**806734.55**	
Vocational Futures Planning and Support Total:							**121330.40**
Vocational Futures Planning and Support	☒	Each	104	1.55	752.67	**121330.40**	

GRAND TOTAL:	**3673675857.15**
Total: Services included in capitation:	3673675857.15
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**78618**
Factor D (Divide total by number of participants):	**46728.18**
Services included in capitation:	46728.18
Services not included in capitation:	
Average Length of Stay on the Waiver:	301