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:

Appendix C.2.a. - Required all providers who have regular direct contact with a member to be subject to caregiver and criminal background checks. Previous language excluded providers serving self-directing members.

Appendix C.1/C.3. - Expanded existing supportive home care service to add bed bug inspection and/or extermination services.

Appendix B.6.c. - Updated qualifications for individuals performing initial member level-of-care determinations. Previous qualifications: four-year social work degree and specialized knowledge of managed long-term care target populations. New qualifications: Bachelor of Arts 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.

Appendix D.1.b. - Allowed United Community Center to provide both case management and other waiver services to Hispanic members in Milwaukee County.

Appendix D.1.d. - Updated to reflect that PIHPs must obtain provider signatures on the Member-Centered Plan (MCP) and distribute the MCP to the member's essential providers (as defined by the SMA).

Appendix G.3.b.i. - Removed MCP documentation requirements for members with complex medication regimens as it duplicates documentation requirements for the member assessment.

Appendix.5.b. - Defined one consistent methodology to determine member room and board financial obligation to be used by all PIHPs.

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 Waiver Renewal 2020

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.R04.00
Draft ID: WI.018.04.00

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

Regular Waiver

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

01/01/20

Approved Effective Date: 01/01/20

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 is the previously approved 1915(b) waiver. With this 1915(c) waiver renewal, the State has also submitted a corresponding 1915(b) waiver renewal.

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 State Plan Amendment (SPA) approved by CMS and effective 1/1/2008 amended Wisconsin's Medicaid state plan to extend the highly successful Medicaid/Medicaid Family Care Partnership program, which was originally authorized under §1115 waiver authority and provides integrated primary and acute care and long-term care to individuals with long-term support needs. The SPA allows certain categories of Medicaid beneficiaries to voluntarily enroll in managed care entities while complying with provisions of §1902 of the Social Security Act on statewideness, freedom of choice, or comparability.

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

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

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

H. Dual 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 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 overall quality of the long-term care system by focusing on achieving people's health and social outcomes
COST-EFFECTIVENESS – Create a cost-effective long-term care system for the future

Family Care is a risk-based capitated program that incorporates the consumer-centered values of Wisconsin's home and community-based programs and services in a managed care service delivery system. The target groups are frail elders, adults with physical disabilities, and adults with intellectual disabilities who have long-term care needs. The State Medicaid Agency (SMA) contracts directly with prepaid inpatient health plans (PIHPs) to deliver comprehensive long-term care 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.

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.

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

On 7/1/18, Family Care became statewide. Family Care has achieved lower per person costs than the fee-for-service HCBS waiver programs that it replaced. Furthermore, in 14 counties, including the State's two largest, Milwaukee and Dane, eligible persons may choose the Family Care Partnership Program. Partnership is a §1932(a)/1915(c) managed care model that provides one-stop, fully integrated health and long-term care services, combining the Family Care long-term care benefit with primary and acute health care services, including Medicaid and Medicare services. For dual eligibles, Medicare services are provided through a Medicare Advantage Fully Integrated Dual Eligible (FIDE) Special Needs Plan.

The SMA believes that its practice and policy with respect to paraprofessional direct home care services provided under this waiver are aligned with the federal Fair Labor Standards Act (FLSA). The SMA bases this judgment on the delineation of responsibilities for hiring, directing, and managing such workers, as specified in Appendix E, for members who self-direct their home care services as common law employers. When applying the Department of Labor's written interpretation, such workers would be solely the member's employee and not the joint employee of the member and the PIHP or the member and the SMA. As such, the waiver aligns with the FSLA. However, the SMA notes that, under the FLSA, a judgment on employer status ultimately depends on the unique facts of each case. Accordingly, because individual case facts may vary from the responsibilities specified in Appendix E, employer status might conceivably vary as well.

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 September 2018, the SMA extended an invitation to all of its stakeholders (contracted PIHPs, tribes, members of the long-term care community, advocates, providers, etc.) to provide any ideas they would like the SMA to consider in preparing this waiver renewal. The SMA received numerous submissions and conducted extensive review of the submissions.

Major Wisconsin newspapers contained public notices on 5/31/2019 that the draft Family Care 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/whatsnew.htm. The draft Family Care 1915(c) and (b) waiver renewal applications were posted for a 30-day public input period. The public input period ended July 1, 2019. As described in the newspaper publications, members of the public could request paper copies of the waiver renewal applications by sending an email request to dhsfcwebmail@wisconsin.gov or mailing a request to Attn: Family Care 1915(b) Waiver Renewal or Family Care 1915(c) Waiver Renewal, PO Box 309, Madison, WI 53701-0309.

Wisconsin tribes received written notice that the draft Family Care waiver renewal applications were available on the SMA's website for a 30-day tribal input period on 5/31/19. The SMA also provided in person tribal consultation on 5/7/19 at the Mid-Year Tribal Consultation Meeting and on 5/8/19 at the Tribal Health Directors Meeting. The written notice, agendas, and meeting notes are included with this waiver renewal submission.

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: Poole

First Name: Diane

Title: Chief of Family Care Policy and Federal Relations

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) 267-4896 **Ext:** ☐ **TTY**

Fax: (608) 266-5629

E-mail: Diane.Poole@dhs.wisconsin.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wisconsin**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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: DIANE POOLE

State Medicaid Director or Designee

Submission Date: Nov 19, 2019

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

Last Name: Poole

First Name: Diane

Title: Family Care Policy and Federal Relations Chief

Agency: Department of Health Services

Address: 1 W Wilson Street

Address 2:

City: Madison

State: **Wisconsin**

Zip: 53707

Phone: (608) 267-4896 **Ext:** ☐ **TTY**

Fax: (608) 266-5629

E-mail: diane.poole@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:

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.

The State assures that this waiver renewal will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The State will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

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

Comment: For the room and board methodology, hold residential providers harmless. SMA Response: The methodology determines the member's obligation. Rates are negotiated between the provider and the PIHP. The SMA does not set provider rates. The SMA continues to be committed to working with providers on residential issues.

Comment: Adjust room and board rates annually. SMA Response: Adjustments to the member's obligation will be annual, based on the HUD FMR.

Comment: Publish the SSI-E, FoodShare/SNAP and county-specific HUD rates. SMA Response: In response to public comments, the SSI-E cap was removed from the proposed room and board methodology. Foodshare and HUD data are available at www.dhs.wisconsin.gov/foodshare/fpl.htm and www.huduser.gov/portal/datasets/fmr.html.

Comment: Require capitation rates to reflect projected provider cost increases based on accepted cost data and indices. SMA Response: Capitation rates are required to be actuarially sound.

Comment: Establish a mandatory MLR of 85%/15% for PIHPs. Exclude direct care workforce funding when calculating MLR. SMA Response: CMS sets MLR requirements and dictates MLR service exclusions.

Comment: Residential providers should provide care management and daily care planning. SMA 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 . . . . "

Comment: Prohibit PIHPs from paying less than the applicable fee-for-service rate. SMA Response: Managed care arrangements delegate provider contracting and rate negotiations to PIHPs.

Comment: Allow PIHPs to cover room and board for members with inadequate resources, if doing so is more cost-effective than relocation. SMA Response: 42 USC 1396n(c)(1) prohibits using Medicaid dollars to pay for room and board. SMA-PIHP contract allows PIHPs to cover member shortfalls, but those payments cannot be used to determine future capitation rates.

Comment: Upon request of a residential provider and before rate settlement, require the PIHP to disclose the member's room and board obligation and cost of care and support. SMA Response: The member's room and board obligation is a matter between the member and PIHP. The member does not have any other residential financial obligation. The room and board methodology determines the member obligation; it does not set provider rates.

Comment: Require PIHPs to disclose to residential providers the methodology used to determine rates for care and support including member specific data. The disclosure must be timely and prior to any final rate settlement. SMA Response: PIHPs and their providers should negotiate terms that meet their operational needs.

Comment: Require PIHPs to use the full quarter for average acuity. If a PIHP uses the average CMI methodology, require it to use the CMI data from the full quarter. Otherwise, require it to pay based on the resident's actual RUG level. SMA Response: Managed care arrangements delegate provider contracting and rate negotiations to PIHPs. PIHPs and providers can include this in their contracts.

Comment: The description of the Ombudsman program says it is available to members age 18-59. The Board on Aging and Long Term Care provides similar services to people age 60+. SMA Response: Language accurately reflects the contracted ombudsman program.

Comment: The language in B.7 was better before and should be retained. SMA Response: Language was revised to more accurately respond to the question presented.

Comment: Add to home modification service: "Includes evaluation of the environmental accessibility needs of a member, including functional evaluation of the impact of the provision of appropriate home modifications in the member's home or customary environment." SMA Response: Service covers services or items related to the assessment of need for home modifications.

Comment: Appendix C-2 expands policy regarding "usual familial responsibilities" from parents of minor children and spouses to all relatives. Disagrees. The only relatives who have a legal responsibility to care for a member are parents of minors and spouses. Retain current language and fix inconsistent and broad policy. SMA Response: The SMA, in consultation with this

stakeholder, clarified this language to address this concern.

Comment: CMS' requirement for providers to sign and distribute the member-centered plan is unfortunate. Adds administrative burden without improving care or quality. Supports SMA's efforts to maximize privacy protections for members by limiting MCP distribution to essential providers. SMA should exercise discretion to lessen the impact of this requirement. SMA Response: The SMA will meet federal requirements, work to protect member confidentiality and reduce disruption to members and PIHPs.

Comment: Appendix E-1 (4/13): restore language from current waiver that requires IDTs to explain how the SDS budget was derived. SMA Response: Changes comply with the SMA-PIHP contract. Budget derivations are described in section E-2.b.

Comment: Appendix E-1 (6/13): Obligate PIHPs to make self-directed services a part of the Family Care narrative. Appendix E-2 (3/6): it is unclear which, if any, of the 3 methods a PIHP is using. Information about these methodologies (or the ones PIHPs use) has never been made publicly available. PIHPs do not release the specifics of their methodologies. The lack of transparency makes it difficult for clients to challenge their SDS budget. The SMA should publish a description of the methodologies that PIHPs use. SMA Response: The waiver (containing the methodologies) is posted on the SMA's website. The SMA may explore how to improve member awareness and transparency in the future.

Comment: Appendix E-2 (4/6): fails to explain how a member can request a budget adjustment and doesn't state his/her right to appeal the budget calculation. Members should get a notice of action and appeal rights when there is a budget determination. SMA Response: Language indicates member can discuss the budget with the PIHP, use the RAD tool to determine whether a budget is fair, and appeal the budget determination.

Comment: Ensure members have access to county mental health and substance use services. Increase accountability for PIHPs, care teams, ADRCs, and county behavioral health agencies to provide access. SMA Response: ADRC and county oversight is out of scope. PIHPs are responsible for providing services in the benefit package. Members may access these benefits as a waiver service or as a card service.

Comment: Add or expand a service to provide parenting supports for members who are parents. Could include parenting skills and classes, mentoring, and residential settings that can provide wraparound support for parents and children, like adult family homes. SMA Response: 42 CFR 440.180(b)(9) requires "other services requested by the agency and approved by CMS as cost effective and necessary to avoid institutionalization." It is unclear how parenting supports would help members avoid institutionalization.

Comment: Allow Uber and Lyft in addition to medical and non-medical providers like taxis. SMA Response: The SMA may explore these transportation options in the future.

Comment: Include pilot projects to demonstrate the advantages of care alignment. SMA Response: Unclear what pilot projects are being proposed.

Comment: Strike the requirement that Registered Nurses be on the Interdisciplinary Team. SMA Response: The inclusion of registered nurses helps protect members' health and safety.

Comment: Modify transportation service to allow creative billing solutions (paying families/community members, reimbursing mileage and fuel costs for volunteers, reimbursing for shared rides, etc.). SMA Response: The SMA may explore these transportation options in the future.

Comment: Require care plans to include the transportation services needed to meet plan goals. When families provide transportation, it should be documented in the care plan. SMA Response: Language requires all necessary and authorized services to be included in the member-centered plan.

Comment: Add remote support technologies and remote monitoring services; include training for care managers, providers, families, and members on these. SMA Response: Various technologies are covered. More detail needed to respond.

Comment: Add a service for provider, member, and family training on alternatives to guardianship including Supported Decision-Making and its use within person-centered planning. SMA Response: Legal services are not a covered benefit.

Comment: Require Supporters identified in Supported Decision-Making agreements to be included in the person-centered planning process, member directed services process, and any other processes where the member is asked to make a decision that

falls within the scope of the supported decision-making agreement. SMA Response: Items listed are part of the MCP process. Waiver allows the member to involve whomever s/he would like.

Comment: Add self-advocacy training service. SMA Response: Added language to Consumer Education and Training service to reflect self-advocacy skills development.

Comment: Require care teams to work with families to develop a succession plan to ensure children can live in community supported living or other non-provider operated settings and avoid high cost, restrictive residential placement. SMA Response: Language was added to the Care Management service to include developing a plan to ensure continuity of a member's independence, care, living arrangements, and preference.

Comment: Add services from Tennessee's Employment and Community First CHOICES waiver. SMA Response: The SMA may explore including these services in the future.

Comment: Add employment navigator services. SMA Response: Covered under existing employment services; however, the SMA may explore this as a standalone service in the future.

Comment: Continue to include paid coworker supports Supported Employment service definition. SMA Response: This was retained.

Comment: Add the IRIS waiver language that requires plan review after two years of prevocational services. SMA Response: Prevocational providers must complete a six-month progress report and service plan to assure services are assisting members progress toward integrated employment. If progress is not made, the PIHP will work with the member and provider or adjust the MCP.

Comment: Add Building Full Lives service. SMA Response: The Building Full Lives approach/service is duplicative of the daily living skills and day services.

Comment: Provide money management and limit use of rep payees. SMA Response: Waiver includes financial management services.

Comment: Allow self-direction of all services. SMA Response: Not every service accommodates self-direction (e.g. residential services, case management).

Comment: Participants should have full budget and hiring authority. SMA Response: Budget and employer authority is permitted for nearly every service.

Comment: The self-directed option must allow participants to set their own goals. SMA Response: This is allowed.

Comment: Participants who self-direct services should not have to consult with IDTs. SMA Response: Family Care is a managed care program. PIHPs are responsible for the member's health and safety. Thus, IDTs must work with the member to assure the member's wellbeing.

Comment: Ensure that people only receive services they want and need. SMA Response: This is the program model.

Comment: Ensure all individuals, including high-cost individuals, have the right to live in the community and receive services in the least restrictive setting. SMA Response: This is the program model.

Comment: Develop plans to increase provider capacity in geographic areas and service categories that lack capacity. SMA Response: More detail needed to respond.

Comment: Reduced transportation service is increasing isolation. SMA Response: PIHPs are required to provide services identified in the MCP.

Comment: PIHPs are squeezed by the State's cuts to the capitated rate. SMA Response: Capitation rates are required to be actuarially sound.

Comment: From January through April of 2019, people with disabilities were institutionalized on an emergency basis for a total of 148 days. This number surpasses the combined totals for 2017 and 2018. SMA Response: More detail needed to respond.

Comment: Fragmentation of the current system makes accountability challenging. SMA Response: More detail needed to respond.

Comment: A Dane County provider was concerned with a 60% rate cut. SMA Response: PIHPs negotiate rates with providers.

Comment: Disappointed by a lack of transportation services. SMA Response: PIHPs are required to provide services identified in the MCP.

Comment: Inadequate funding threatens the stability of the managed care system. SMA Response: More detail needed to respond.

Comment: Positive outcomes for people with disabilities are threatened without improvements to Family Care. SMA Response: More detail needed to respond.

Comment: Heartening to see Dane County awarded a grant from DHS to confront this increase within the managed care system. SMA Response: More detail needed to respond.

Comment: Change of PIHPs and/or providers is a disruption. SMA Response: More detail needed to respond.

Comment: The biggest issue is lack of good caregivers. SMA Response: PIHPs are required to develop adequate and qualified provider networks.

Comment: For parents who need to hire their own staff, there is not a suitable backup plan. SMA Response: More detail needed to respond.

Comment: Promote person-centered relationships throughout the system. SMA Response: This is the existing program model.

Comment: Work with Dane County to provide financial support for transportation solutions. SMA Response: More detail needed to respond.

Comment: Monitor quality assurance and contract negotiations for Family Care and IRIS. SMA Response: The SMA provides oversight of PIHPs. PIHPs negotiate service provider contracts.

Comment: There is caregiver fraud. SMA Response: Fraud should be reported to the PIHP and/or SMA.

Comment: People with disabilities should be allowed to become caregivers. SMA Response: This is allowed.

Comment: The member should choose how they access the community. SMA Response: This is the existing program model.

Comment: Transportation needs to be a priority. SMA Response: PIHPs must provide services identified in the MCP.

Comment: Participants need to know about quality improvements so they don’t accept delays in service. SMA Response: More detail needed to respond.

Comment: Reimburse direct care workers’ mileage. SMA Response: The provider and PIHP negotiate rates.

Comment: Provider training costs should be reimbursed. SMA Response: The provider and PIHP negotiate rates.

Comment: Family Care members should be educated on working with direct care professionals. SMA Response: These opportunities exist in the consumer education and training and/or habilitation services.

Comment: Explore opportunities to expand and formalize risk-sharing between PIHPs and providers. SMA Response: More detail needed to respond.

Comment: Fund training for recognizing and addressing social determinants of health. SMA Response: The member-centered planning process includes assessing all member needs.

Comment: Cover environmental assessments. SMA Response: This is covered.

Comment: PIHPs should cover IMD placement and crisis services. SMA Response: Federal law excludes IMD placement. Crisis services are available through fee-for-service.

Comment: The PIHPs capitated rates do not cover costs for members with complex needs. Create a 3rd tier for members in a psychiatric hospital waiting for a new placement. PIHPs should pay for members who wait for placement in a transitional facility, not an IMD. SMA Response: Capitation rates are required to be actuarially sound.

Comment: Include a tiered rate structure to enhance wages for workers serving individuals or populations with higher health care and support needs. SMA Response: Capitation rates are required to be actuarially sound. Provider rates are negotiated between the provider and PIHP.

Comment: Include a tiered rate structure to enhance wages for workers in areas with provider shortages. SMA Response: Capitation rates are required to be actuarially sound. Provider rates are negotiated between the provider and PIHP.

Comment: Include inflationary rate increases for providers, with targeted funds for increasing wages and/or benefits of direct care workers. SMA Response: Capitation rates are required to be actuarially sound. Provider rates are negotiated between the provider and PIHP.

Comment: Unbundle transportation from the residential service. SMA Response: State Administrative Code requires 3-4 bed AFHs, CBRFs, and RCACs to provide transportation.

Comment: Reinstate retroactive eligibility for Family Care benefits back to application date. SMA 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: Adjust direct care worker pay rates in counties bordering other states so direct care worker rates compete with rates in adjacent states. SMA Response: Capitation rates must be actuarially sound. PIHPs and providers negotiate rates.

Comment: Modify background check requirements to ensure qualified workers are not excluded from the workforce based on minor infractions and align requirements among all long-term care programs. SMA Response: The program complies with statutory background check requirements.

Comment: Add caregiver training for unpaid caregivers. SMA Response: Services exist: training services for unpaid caregivers and consultative clinical and therapeutic services for caregivers (paid and unpaid).

Comment: Use the same reimbursement rate for institutional and HCBS services. Using the same acuity-adjusted Per Member Per Month rate for institutional and HCBS services creates incentives for PIHPs to avoid institutional placements and transition to other settings. SMA Response: Capitation rates are required to be actuarially sound.

Comment: Give incentive payments to PIHPs with high community transition rates. Hold PIHPs at full risk for Nursing Facility admissions and use a reconciliation process to encourage PIHPs to transition residents to the community. SMA Response: The program model provides this incentive.

Comment: Include the population in the state centers for the developmentally disabled and other ICF-IDs in the capitated rate, incentivize deinstitutionalizing that population. SMA Response: More information is needed to respond.

Comment: Use a rate structure to incentivize individualized, community-based supports—including integrated employment, integrated day services, and independent living— rather than congregant settings. SMA Comment: This is the existing program model.

Comment: Establish Community Supported Living and residential supports provided by workers not affiliated by a provider agency as the first/preferred option for reimbursable residential supports. SMA Comment: Services available through “Community Supported Living” are available under existing waiver services. The FC model offers member choice to select providers.

Comment: Reward PIHPs for piloting integrated community day programs that meet service delivery outcomes including independent living skills experience and training, opportunities to build relationships and natural supports; opportunities to engage in activities/interests of the person like in adult education, volunteering, community activities, and recreation/leisure

opportunities. Pilots should collect data to measure performance and outcomes. SMA Response:Funding pilots is not a waiver service.

Comment: Enhance rates in rural areas to incentivize development and increases in provider capacity. SMA Response: Capitation rates must be actuarially sound. PIHPs and providers negotiate rates.

Comment: Incentivize integration efforts that result in reportable outcomes (specifically integrated employment, transportation to employment, integrated day services, living in non-congregate residential settings.) SMA Response: Capitation rates must be actuarially sound. PIHPs and providers negotiate rates.

Comment: Modify housing counseling service to include identifying affordable housing and checking and matching for section 8 public housing vouchers. SMA Response:Existing service includes identifying/assisting in access to financing for housing. However, service is excluded if it is otherwise provided free to the public.

Comment: Revise employment services to differentiate between services for reaching community integrated employment outcomes and revise the rate structure so that higher rates are paid for community integrated employment services. SMA Response: The SMA may explore further development of employment services in the future. PIHPs and providers negotiate rates.

Comment: Encourage PIHP employment service provider contracts to have higher payments for competitive integrated employment outcomes and factor the member's acuity into the rate-setting methodology. SMA Response: PIHPs and providers negotiate rates.

Comment: Expand community integrated employment/supported employment service to members at the non-nursing home level of care. SMA Response: Members at the non-nursing home level of care are not eligible for community waiver services per 42 CFR 441.301(b)(1)(iii).

Comment: Add accessibility assessments service, which may include the following components: Adaptive Aids, Assistive Technology/Communications Aids, Home Modifications, Environmental Accessibility Adaptions, Vehicle Modifications. SMA Response: Language added to existing services to clarify that assessments are included.

Comment: Include access to the Adaptive Aids program and diagnostic capacity housed within Central Wisconsin Center. SMA Response: PIHPs can contract with the CWC.

Comment: Include Supporters identified in Supported Decision-Making agreements in person centered planning and participant directed services. SMA Response: Language added to the member-centered planning process in section D-1.d.

Comment: Train caregivers and providers to care for their son with I/DD. SMA Response: Caregiver training is available under the waiver. PIHPs must contract with qualified providers.

Comment: Carve out mental health services. PIHPs lack the expertise to serve members with a mental health diagnosis. SMA Response: All PIHPs have mental health and behavioral health specialists or access to a specialist when needed.

Comment: Require PIHPs to place members as soon as discharged from inpatient IMDs/hospitals. SMA Response: SMA and PIHPs work with the IMD on discharge planning so residential plans are in place when the member is ready for discharge.

Comment: Require a doctor's referral in order to get a Functional Screen Assessment for eligibility into the program. SMA Response: Functional screen requires verification of physician diagnosis.

Comment: Clarify Appendix D-1 (4/8) by adding "Regardless of who initiates a review and update of a member centered plan, the member remains at the center of the decision making." SMA Response: This is the program model.

Comment: IDTs should include family members in problem solving to develop back up plans, but IDTs should not expect them to be the primary back up. SMA Response: Members may include anyone they wish in developing the MCP, which includes developing back up plans. Family is not required to participate.

Comment: The application retains the limit of requests for new IDTs to 2 times/year but adds "…if IDTs are available." Add "…unless there is a strong and justifiable reason that IDTs are not available." SMA Response: The SMA declines to require that 2 IDTs be available at all times.

Comment: Objects to changing restrictive measure reporting from monthly to quarterly. SMA Response: Restrictive measure use requires SMA approval prior to implementation. The reports are a summation of approved measures.

Comment: Provide trauma-informed care training to IDTs, IRIS Consultants, and direct care staff. SMA Response: Out of scope of the waiver for IRIS consultants. IDTs must have the necessary training to perform their duties. Direct care staff can receive training via consultative clinical and therapeutic services for caregivers and/or training services for unpaid caregivers.

Comment: Require PIHP IDT members and mental health and substance abuse treatment professionals to have knowledge of recovery concepts, evidence-based practices for mental health and substance abuse treatment, and trauma informed assessment and services. SMA Response: State Plan service requirements are out of scope of the waiver. All PIHPs have mental health and behavioral health specialists or access to a specialist when needed.

Comment: Reasonable accommodations must be documented in the MCP. SMA Response: This is required.

Comment: Certified Peer Specialists service should be added. SMA Response: This service is available fee-for-service.

Comment: Increase provider capacity for community based, IDD-informed psychotherapy. Consider clinicians experienced in serving persons with IDD and behavioral health needs, especially when there is a history of trauma. SMA Response: IDD-informed psychotherapy is in the benefit package. PIHPs are required to provide services identified in the MCP.

Comment: Encourage advance crisis planning and coordination with law enforcement, community mental health practitioners, and counties who have statutorily defined responsibilities for providing crisis care. SMA Response: Out of scope. The SMA, PIHPs and counties continue to explore crisis options.

Comment: Require MCPs to assess transportation needed to meet plan goals, transportation resource mapping, and a transportation analysis based on the following factors: a) Reliability, ride is timely b) Availability, can be used routinely c) Flexibility, can use after business hours/on weekends d) Affordability, fares/charges are within care plan or self-directed services budget e) On-demand scheduling, don’t need to schedule days in advance f) Geographic range, can go farther /major destinations, next town or county g) Accessibility, vehicle can meet member’s mobility and other disability related needs. SMA Response: Transportation is in the benefit package.

Comment: Remove the master’s degree requirement from Vocational Futures Planning Support service definition but require certification using the advance training from the VSPS training program (www.vfpstraining.com). SMA Response: The SMA may explore revising provider requirements in the future.

Comment: Modify the integrated community day program service to clarify services meet outcomes including independent living skills experience and training, opportunities to build relationships and natural supports; opportunities to explore and engage in activities/interests of the person like in adult education, volunteering, community activities, and recreation/leisure opportunities. Include data to measure performance and outcomes of integrated day services. SMA Response: More detail needed to respond.

Comment: Include mechanisms for providers and members to report/document services that were not received, delivered incompletely/partially, late, provided by substitute staff or completed by family members or informal supports because paid/authorized providers were unable/unavailable. SMA Response: Members can report to the PIHP, SMA, Ombudsman, or EQRO. Providers can report to the PIHP, SMA, or Ombudsman.

Comment: Guarantee that services will not be reduced, changed, or ended without a documented change in needs that can be independently reviewed and appealed. SMA Response: The RAD process evaluates and documents member needs and corresponding services (with duration of service). A new RAD is required when a member’s needs and services change.

Comment: Require at least one non-disability specific integrated residential, day, and employment setting, and service delivery option be available in all areas of the state without wait lists. SMA Response: PIHPs are required to have adequate provider networks.

Comment: Require all working-age members to have a community integrated employment goal in their care plan. SMA Response: The member care plan is member specific and based on needs, goals, and outcomes.

Comment: Expand Accessibility Adaptations (Home Modifications) to address social determinants of health that lead to worsened health conditions. SMA Response: Unnecessary. Currently covered under supportive home care or environmental

accessibility adaptations (home modifications).

Comment: Retain current one-year contract period. SMA Response: Current SMA-PIHP contract is for a two year period.

Comment: Revise provider qualifications for adaptive aids to clarify that the "reputable provider with experience providing and training service dogs" does not serve as a limitation on which dogs may have their ongoing maintenance costs reimbursed. SMA Response: The SMA declines to cover the costs (purchase, training, or maintenance) of non-professionally trained dogs. The proposed language has been modified to clarify this.

Comment: Include PIHP incentives to support independent living such as the Supported Independent Living ("SIL") model. SMA Response: It is unclear how the SIL model would differ from the Family Care model.

Comment: Providers awaiting the SMA's determination of HCBS settings rule compliance should receive funding. SMA Response: New settings must meet all HCBS requirements. Ongoing settings may receive funding until the SMA determines they are "non-compliant."

Comment: PIHPs and providers verbally requested removal of the SSI-E cap from the room and board methodology. SMA Response: The SMA made this change.

Comment: Capitated rates are insufficient to cover the costs of complex needs members, ie, placements from an IMD. SMA Response: Capitation rates must be actuarially sound.

Comment: Capitated rates are insufficient to cover member care costs. SMA Response: Capitation rates must be actuarially sound.

Comment: Enable members to self-identify any cultural or linguistic preferences and any other information they feel pertinent to delivery of individualized services. SMA Response: Provided in 1915(c) waiver (WI.0367), B-8, D-1.c., and D-1.d., and 1915(b) waiver (WI.0007), A.IV.A.2.b.3. and A.IV.B.2.a.

Comment: Add language translation and interpretation as a service, available upon request, for written materials and verbal meetings, guaranteed to be timely, for any language (including ASL). SMA Response: Provided in 1915(c) waiver (WI.0367), B-8, D-1.c., and D-1.d., and 1915(b) waiver (WI.0007), A.IV.A.2.b.3. and A.IV.B.2.a.

Lac Courte Oreilles Tribe:

Comment: Appendix B-7.a. states that if the individual is an Indian, s/he is informed of the option to choose to receive services from the IHCP (if available) or PIHP network. S/he may choose to receive services from both. SMA Response: Language revised to, "…IHCP (if available) and/or PIHP network providers" for clarity.

Comment: Appendix D-1.e.states"Member handbooks are provided to every member and describe the process for requesting an out-of-network provider…" The PIHP member handbook that is distributed to Indians should include language regarding Indians' rights and protections. It is not enough to provide a member handbook to a person who is within a vulnerable population. Also, all rights and protections should be explained to Indians during options/enrollment counseling. SMA Response: Out of scope.

Comment: 42 CFR Title Part 438 establishes requirements that apply to PIHP, PAHP, and PCCM contracts involving Indians, Indian health care providers and Indian managed care entities. Reference 42 CFR 438.14 in relevant sections to assure compliance with federal requirements regarding Indians and Indian health care providers. SMA Response: Out of scope of the waiver instructions.

Comment: Appendix A3. Add the IHCP and TADRS as contracted entities. Respect the tribe as a federally recognized tribe and a sovereign political government. Respect the government-to-government relationship between the state and the tribe. Remove barriers to American Indian participation in Medicaid. IHCP care managers perform in the same manner as the PIHP care managers. The TADRS is a contracted position under a TADRS Scope of Services Agreement between the SMA and Tribe. The description of the TADRS functions that can include using the SMA's automated Long Term Care Functional Screen Tool should be added to this section. SMA Response: The SMA recognizes that the IHCP provides an important role on behalf of American Indian Family Care members. However, this section of the waiver is for entities providing waiver operational and

administrative functions on behalf of the SMA. As such, the waiver would only reflect the administrative functions of the Tribal Aging and Disability Resource Specialist pursuant to the Scope of Services Agreement. The SMA has now updated the waiver language to reflect this in response to this comment. The SMA-IHCP-PIHP agreement does not delegate waiver operational and administrative functions to the IHCP; rather it outlines the roles and responsibilities of the parties when an IHCP provides the case management service.

Comment: The TADRS should be listed in Appendix A.6.Assessment Methods and Frequency. The methods used to assess the TADRS' performance includes monthly information and assistance activity reports, monthly expenditure reports, monthly time reports, annual expenditure report, and an annual narrative/update. The IHCP will perform the same functions as the PIHP care managers and the methods used to assess performance by agency type should include the IHCPs in addition to PIHPs. Separate data for IHCPs should be collected and SMA oversight teams should meet directly with the IHCP related to member specific issues or concerns, member incidents, etc. SMA Response: This section is to assess performance of contracted entities that perform waiver and administrative functions in accordance with waiver requirements as described in Appendix A.3.

Comment: Appendix A.Quality Improvement. 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. IHCP care managers perform waiver functions; however, the PIHP has oversight responsibility, thereby creating a subservient relationship of a sovereign political government to a nongovernmental entity. SMA Response: This section is to assess performance of contracted entities that perform waiver and administrative functions in accordance with waiver requirements as described in Appendix A.3.

Comment: Appendix A.a.i. Performance Measures: General Comments. Performance measures should be revised to include both PIHPs and IHCPs. Monitoring IHCP data separately allows the tribe and SMA to recognize the need for technical assistance, policy development, and/or other quality related strategy that leads to quality improvement when necessary. To preserve, improve, and protect the health and safety of our most vulnerable tribal citizens is of great importance to the Tribal Governing Board, and as a political government the tribe has a right and responsibility to monitor performance measures. SMA Response: This section is to assess performance of contracted entities that perform waiver and administrative functions in accordance with waiver requirements as described in Appendix A.3.

Comment: Appendix B-6 b. Responsibility for Performing Evaluations and Reevaluations. In addition to the PIHP, note that IHCPs perform level of care reevaluation for members. SMA Response: Level of care reevaluation is a waiver administrative function and is the responsibility of the PIHP. IHCPs may contract with PIHPs to perform this administrative function. Two IHCPs are currently doing this. Subcontract arrangements like this are not reflected in the waiver.

Comment: Appendix B-6 c. Qualifications of Individuals Performing Initial Evaluation. Lac Courte Oreilles recognized the validity in the requirement that a qualified screener must pass the online training to prepare the individual to use the SMA's automated long-term care functional screen tool. Further, we agree with the State's lawmakers who place value on experience and formal and on-the-job training as evidenced by Wisconsin Administrative Rule DHS Chapter 10. The tribe recommends SMA review of Administrative Rule found within DHS 10.23(5) that set forth the staff qualifications to perform the functional screen. It is further recommended that the staff qualifications written into the waiver remain consistent with the established Wisconsin Administrative Rule, without omission of parts of the whole rule, and that includes that the individual be competent and shall meet one of the following three requirements:

10.23(5)(b)2.a. the Bachelor of arts or science, or

10.23(5)(b)2.b. four years of post-secondary education and experience or an equivalent combination, or

10.23(5)(b)2.c. Other experience, training or both, as approved by the department based on a plan for providing formal and on-the-job training to develop the required expertise. The TADRS Scope of Services agreement between the SMA and Lac Courte Oreilles Tribe sets forth the operational and administrative requirements and services for services to be provided by the TADRS. In addition to the required services, the Lac Courte Oreilles elect to provide the optional services, including eligibility and enrollment functions for publicly funded long-term care. It is important to Lac Courte Oreilles to recruit and hire staff that reflects the backgrounds of our service population. Lac Courte Oreilles' philosophy is that maximum employment of tribal citizens in the provision of LTSS and maximizing enrollment of tribal citizens into Medicaid waiver programs go hand-in-hand. We know that tribal citizens are often reluctant to seek services that are outside of the tribes service delivery system. Therefore it is important that tribal hires conduct the functional screens. The educational requirement of a Bachelor's degree may potentially create a barrier that negatively impacts our ability to hire tribal members and/or it may be a barrier to tribal hires becoming certified functional screeners. Lac Courte Oreilles places value on education, however, we recognize that higher education does not necessarily equate to higher quality staff. Because trust is the principle element to tribal citizens seeking and accepting services, in our community emphasis is placed on the importance of cultural competence and sensitivity, familiarity and trust when hiring qualified staff. It is important that the tribe recruit and hire staff that our membership is comfortable with and with whom members will choose to share their personal information. The expectation of Lac Court Oreilles is that the TADRS

adheres to the unbiased, person-centered enrollment counseling. Further, in-person and online training already exists to develop ADRC Specialists skills in the provision of services for determination of functional eligibility, facilitation of the financial eligibility process, enrollment, and more, and the same training is expected to be available to the TADRS. The completion of required training and the ability to administer the automated Long Term Care Functional Screen Tool, complete the certified screener continuing knowledge and skills test, meet the requirements outlined in the ADRS Scope of Service, and provide culturally appropriate service are the greater qualifying measures for a successful TADRS than is whether the individual has a Bachelor's degree. SMA Response: DHS 10 allows a variance to the minimum education requirements for ADRCs only. ADRCs conduct the initial screen only. Re-screening in Family Care program requires the teams and the screener to perform an assessment of the individual, identify risks, and develop a care plan based on the member's needs.

Comment: Appendix B-6 c. Identify that records of TADRS screener's education and experience credentials are created and maintained by the IHCP. SMA Response: This question only asks about the qualifications of Individuals Performing Initial Evaluations. Extra language was removed.

Comment: Add reference to TADRS and IHCP in Appendix B-6 f. SMA Response: Reference to TADRS has been added for new enrollees. Level of care reevaluations are an administrative function and are the responsibility of the PIHP. IHCPs may contract with PIHPs to perform this administrative function. Two IHCPs are currently doing this. Subcontract arrangement such as this are not reflected in the waiver.

Comment: The IHCP should be added as sharing the same responsibility in Appendix B.6.i. SMA Response: Level of care reevaluations are an administrative function and are the responsibility of the PIHP. IHCPs may contract with PIHPs to perform this administrative function. Two IHCPs are currently doing this. Subcontract arrangement such as this are not reflected in the waiver.

Comment: Appendix B-6 j. Add access to newly activated screens for those who receive care management services from the IHCP. SMA Response: Response went beyond answering the question asked. Removed excess language.

Comment: Performance measures for the sub-assurances a. and b. in Appendix B. should apply to the IHCP in addition to the PIHP. SMA Response: Level of care reevaluations are an administrative function and are the responsibility of the PIHP. IHCPs may contract with PIHPs to perform this administrative function. Two IHCPs are currently doing this. Subcontract arrangement such as this are not reflected in the waiver.

Comment: Add that copies of member-centered plans, for Indians that choose care management service from the IHCP, will be maintained by the IHCP. SMA Response: Per the SMA-IHCP-PIHP Agreement, the Indian Health Care Provider (IHCP) must utilize the PIHP's electronic case management system for maintaining member records.

Comment: List the PIHP and IHCP as the entities responsible for verification of provider qualifications. SMA Response: Per the SMA-IHCP-PIHP Agreement, the IHCP shall only use third party providers that meet SMA requirements. All case management providers are required to utilize qualified providers. All case management providers are not listed in the waiver.

Comment: Because the IHCP case manager will perform the same functions as the PIHP care managers, the IHCP should be added whenever the PIHP is named in Appendix C (or generalize to include all providers). SMA Response: Per the SMA-IHCP-PIHP Agreement, the IHCP shall only use third party providers that meet SMA requirements. All case management providers are required to utilize qualified providers. All case management providers are not listed in the waiver.

Comment: Add that the IHCP may only enter a provider agreement with adult day care centers that have been certified. SMA Response: Per the SMA-IHCP-PIHP Agreement, the IHCP shall only use third party providers that meet SMA requirements. All case management providers are required to utilize qualified providers. All case management providers are not referenced in the waiver.

Comment: Modify the language throughout Appendix D and create transparency on the responsibilities and requirements of the IHCP and role of the TADRS. SMA Response: Need more detail. The current language accurately reflects the roles of the IHCP and PIHP.

Comment: Identify the TADRS role in Appendix D-1 d. SMA Response: The SMA added this reference.

Comment: Performance measures should be applicable to IHCPs. SMA Response: Quality and performance measures are used to assess contracted waiver entities. Tribes are not a contracted waiver entity, but are able to apply to become one.

Several public comments were received that were out of scope of the waiver. The SMA response is "out of scope of waiver":

- Require PIHPs to timely disclose how they arrive at rates, with member-specific data.
- Require PIHPs to share members' LTCFS or other assessment data with residential providers.
- Secure a waiver to pool/consolidate Medicare and Medicaid funding and authorize provider-based long-term care organizations to provide care management services to dual eligibles.
- Pursue options for caregivers receiving BadgerCare benefits to work additional hours without fear of losing benefits.
- Ensure the direct care workforce funding is a separately identified payment to providers.
- Statutorily grant residential providers the right to appeal a PIHP's decision to reduce provider rates when not related to acuity or service reductions.
- The SMA received links to nearly identical letters with numerous suggestions, dated 4/30/18 and 10/10/18. These letters are attached to the waiver submission for reference.
- The effective date of the new rate (RUG) when a new MDS is completed should be the Assessment Reference Date, like when a new rate is effective for Medicare.
- Give providers access to the electronic MDS information so PIHPs know when a resident's rate needs to change.
- Correct flaws in the functional screen and its instructions.
- Acknowledge the DQA's incapacity to monitor facilities and respond adequately to complaints that do not involve abuse, neglect, poor care or unsafe conditions. DMS should create a specialized investigative unit to investigate complaints of lack of integration and other HCBS rule violations.
- Wants to work with the SMA on the direct care workforce shortage and enhancing provider capacity.
- Aligning long-term care with acute and primary care should be the SMA's top policy goal.
- Pay increases, extension of benefits, or other flexibilities given to agencies to promote worker retention should be given to the entire waiver workforce.
- Require providers to confirm the identity of member's guardian and scope of the guardian's decision-making authority by retaining a copy of the letter of guardianship.
- Add service for provider training on guardians' duties and decision-making authority.
- Add "continuous outcome improvement initiatives" service to reimburse evidence-based pilot projects/approaches that seek to increase community integrated employment, transportation options, and community living outcomes for people with disabilities.
- Provide information that supports alternatives to guardianship.
- The Family Care contract should require data collection and reporting on the number of people self-directing services.
- Require training to be certified as a "preferred provider" by meeting performance-based outcomes.
- Require PIHPs to post employment outcomes data on a public website.
- Require data collection and reporting of key non-clinical quality of life indicators and participant experiences.
- Focus on data collection to shift funds toward the highest investment return. Track expenses for integrated employment compared with other day services.
- Praised ADRCs.
- A small sample of IRIS participants showed that most people who chose IRIS are reasonably satisfied with their services.
- Getting reimbursed for Durable Medical Equipment (DME) is problematic because of new "red tape."
- A SSI Managed Care provider wanted to become familiar with resources for a client.
- IRIS consultants are not consistent.
- Provided information about a survey of IRIS recipients.
- Programs are removed from local control and accountability.
- Inability in the managed care system to be nimble during crises.
- Need for Support Brokers in IRIS.
- Need for quality control in the IRIS program.
- Parent provided testimony related to child in IRIS.
- IRIS is putting budgets first, not person-centered care.
- Better experience with IRIS, still a fair amount of issues.
- There is a caregiver crisis for the Developmental Residential facilities.
- Testimony about IRIS.
- Family Care no longer provides list of people looking for roommates.
- Rocky past year experience switching to IRIS.
- Person wrote about her experiences from the perspective being elderly with autism.
- Person wrote about the overall budget under IRIS.
- Inconsistencies of IRIS Consultants.
- More adult day care centers with hours from 7am-7m.
- Wants specific requirements for CBRFs offering memory care.

- Require CBRFs to accept people who are two-person transfers or list CBRFs that accept two-person transfers.
- Wants website like YELP that provides consumer reviews of assisted living and nursing home facilities.
- Wants more funding for quality monitoring of assisted living facilities and nursing homes.
- Consider moving quality monitoring of assisted living facilities and nursing homes from the State to the County.
- Plan for aging population.
- Disappointed with changes coinciding with the switch over to FC/IRIS.
- Wants monthly newsletter for aging folks.
- Continue to monitor and provide the necessary funding.
- Institutions should be closed and institutional staff should be employed in the community.
- People need to understand what guardianship is.
- Participants need to be educated about the right to vote.
- Personal care agencies need better information about sharing about employees.
- Create a data-sharing process for communication between agencies and IDTs.
- Eliminate the settings restriction for personal care.
- Require residential facilities to accept Family Care payments as payment in full.
- Members should be educated on the ability to receive 24-hour care.
- Indicate that the “caretaker child” exception applies to Family Care.
- Caseworkers handling functional screen requests should not address financial eligibility.
- Establish a rate to reimburse personal care workers for transportation (mileage, bus fare, etc.) between client homes.
- Hire an external contractor to conduct an assessment of current network capacity, project needed capacity and inform actuaries to lead to more accurate rate setting.
- Redefine “imminent risk of institutionalization” to recognize the growing number who meet nursing home level of care and whose ability to live and work independently in the community is at risk without adequate services.
- Issue guidance to home care and personal care provider agencies to explain how low-income caregivers can access BadgerCare benefits.
- Contract with an interface used by all PIHPs to enable members to match their needs with available workers, schedule support, and track hours.
- Create an incentive payment structure for PIHPs to reimburse costs for care planning that occurs before individuals enroll and relocate from institutions, as well as actual relocation costs.
- Use a tiered bonus system to reward PIHPs with higher ratios of service providers to participants and high community outcomes—participants successfully working in community integrated employment, living independently etc.
- SMA-PIPH contract should require working-age members have a community integrated employment goal, integrated employment outcome targets, performance metrics for employment services, specific data collection and reporting requirements, and tie employment outcomes to incentives.
- Waive certain residential licensing policies that prohibit use of remote support technologies in otherwise appropriate circumstances.
- Testimony about IRIS.
- Require DHS, PIHPs, and counties to jointly assess how mental health and substance abuse disorder needs are being addressed.
- Add a mechanism within the MCP for providers to document a member’s capacity for greater community integration and for the member to indicate their wishes for greater community integration when a guardian’s decision-making may result in a more restrictive residential placement or employment setting than the member desires.
- Direct PIHPs to require provider entities to self-assess their cultural and linguistic competence using an evidence-based tool.
- Members using pre-vocational services should be provided with targeted information to facilitate progress toward community integrated employment goals.
- Create a system to give providers up-to-date information when a member switches PIHPs or switches from Family Care to IRIS or vice versa.
- Require PIHPs to place members when members are ready for discharge from inpatient IMD’s or hospitals. Members have not received services while on decertified status in IMD’s because the PIHP does not have a transitional placement contract with its vendors or won’t develop one because of cost. This practice violates their rights to least restrictive treatment under WI Statute 51.
- Individual indicated day presents many challenges – is able to the bathe and dress. However, then problems begin.
- Mandate and fund an Ombudsman to member ratio of 1:2500.
- In one PIHP rural areas allow grieves/appeals of PIHP actions that deny a member’s right to out of network services.
- Improve mental health and/or substance abuse disorder supports and services.

The following public comments were out of scope of the waiver, however, the SMA provided an additional response:

Comment: Require PIHPs to notify the SMA when an involuntary residential discharge is due to a provider rate reduction. SMA

Response: Out of scope. Required by the SMA-PIHP contract.

Comment: Give members the right to grieve or appeal relocation when the provider will not accept a rate cut. SMA Response: Out of scope. Members can appeal an MCP which specifies residential placement.

Comment: Limit relocation to a facility of close proximity (30 miles or less) to the resident's current facility or 10 miles or less from the community spouse's residence. SMA Response: Out of scope. Multiple factors must be considered such as the member's health/medical needs and preferences.

Comment: Require PIHP to comply with its transition of care policy. SMA Response: Out of scope. Required by SMA-PIHP contract.

Comment: Require PIHPs to update the LTCFS or related assessment tool within 30 days when a residential provider reports a change in member condition raising the level of care and services. SMA Response: Out of scope. The SMA-PIHP contract requires a re-screen whenever a member's condition or situation changes significantly. The PIHP, not the provider, determines what is significant.

Comment: Require PIHPs to grant retroactive nursing home rate increases as provided in the fee-for-service system. Put this in statute. SMA Response: Out of scope. Included in the SMA-PIHP contract.

Comment: Require the Legislative Audit Bureau to report on capitation rate setting and rates passed on to providers. Include how rates reflect actual PIHP and provider costs and projections used to estimate future costs. SMA Response: Out of scope. The SMA does not oversee the Legislative Audit Bureau.

Comment: Include minimum time, distance and other network adequacy standards. Require data collection to show that geographic access, provider-client ratios and timely access to care are met for all services or that a plan to increase provider capacity is implemented. SMA Response: Out of scope. Network adequacy standards will be incorporated into the SMA-PIHP contract pursuant to 42 CFR 438.68.

Comment: Provide a monthly bus pass. Provide a care provider to help cook, clean, and maintain home and safety. Functional criteria is too strict. SMA Response:Out of scope. SMA contacted member to ensure needs are met.

Comment: Design and fund Family Care to support long-term planning and sustainable wages for caregivers. SMA Response: Out of scope. The 2020-21 State budget added $67,985,100 (GPR&FED combined) funding for Family Care Direct Care Reimbursement.

Comment: Use rate bands to create career and pay progression for workers to reward certifications and additional skills training, experience, care of high needs members, and progression into supervisory duties. SMA Response: Out of scope. PIHPs and providers negotiate rates.

Comment: When a PIHP's decision to relocate a member is appealed, the relocation should be held in abeyance pending resolution. SMA Response: Out of scope. PIHPs are required to continue services as they currently exist until an appeal is resolved.

The following supportive comments were received:

- Supports expanding background check requirement to workers hired by self-directing members.
- Supports the use of a consistent methodology to determine member room and board obligation. This will reduce confusion and promote consistency for members.
- Supports Support Brokers.
- Pleased with mobile assistance.
- Supports draft waivers.

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 (private or public entities):
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 assisting in the development of 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;
11) Offers members assistance upon member request for a State Fair Hearing; and
12) 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, such as assessment, member-centered plan, service authorization process, training plan, self-directed supports options, and member rights); iii.) provider management - verification of licensure/certification, verification providers are not barred from providing Medicaid services, and background checks; iv.) monitoring of member health and safety - reporting and investigation of member incidents and restrictive measures policies; and v.) 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.

b. WI statutes require the SMA to certify PIHPs annually & prohibits the SMA from contracting with a PIHP that has not been certified. During the initial and annual certification process, the SMA reviews: provider network & capacity; marketing plan & materials; member handbook; contract template; functional screen quality; cost share; claims adjudication/provider appeals; financial reporting; incurred but not reported (IBNR); investment policy; managing capitation and enrollment discrepancies; & encounter reporting & claims system. The SMA reviews as needed: 24-hour on call; comprehensive member assessments; member-centered plan policy, procedure, & template; service authorization policy; care management training plan; safety & risk policy; restrictive measures policy; prevention and wellness policy; self-directed supports policy; notice of action procedures; & quality management plan & activities. A site readiness visit is completed by the SMA prior to issuance of initial certification. Certification criteria are reviewed & modified, where appropriate, on an annual basis.

c. An SMA oversight team is assigned to each PIHP. The team includes contract, fiscal, & quality content experts. Additional experts are consulted as needed. Teams monitor ongoing operations of the PIHP through review of periodic reports. Member-specific concerns are reviewed & responded to as they are submitted. Teams review the following reports: grievances & appeals, member incidents, encounters, financial, annual EQRO, audited PIHP year-end financial, & others required by contract. 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 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 MCPs, services, poor quality, abuse, & discrimination; & track & 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 federal requirements for an EQRO under 42 CFR § 438.354. 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: 1) the level & quality of assistance & support provided to the SMA in quality monitoring activities; 2) the quality of periodic monitoring reports & an annual EQRO report; 3) performance of optional EQRO activities; & 4) compliance with the EQRO contract. EQRO activities occur annually unless specified below.

b. The EQRO conducts an on-site Annual Quality Review (AQR) at 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 - 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, using the CMS EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0. The EQRO & the SMA coordinate in identifying SMA expectations or standards for PIHPs, including compliance thresholds & rules for compliance scoring for each federal and/or regulatory provision or contract requirement. A three-point rating structure is used to assess the level of compliance of each PIHP with the standards. The QCR occurs on a three-year cycle. The first year is a comprehensive review of all standards. The second & third years review standards not met in the previous years 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.

e. Recommendations for improvement may be identified as a result of EQRO review activities. The SMA reviews the recommendations, identifies priorities, & monitors PIHP progress.

f. When issues requiring mandatory remediation are identified, the SMA requires a remediation plan. The PIHP provides status information to the SMA, & the SMA gives feedback to the PIHP on its progress.

g. The SMA reviews quality trends identified by the EQRO with PIHPs & the EQRO. Trends requiring action are prioritized by the SMA.

3. PIHP Leadership - SMA managers meet regularly with PIHP leadership to identify & prioritize issues, including systems improvements.

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

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

6. Aging & Disability Resource Centers (ADRCs) - ADRCs disseminate information regarding the waiver to potential members; review options counseling materials annually; assist individuals in waiver enrollment; monitor enrollment processes on an ongoing basis; review grievances & appeals quarterly; & conduct level of care evaluation activities.

a. The SMA provides ADRCs with unbiased, person-centered enrollment counseling materials that meet CMS requirements for readability, availability in prevalent languages, & annual updates. The enrollment process is monitored regularly via an enrollment plan & documentation that outlines the roles, responsibilities, & processes for eligibility & enrollment. The SMA provides ADRC oversight & directs quality improvement activities. The SMA also provides technical assistance & oversight for adherence to documented procedures. Quality of ADRC services for determination of functional eligibility, facilitation of the financial eligibility process, & enrollment is ensured by ongoing ADRC training both in-person and online.

b. ADRC governing boards review grievances & appeals. A statewide grievance & appeal policy is followed to resolve complaints & to inform individuals of their appeal rights. Additionally, the SMA can access ADRC client tracking databases for quality assurance reviews & independent investigations of complaints & grievances.

c. The SMA conducts quality reviews of level of care evaluations using the automated Long Term Care Functional Screen on an ongoing basis and provides feedback & remediation to the ADRCs & PIHPs. Certified screener continuing knowledge & skills are tested at a minimum of every two years. The SMA offers functional screen administration trainings to ADRCs multiple times per year, conducts quarterly screen liaison calls, & provides screen reviews upon request.

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

7. Ombudsman - The SMA-Ombudsman contract has the following performance expectations:

a. Respond timely to member's calls: 100% of all initial contacts must receive an attempted follow up call within two business days;
b. Provide informative written communication to members: 95% of brief cases & 100% of full cases must receive an opening & closing letter;
c. Be knowledgeable & professional: 100% of ombudsman must meet the ombudsman entity's core competency expectations as measured in annual performance reviews;
d. Maintain an effective relationship with the entity that provides ombudsman services to individuals age 60 and older to identify issues & coordinate improvement efforts;
e. Maintain a collaborative relationship with the PIHPs: Ombudsman must meet at least annually with the PIHPs to discuss advocacy issues & promote collaboration on patterns of issues; &
f. Use informal means (i.e. without PIHP appeal for fair hearing) for case resolution when possible: Ombudsman must resolve at least 75% of cases informally.

The SMA-Ombudsman contract requires a quarterly report on the performance expectations & requires the Ombudsman to perform the following quality assurance activities:

a. Distribute an annual recipient survey to individuals it has assisted to measure consumer satisfaction with the Ombudsman's service & report results to the SMA. If the results are unsatisfactory, the SMA can require a corrective action plan;
b. Participate in & present data at meetings upon SMA request; &
c. Conduct ongoing internal quality assurance activities, including:
i. Regular supervisory case progress reviews;
ii. Monthly team case rounds;
iii. Annual supervisory file reviews;
iv. Annual performance reviews of all staff.

The Ombudsman provides monthly, quarterly, & annual reports: # of member contacts & issue; member result/outcome (resolved to member's full, partial, or no satisfaction); resolution method (informal, PIHP appeal, or fair hearing); # resolved member cases; # cases that identified pattern; ADRC or PIHP non-compliance; & public outreach efforts.

8. Other performance issues may be reported by agencies that provide advocacy services.
9. SMA oversight of TADRS includes: SMA Regional quality specialists are centrally located to tribes; SMA screen liaison for TADRS that provide the long-term care functional screen; SMA performs desk reviews to ensure consistency & accuracy; SMA ongoing technical assistance regarding matters associated with the TADRS scope of work, including functional screen; & regional, on demand, & in-person trainings for TADRS.

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	☒	☒

Function	Medicaid Agency	Contracted Entity
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:
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:

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 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:
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):
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 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**	☐ **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:

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 such communication and direct observation. As needed, teams direct remediation of individual member concerns, as well as isolated operational concerns. Teams also use information gathered through direct interaction with the PIHP, and from many available sources, to identify and direct remediation of systemic problems or issues within the PIHP. Teams have the ability to respond quickly to any issue that affects member health or safety identified through routine discovery activities, and can respond quickly to other issues as they are identified. Each team documents issues and concerns and any resolution or remediation in a tracking system maintained by the SMA. An issue cannot be closed in the tracking system without approval of the team's SMA supervisor. The SMA has also developed policies and procedures for the EQRO and SMA oversight teams to report concerns that rise to a level where they require the immediate attention of SMA leadership.

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:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **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	

Waiver Year	Unduplicated Number of Participants
	65311
Year 2	67531
Year 3	69707
Year 4	71840
Year 5	73973

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

the waiver.

e. Allocation of Waiver Capacity.

Select one:

○ **Waiver capacity is allocated/managed on a statewide basis.**

◉ **Waiver capacity is allocated to local/regional non-state entities.**

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

◉ **§1634 State**

○ **SSI Criteria State**

○ **209(b) State**

2. Miller Trust State.

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

◉ **No**

○ **Yes**

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

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

☒ **Low income families with children as provided in §1931 of the Act**

☒ **SSI recipients**

☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

☒ **Optional state supplement recipients**

☐ **Optional categorically needy aged and/or disabled individuals who have income at:**

Select one:

○ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

☐ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

☒ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

- 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:

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

In FFS waivers, Medicaid pays the actual cost of the § 1915(c) services that a member receives. In a managed care program, Medicaid pays a capitation rate to the PIHP for § 1915(c) and other services. Accordingly, under a capitated system, the benefit becomes the amount the SMA expends on behalf of the member, or the capitated payment. To ensure that excess income is only applied to the cost of the § 1915(c) waiver services, the SMA uses the portion of the average capitation rate that is attributable to § 1915(c) waiver services as the dollar amount that the individual is liable for because the capitated portion of the rate that is attributable to § 1915(c) waiver services is the actual amount that the SMA pays to the PIHP for these services. This amount represents the member's maximum 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:

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

  In FFS waivers, Medicaid pays the actual cost of the § 1915(c) services that a member receives. In a managed care program, Medicaid pays a capitation rate to the PIHP for § 1915(c) and other services. Accordingly, under a capitated system, the benefit becomes the amount the SMA expends on behalf of the member, or the capitated payment. To ensure that excess income is only applied to the cost of the § 1915(c) waiver services, the SMA uses the portion of the average capitation rate that is attributable to § 1915(c) waiver services as the dollar amount that the individual is liable for because the capitated portion of the rate that is attributable to § 1915(c) waiver services is the actual amount that the SMA pays to the PIHP for these services. This amount represents the member's maximum 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 evaluations for new applicants are conducted by Aging and Disability Resource Centers or Tribal Aging and Disability Resource Specialists. Reevaluations of level of care for members are performed by PIHPs.

- ( ) **Other**

Specify:

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Initial evaluation of level of care is performed by 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 pass a test of continuing 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 a face-to-face 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 the PIHP during face-to-face meetings with the member, using the same tool.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

Every 365 days.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- (●) **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ( ) **The qualifications are different.**
  Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Annual reevaluation of level of care is a 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 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 within 90 days of notification of error by SMA. Numerator: Number of level of care evaluation errors remediated by PIHP within 90 days of notification by SMA. Denominator: Number of level of care evaluation errors identified by SMA.

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

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 errors 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 level of care application (FSIA).

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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 screener 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 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. 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:	☐ **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 ADRC or TADRS is required by contract to inform the potential enrollee and/or his or her legal representative about 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 documents his or her choice by signing an enrollment form, which is maintained by the ADRC or TADRS.

If the individual is an Indian, the ADRC or TADRS informs the potential enrollee and/or his or her 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 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.

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 (TADRS) are required to have enrollment forms and other materials related to managed long-term care, including an SMA-developed brochure and the PIHP member handbook, available in the prevalent non-English languages spoken in Wisconsin: Arabic, Chinese (Mandarin), Hmong, Laotian, Serbo-Croation, Somali, and Spanish. ADRCs are also required to obtain interpreters or telephonic interpretation services when needed by an applicant or member.

The SMA requires PIHPs to include, in all written materials for potential members, taglines in the prevalent non-English languages, as well as large print (no smaller than 18-point font), explaining the availability of written translation or oral translation to understand the information, the toll free number of the ADRC providing choice counseling, and the toll free and TTY/TDY telephone number of the PIHP’s member/customer service unit. PIHPs must also make all written materials that are critical to obtaining services, including provider directories, handbooks, appeal and grievance notices, and denial and termination notices, available in all prevalent, non-English languages in the PIHP’s service area. Members may also request auxiliary aids and services or for materials produced and/or used by the PIHP to be made available in alternative formats, at no cost. 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**

Service Type	Service		
Statutory Service	Respite		
Statutory Service	Supported Employment - Individual Employment Support		
Supports for Participant Direction	Consumer Directed Supports (Self-Directed Supports) Broker		
Supports for Participant Direction	Financial Management Services		
Other Service	Adaptive aids		
Other Service	Adult residential care - 1-2 bed adult family homes		
Other Service	Adult Residential Care - 3-4 Bed Adult Family Homes		
Other Service	Adult Residential Care - Community-Based Residential Facilities (CBRF)		
Other Service	Adult Residential Care - Residential Care Apartment Complexes (RCAC)		
Other Service	Assistive Technology/Communication aids		
Other Service	Consultative Clinical and Therapeutic Services for Caregivers		
Other Service	Consumer Education and Training		
Other Service	Counseling and Therapeutic Resources		
Other Service	Environmental Accessibility Adaptations (Home Modifications)		
Other Service	Home Delivered Meals		
Other Service	Housing Counseling		
Other Service	Personal Emergency Response Systems (PERS)		
Other Service	Relocation services		
Other Service	Self-Directed Personal Care		
Other Service	Skilled Nursing Services RN/LPN		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Supported Employment - Small Group Employment Support		
Other Service	Supportive Home Care		
Other Service	Training Services for Unpaid Caregivers		
Other Service	Transportation (Specialized Transportation) - Community Transportation		
Other Service	Transportation (Specialized Transportation) - Other Transportation		
Other Service	Vocational Futures Planning and Support		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care Services

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2: 04 Day Services

Sub-Category 2: 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, supervision and/or protection. Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site. Transportation between the member's place of residence and the adult day care center may be provided as a component part of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care services. Meals provided as part of adult day care may not constitute a "full nutritional regimen" (3 meals per day). The PIHP may only enter a provider agreement with adult day care centers that have been certified by the Department, under Wis. Stat. § 49.45(2)(a)(11), to provide adult day care services.

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Adult Day Care Services

Provider Category:

Agency

Provider Type:

Adult day center services/treatment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. § 49.45

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Care Management

HCBS Taxonomy:

Category 1:	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 (sometimes called support and service coordination) are provided by an interdisciplinary care management team (IDT). The member is the center of the IDT. The IDT consists of, at minimum, a registered nurse and a social services coordinator, and may also include other professionals as appropriate to the needs of the member, as well as family or other informal supports requested by the member. The IDT initiates and oversees the initial comprehensive assessment of needs and reassessment process, the results of which are used in developing the individual's member-centered plan (MCP). The IDT identifies the member's preferred outcomes and the services needed to achieve those outcomes and monitors the member's health and welfare, the delivery of services, and progress in achieving identified outcomes. The IDT also carries out activities that help members and their families to identify other service needs and gain access to medical, social, rehabilitation, vocational, educational and other services identified.

Care management is always provided by individuals employed by the 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, 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 services are provided by the IDT with the member and other participants of the interdisciplinary team and include:

• A comprehensive assessment of the member's strengths, abilities, functional limitations, lifestyle, personal circumstances, values, preferences and choices.
• Development of the MCP.
• Authorization for the purchase of paid services identified in the MCP.
• Monitoring of the delivery of and quality of the paid services identified in the plan of care.
• Monitoring of the member's circumstances and ongoing health and well-being.
• Maintenance of a member record and all documentation associated with the delivery of services and any required waiver procedures.
• Development of a plan to assure continuity of the member's independence, care, living arrangements and preferences in the face of changes in circumstances.

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)*:

Social worker certified in Wisconsin under Wis. Stat. Ch. 457, or have a minimum of a four year bachelor's degree or more advanced degree in human services area, 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 with persons in the Family Care target population.

Other Standard *(specify)*:

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

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

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

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Daily Living Skills Training

Provider Category:

Individual

Provider Type:

Daily living skills trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Daily Living Skills Training

Provider Category:

Agency

Provider Type:

Daily living skills training agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:
• Accreditation by a nationally recognized accreditation agency.
• Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing daily living skills training, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment, or similar services.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: 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 services are the provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that enhance social development and develop skills in performing activities of daily living and full community citizenship. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.

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

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

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Habilitation Services

Provider Category:

Agency

Provider Type:

Adult day center services/treatment

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code §§ DHS 61.41, 61.75

Other Standard *(specify):*

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:
• Accreditation by a nationally recognized accreditation agency.
• Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment, or similar services.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	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 path to integrated community-based employment for which an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services allow the member to develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time as determined by the member and his or her care planning team. Services are expected to specifically involve strategies that enhance a member's employability in integrated, community settings.

Prevocational services should enable each member to attain the highest possible wage and work in the most integrated setting that is matched to the member’s interests, strengths, priorities, and abilities. Services intend to develop general skills that lead to employment, including the ability to communicate effectively and establish appropriate boundaries with supervisors, co-workers, and customers; express and understand expectations; engage in generally accepted community workplace conduct and adopt appropriate workplace dress; follow directions; attend to tasks; problem-solve; manage conflicts; and adhere to general workplace safety. Services may include mobility training.

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

Prevocational services, regardless of how and where they are delivered, are expected to help people make reasonable and continued progress toward participation in at least part-time, integrated employment. Prevocational services are not considered outcomes; competitive employment and supported employment are considered successful outcomes of prevocational services. The optimal outcome of the provision of prevocational services is permanent integrated employment at or above the minimum wage in the community.

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

The contracted provider of pre-vocational services must complete a six-month progress report and service plan document for the 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.

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

Members participating in prevocational services shall be compensated in accordance with applicable Federal and State laws and regulations.

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

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

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

Prevocational services may be provided to supplement, but may not duplicate 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.

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	Prevocational Services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Prevocational Services

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	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 caregiver(s) from daily stress and care demands. Respite care may be provided in an institution such as a certified Medicaid setting (hospital, nursing home) or other licensed facility. Respite care may also be provided in a residential facility such as a certified or licensed adult family home, licensed community-based residential facility, certified residential care apartment complex, in the member's own home, or the home of a respite care provider.

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Supportive home care agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

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

Provider Qualifications
License *(specify):*

Hospital: Wis. Admin. Code Ch. DHS 124
Nursing home: Wis. Admin. Code Ch. DHS 132 and Ch. DHS 134
Community-based residential facility: Wis. Admin. Code Ch. DHS 83
3-4 bed adult family home - 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:
Individual
Provider Type:

Individual respite provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal care agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 105.17

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: 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 the ongoing supports provided to members who, because of their disabilities, need intensive ongoing support to obtain and maintain competitive, customized, or self-employment, in an integrated work setting, in the general workforce. A member receiving this service shall be compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above minimum wage, in an integrated setting, in the general workforce, and in a job that meets personal and career goals.

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

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

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

Supported employment services do not include vocational services that are provided in facility-based work settings and not in general community work places. Supported employment services may not include volunteer work.

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

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

Coverage does not include incentive payments, subsidies, or unrelated vocational training expenses, such as (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.

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

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

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

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual Employment Support

Provider Category:

Individual

Provider Type:

On the job support person

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:
• Holding the Certified Employment Support Professional accreditation.
• Meeting the ASPE Quality Indicators for Supported Employment Personnel.
• Comparable experience for a qualified individual, including a minimum of two years of experience working with the target population providing supported employment. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PIHP and member shall ensure that the individual provider has the member-specific competencies needed to effectively provide the service.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual Employment Support

Provider Category:

Agency

Provider Type:

Supported employment agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:
• Accreditation by a nationally recognized accreditation agency.
• Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
• Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
• Comparable experience for a qualified entity, including a minimum of two years of experience working with the target population providing integrated employment services in the community.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

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

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

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

Provider Category:

Agency

Provider Type:

Support broker agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Consumer Directed Supports (Self-Directed Supports) Broker

Provider Category:

Individual

Provider Type:

Individual support broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	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 to manage service dollars or their personal finances to prevent institutionalization. This service includes a person or agency paying service providers after the member, guardian, or other authorized representative authorizes payment to be made for services included in the member's approved self-directed supports plan. Financial management services providers, sometimes referred to as fiscal intermediaries or fiscal agents, are organizations or individuals who pay personnel costs, tax withholding, worker's compensation, health insurance premiums, and other taxes and benefits as indicated in the member's self-directed supports plan and budget for services. Financial management services are purchased directly by the PIHP or IHCP and made available to the member/family 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 his or her guardian and keeping an account of disbursements.

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

Excludes payments to court-appointed guardians or court-appointed protective payees if the court has directed them to perform any of these functions.

Excludes payment for the cost of room and board.

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Financial Management Services

Provider Category:

Individual

Provider Type:

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 representative, promptly issues payments as authorized, documents budget authority, and summarizes payments in a manner that can be readily understood by the member or legal representative.

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:

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 representative, promptly issues payments as authorized, documents budget authority, and summarizes payments in a manner that can be readily understood by the member or legal representative.

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:

Adaptive aids

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):*

Adaptive aids are controls or appliances that enable members to increase their abilities to perform ADLs and IADLs or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services and material benefits that enable members to access, participate and function in their community and competitive integrated employment. These include the purchase of vehicle modifications (such as van lifts, hand controls, equipment modifications etc. that allow the vehicle to be used by the member to access the community), or those costs associated with the maintenance of these items. The adaptive aids service includes the evaluation of the adaptive aids needs of a member, including a functional evaluation of the impact of the provision of appropriate adaptive aids in the customary environment of the member.

The adaptive aids 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 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 an adaptive aid benefit, 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.

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

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

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

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

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adaptive aids vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive aids

Provider Category:

Agency

Provider Type:

Adaptive aids vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Medicaid certified provider

Other Standard *(specify):*

UL or FCC standards for electronic devices.

Reputable provider with experience providing 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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult residential care - 1-2 bed adult family homes

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):*

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

Adult family home services also include coordination with other services 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.

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

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

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

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

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

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

- [x] **Legally Responsible Person**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Adult family home sponsor

Appendix C: Participant Services

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

Service Type: Other Service

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

Provider Category:

Individual

Provider Type:

Adult family home sponsor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Residential Care - 3-4 Bed Adult Family Homes

HCBS Taxonomy:

Category 1:	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):*

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

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

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

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

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

- [ ] **Participant-directed as specified in Appendix E**
- [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	Licensed adult family home

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Licensed adult family home

Provider Qualifications

License *(specify):*

Wis. Admin. Code 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: Service Specification

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

Service Type:

Other Service

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

Service Title:

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

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation

Category 2: 02 Round-the-Clock Services

Sub-Category 2: 02013 group living, other

Category 3: 02 Round-the-Clock Services

Sub-Category 3: 02012 group living, mental health services

Category 4:

Sub-Category 4:

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 community-based residential facility (CBRF) is a residence where five (5) or more adults, not related to the operator or administrator of the facility, reside and receive care, treatment, support, supervision, and training. An individual with an intellectual disability may only reside in a CBRF that is licensed for eight (8) or fewer residents, unless that person has been determined to require No Active Treatment (NAT) for her or his intellectual disability. Services may include supportive home care, personal care, supervision, behavior and social supports, daily living skills training, transportation, and up to three hours per week of nursing care per resident.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed CBRF

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Licensed CBRF

Provider Qualifications

License *(specify):*

Wis. Admin. Code 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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adult Residential Care - Residential Care Apartment Complexes (RCAC)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02033 in-home round-the-clock services, 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):*

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified RCAC

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Certified RCAC

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code Ch. 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: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology/Communication aids

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
17 Other Services	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):*

Assistive technology is an item, piece of equipment, or product system – whether 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. Assistive technology service is a service that directly assists a member in the selection, acquisition, or use of an assistive technology device. 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 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. Assistive Technology includes communication aids, which are 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, and improve social and emotional well-being.

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

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

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

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

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.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Individual interpreters

Provider Qualifications

License *(specify):*

Certificate *(specify):*

State or national registry

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Communications aids vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Medicaid certified providers

Other Standard *(specify):*

UL or FCC standards for electronic devices

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of authorization/purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consultative Clinical and Therapeutic Services for Caregivers

HCBS Taxonomy:

Category 1:	**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 services is to improve the ability of unpaid caregivers and paid direct support staff to carry out therapeutic interventions. Clinical and therapeutic services assist unpaid caregivers and/or paid support staff in carrying out the member's treatment/support plans, are not covered by the Medicaid State Plan and are necessary to improve the member's independence and inclusion in their community. The service includes assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans, and monitoring of the member and the caregiver/staff in the implementation of the plans. This service includes the provision of training for caregivers/staff that are or will be serving members with complex needs (beyond routine care). For example, when an individual with complex needs is relocating from one of the State Centers for the Intellectually Disabled, this service could be used to train caregivers/staff on the behavioral support plans necessary for community integration. This service may also include consultation with service providers and potential providers to identify providers that can meet the unique needs of the member and to identify additional supports necessary for caregivers to perform therapeutic interventions.

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

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

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

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

- [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	Counseling agencies
Individual	Individual counselors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services for Caregivers

Provider Category:

Agency

Provider Type:

Counseling agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 61.35

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At the time of authorization/purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services for Caregivers

Provider Category:

Individual

Provider Type:

Individual counselors

Provider Qualifications

License *(specify):*

Professionals with current state licensure in their field of practice

Certificate *(specify):*

Professionals with current state certification in their field of practice

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of authorization/purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Consumer Education and Training

HCBS Taxonomy:

Category 1:	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):*

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 other 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 representatives that is directly related to developing such 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.

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

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

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

Excludes education/training costs exceeding $2500 per member annually.

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

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

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

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

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

Provider Specifications:

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: 11 Other Health and Therapeutic Services

Sub-Category 3: 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 services is the provision of professional, treatment-oriented services to address a member's identified needs for personal, social, physical, medical, behavioral, emotional, cognitive, mental, or substance abuse disorders.

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

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

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.

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

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

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

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

- [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	Counseling agencies
Individual	Individual counselors

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Counseling agencies
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 61.35
Other Standard *(specify):*

Employing or contracting with professionals with current state licensure or certification in their field of practice
Verification of Provider Qualifications
Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of authorization/purchase

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:

Individual counselors
Provider Qualifications
License *(specify):*

Professionals with current state licensure in their field of practice
Certificate *(specify):*

Professionals with current state certification in their field of practice
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of authorization/purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Environmental Accessibility Adaptations (Home Modifications)

HCBS Taxonomy:

Category 1:	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 a member's living quarters 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. Home modifications may include materials and services, such as ramps; stair lifts, wheelchair lifts or other mechanical devices to lift persons with impaired mobility from one vertical level to another; kitchen and/or bathroom modifications; specialized accessibility/safety adaptations; and voice-activated, light-activated, motion-activated, and other electronic devices that increase the member's self-reliance and capacity to function independently. Home modifications may include modifications that add to the square footage of the residence if the modifications are to assure the health, safety, or independence of the person; prevent institutionalization; and are the most cost effective means of meeting the accessibility or safety need.

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.

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual carpenters
Agency	Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations (Home Modifications)

Provider Category:
Individual
Provider Type:

Individual carpenters

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At the time of authorization/purchase.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations (Home Modifications)

Provider Category:

Agency

Provider Type:

Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of authorization/purchase.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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:	Sub-Category 1:
06 Home Delivered Meals	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 recipients who are unable to prepare or obtain nourishing meals without assistance, including those who may be unable to manage a special diet recommended by their physician. Home delivered meal costs may include the costs associated with the purchase and planning of food, nutrition services, supplies, equipment, labor and transportation to deliver one or two meals a day.

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

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

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

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

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

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

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

Provider Specifications:

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

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:

Hospitals or nursing homes

Provider Qualifications

License *(specify):*

Wis. Admin. Code Ch. DHS 124, 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: 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 acquiring housing in the community, 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 his or her family. Services include counseling and assistance in identifying housing options; identifying financial resources and determining affordability; identifying preferences of location and type of housing; identifying accessibility and modification needs; locating available housing; identifying and assisting in access to financing; explaining the rights and responsibilities of a tenant with disabilities, including how to ask for reasonable accommodations and modifications and how to file a complaint; and planning for ongoing management and maintenance. Housing counseling is not a one-time service and may be accessed by a member at any time. A qualified provider must be an agency, or unit of an agency, that provides housing counseling to people who need assistance with housing as a regular part of its mission or activities. Counseling providers must have specialized training and experience in housing issues.

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

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Housing counseling agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Counseling

Provider Category:
Agency
Provider Type:

Housing counseling agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of authorization/purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response Systems (PERS)

HCBS Taxonomy:

Category 1:	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 someone living in the community and health professionals to secure immediate response and assistance in the event of a physical, emotional, or environmental emergency. This service may include devices and services necessary for operation of PERS when otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as appropriate.

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

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

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

- [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
Individual	PERS Vendors

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

PERS Vendors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

UL Standards for electronic devices or FCC regulations for telephonic devices

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Relocation services

HCBS Taxonomy:

Category 1:	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 services and essential items needed to establish a community living arrangement for members who are relocating from an institution, or a family home, to an independent living arrangement. 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. Relocation services may include the purchase of necessary furniture, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings, and kitchen appliances that are not otherwise included in a rental arrangement if applicable. Relocations services may include the payment of a security deposit, utility connection costs, and telephone installation charges. This service includes payment for moving the member's personal belongings to the new community living arrangement, general cleaning, and household organization needed to prepare the selected community living arrangement for occupancy.

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

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

Relocation services exclude home modifications necessary to address safety and accessibility in the 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.)

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	Moving companies, public utilities, real estate agencies, vendors of home furnishings
Individual	Individual movers/individual landlords

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Relocation services

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable 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: 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: 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 are activities to assist a member with activities of daily living, instrumental activities of daily living, and housekeeping services directly related to the care of the person to maintain the member in his or her place of residence and to assist the member to access the community. Services may include the following:
1. Assistance with activities of daily living (ADLs): bathing; getting in and out of bed; oral, hair and skin care excluding skilled wound care; help with toileting; simple transfers; assistance with mobility and ambulation; assistance with eating; and assistance with dressing and undressing.
2. Assistance with instrumental activities of daily living (IADLs): managing medications and treatments normally self-administered, care of eyeglasses and hearing aids, meal preparation and serving, bill paying and other aspects of money management, using the telephone or other forms of communication, arranging and using transportation, and physical assistance to function at a job site.
3. Housekeeping services related to the care of the person: cleaning in essential areas of the home used when assisting with ADLs and IADLs, laundry of the member's clothes and bedding and changing of bedding, and shopping for the member's food.
4. Accompanying and assisting the member to access the community for medical care, employment, recreation, shopping and other purposes, as long as the provision of assistance with ADLs and IADLs is required during such trips.
5. Medically-oriented tasks delegated by a registered nurse pursuant to an agreement between the member and the interdisciplinary care team (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. The MCP shall specify delegated nursing tasks, if any. The member may use as a provider any individual who passes a background check including a legally responsible relative who qualifies under Appendix C-2 d. 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 or more often as needed. Visits by the consulting RN, who may be a member of the IDT or other nurse consultant, to the member's residence will occur at least once a year unless the member and RN agree on a more frequent visits or the RN determines that delegated nursing tasks need to be reviewed more often. The member and IDT will determine any training needed by selected providers and how it will be obtained. The member shall be the common law employer of individual providers; if the member selects an agency, the member shall be a managing, co-employer of the worker and the agency shall hire any worker referred by the member who passes the background check and is, or can become competent in required tasks. Services may be provided both in the member's residence and outside the residence in other community settings.

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

Medically-Related
• Hospitalization
• Nursing home or ICF/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.

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:

Member-employed individual worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:

Agency-employed, member-directed workers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 105.17

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Skilled Nursing Services RN/LPN

HCBS Taxonomy:

Category 1:	**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.

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

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

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

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
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):*

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: incontinence supplies; wound dressings; IV or life support equipment; orthotics; enteral nutrition products and associated supplies and equipment not covered under the Medicaid state plan but needed for the member to obtain adequate nutrition; over the counter medications with a National Drug Code (NDC) if not covered under the state plan drug benefit and when prescribed by any licensed and authorized prescriber; medically necessary prescribed skin conditioning lotions/lubricants; and prescribed Vitamin D, a prescribed multivitamin and prescribed calcium supplements. (The SMA may add other prescribed vitamins or nutritional supplements in the future based on clear and convincing evidence substantiating their safety and effectiveness in maintaining health or treating or managing a medical condition.) Additionally, allowable items may include books and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, humidifiers, and water treatment systems may be allowable when needed to support a member's health and safety outcomes.

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 in the state plan benefit pursuant to the EPSDT benefit.

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

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

Items or devices provided may be in excess of the quantity of medical equipment or supplies covered under the Medicaid state plan when coverage of the additional items or devices has been denied.

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

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

- [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	Other merchants
Agency	Authorized DME Vendors or 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 merchants

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable merchant

Verification of Provider Qualifications

Entity Responsible for Verification:

PHIP

Frequency of Verification:

At time of authorization/purchase

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Authorized DME Vendors or Licensed Pharmacy

Provider Qualifications

License *(specify):*

Wis. Admin Code § DHS 105.40 or Wis. 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 are services and training activities provided in a regular business, industry, or community setting for groups of two to eight workers. Examples include mobile crews 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. The outcome of this service is sustained paid employment, work experience that leads to further career development, and individual integrated community-based employment for which a member is compensated at or above the minimum wage but not less than the customary wage level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

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

Small group employment support does not include payment for supervision, training, support, or adaptations that are typically available to workers without disabilities who fill similar positions in the business. Employers may be reimbursed for supported employment services provided by co-workers or other job site personnel, when the services that are furnished are not part of the normal duties of the co-worker or other personnel, and when these individuals meet the qualifications established below for individual providers of the service.

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

Members receiving small group employment support may also receive educational, pre-vocational, career planning, and day services. However, different types of non-residential services may not be billed for the same period of time.

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

Coverage does not include incentive payments, subsidies, or unrelated vocational training expenses, like 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.

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

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

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

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

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

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

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment - Small Group Employment Support

Provider Category:

Individual

Provider Type:

On the job support person

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment - Small Group Employment Support

Provider Category:
Agency
Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

- Accreditation by a nationally recognized accreditation agency.
- Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
- Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
- Comparable experience for a qualified entity, including a minimum of two years of experience working with the target population providing integrated employment services in the community.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: 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 people with daily living activities and personal needs and to assure adequate functioning and safety in their home and community. Services include the following:
1. Hands-on assistance with activities of daily living, such as dressing/undressing; bathing; feeding; managing medications and treatments that are normally self-administered; toileting; assistance with ambulation (including the use of a walker, cane, etc.); carrying out professional therapeutic treatment plans; and 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, as well as 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.
3. Providing supervision necessary for member safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, and arrangement and usage of transportation and personal assistance at a job site and in non-employment related community activities.
4. 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, and similar activities that do not involve hands-on care of the member.
5. 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; bed bug inspection and extermination; and home modifications such as ramps. This also may include assistance with packing/unpacking and household cleaning/organizing when a member moves.
An unrelated live-in caregiver may provide any or all of the types of supportive home care services. Services by a related live-in caregiver are subject to the requirements in Appendix C-2-e. Payment of a live-in caregiver may be reduced by the value of room and board in accordance with any applicable wage and hour laws.
Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days 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.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
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 and In-Home Respite 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 and In-Home Respite Care

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: 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.

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

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

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

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training Services for Unpaid Caregivers

Provider Category:

Agency

Provider Type:

Training/Service Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

This training must be provided by 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:
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: 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 gain access to waiver 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, specialized medical vehicle, or other provider directly conveys a member and her or his attendant, if any, to destinations. Whenever possible, family, neighbors, friends or community agencies who can provide this service without charge will be utilized.

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

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

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

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

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

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

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

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

Provider Specifications:

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

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:

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

Members eligible for this service must have decision-making authority over a budget for the purchase of such services. Such members (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.

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

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

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

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Specialized Transportation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. § 85.21 and Wis. Admin. Code § DHS 61.45

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

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:

Individuals (mileage reimbursed)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Valid driver's license, liability insurance.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP - may delegate to member or member's representative

Frequency of Verification:

At the time of authorization/purchase

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:	**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):*

Vocational futures planning and support (VFPS) is a person-centered, team-based comprehensive employment planning and support service that provides assistance for members to obtain, maintain or advance in employment or self-employment/microenterprise. The agency providing VFPS services will ensure that the following service strategies are available as needed to the member:

1) Development of an employment plan based on an individualized determination of the member's strengths, needs, and interests; the barriers to work, including an assistive technology pre-screen or in-depth assessment; and identification of the assets that a member brings to employment;
2) Work Incentive Benefits analysis and support;
3) Resource team coordination;
4) Career exploration and employment goal validation;
5) Job seeking support; and
6) Job follow-up and long-term support.

VFPS must be provided by qualified professionals that include, for example, an employment specialist, a 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.

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

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

VFPS excludes services that could be provided as prevocational or as supported employment. Such services may be used to supplement, but may not duplicate any VFPS services provided under the waiver.

VFPS excludes services funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401(16 and 17)).

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vocational futures planning

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vocational Futures Planning and Support

Provider Category:
Agency
Provider Type:

Vocational futures planning

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All team members shall have skills and knowledge typically acquired through completion of an advanced degree in human services, or an equivalent combination of education and experience, with ongoing training and technical assistance appropriate to their specific specialty.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

  Check each that applies:

  - ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
  - ☐ **As an administrative activity.** *Complete item C-1-c.*
  - ☐ **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).

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. 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. 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)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Adult family home - 3-4 beds	
Community-based residential facility (CBRF)	
Residential Care Apartment Complex (RCAC)	
Adult Residential Care - 1-2 Bed Adult Family Homes	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Required information is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult family home - 3-4 beds

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assistive Technology/Communication aids	☐
Specialized Medical Equipment and Supplies	☐
Adaptive aids	☐
Adult Day Care Services	☐
Prevocational Services	☐
Personal Emergency Response Systems (PERS)	☐
Supportive Home Care	☐
Relocation services	☐
Daily Living Skills Training	☐
Financial Management Services	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Transportation (Specialized Transportation) - Other Transportation	☐
Day Habilitation Services	☐
Housing Counseling	☐
Supported Employment - Individual Employment Support	☐
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☐
Consumer Education and Training	☐
Environmental Accessibility Adaptations (Home Modifications)	☐
Home Delivered Meals	☐
Transportation (Specialized Transportation) - Community Transportation	☐
Skilled Nursing Services RN/LPN	☐
Care Management	☐
Self-Directed Personal Care	☐
Supported Employment - Small Group Employment Support	☐
Vocational Futures Planning and Support	☐
Adult Residential Care - 3-4 Bed Adult Family Homes	☒
Consumer Directed Supports (Self-Directed Supports) Broker	☐
Respite	☐
Counseling and Therapeutic Resources	☐
Adult residential care - 1-2 bed adult family homes	☐
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☐
Training Services for Unpaid Caregivers	☐

Facility Capacity Limit:

4 residents

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Community-based residential facility (CBRF)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assistive Technology/Communication aids	☐
Specialized Medical Equipment and Supplies	☐
Adaptive aids	☐
Adult Day Care Services	☐
Prevocational Services	☐
Personal Emergency Response Systems (PERS)	☐
Supportive Home Care	☐
Relocation services	☐

Waiver Service	Provided in Facility
Daily Living Skills Training	☐
Financial Management Services	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Transportation (Specialized Transportation) - Other Transportation	☐
Day Habilitation Services	☐
Housing Counseling	☐
Supported Employment - Individual Employment Support	☐
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☐
Consumer Education and Training	☐
Environmental Accessibility Adaptations (Home Modifications)	☐
Home Delivered Meals	☐
Transportation (Specialized Transportation) - Community Transportation	☐
Skilled Nursing Services RN/LPN	☐
Care Management	☐
Self-Directed Personal Care	☐
Supported Employment - Small Group Employment Support	☐
Vocational Futures Planning and Support	☐
Adult Residential Care - 3-4 Bed Adult Family Homes	☐
Consumer Directed Supports (Self-Directed Supports) Broker	☐
Respite	☐
Counseling and Therapeutic Resources	☐
Adult residential care - 1-2 bed adult family homes	☐
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☒
Training Services for Unpaid Caregivers	☐

Facility Capacity Limit:

Members w/ an intellectual disability (ID) may only reside in a CBRF licensed for 8 or less residents, unless that member has been determined to require No Active Treatment (NAT) for her or his ID.

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒

Standard	Topic Addressed
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Residential Care Apartment Complex (RCAC)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assistive Technology/Communication aids	☐
Specialized Medical Equipment and Supplies	☐
Adaptive aids	☐
Adult Day Care Services	☐
Prevocational Services	☐
Personal Emergency Response Systems (PERS)	☐
Supportive Home Care	☐
Relocation services	☐
Daily Living Skills Training	☐
Financial Management Services	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Transportation (Specialized Transportation) - Other Transportation	☐
Day Habilitation Services	☐
Housing Counseling	☐

Waiver Service	Provided in Facility
Supported Employment - Individual Employment Support	☐
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☒
Consumer Education and Training	☐
Environmental Accessibility Adaptations (Home Modifications)	☐
Home Delivered Meals	☐
Transportation (Specialized Transportation) - Community Transportation	☐
Skilled Nursing Services RN/LPN	☐
Care Management	☐
Self-Directed Personal Care	☐
Supported Employment - Small Group Employment Support	☐
Vocational Futures Planning and Support	☐
Adult Residential Care - 3-4 Bed Adult Family Homes	☐
Consumer Directed Supports (Self-Directed Supports) Broker	☐
Respite	☐
Counseling and Therapeutic Resources	☐
Adult residential care - 1-2 bed adult family homes	☐
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☐
Training Services for Unpaid Caregivers	☐

Facility Capacity Limit:

No limit (See c.ii.)

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒

Standard	Topic Addressed
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Adult Residential Care - 1-2 Bed Adult Family Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Assistive Technology/Communication aids	☐
Specialized Medical Equipment and Supplies	☐
Adaptive aids	☐
Adult Day Care Services	☐
Prevocational Services	☐
Personal Emergency Response Systems (PERS)	☐
Supportive Home Care	☐
Relocation services	☐
Daily Living Skills Training	☐
Financial Management Services	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Transportation (Specialized Transportation) - Other Transportation	☐
Day Habilitation Services	☐
Housing Counseling	☐
Supported Employment - Individual Employment Support	☐
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☐
Consumer Education and Training	☐
Environmental Accessibility Adaptations (Home Modifications)	☐
Home Delivered Meals	☐
Transportation (Specialized Transportation) - Community Transportation	☐

Waiver Service	Provided in Facility
Skilled Nursing Services RN/LPN	☐
Care Management	☐
Self-Directed Personal Care	☐
Supported Employment - Small Group Employment Support	☐
Vocational Futures Planning and Support	☐
Adult Residential Care - 3-4 Bed Adult Family Homes	☐
Consumer Directed Supports (Self-Directed Supports) Broker	☐
Respite	☐
Counseling and Therapeutic Resources	☐
Adult residential care - 1-2 bed adult family homes	☒
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☐
Training Services for Unpaid Caregivers	☐

Facility Capacity Limit:

1 or 2 residents

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

a. The spouse of a member may be paid to provide personal care and/or supportive home care that the member's interdisciplinary team (IDT) identifies as necessary and is included in the member's member-centered plan (MCP) if: 1) the member's preference is for the spouse to provide the service; 2) 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 3) the spouse will either i. provide an amount of service that exceeds the normal care giving responsibilities for a spouse who does not have a disability, or ii. find it necessary to forego paid employment in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

b. The spouse may be paid only for services that are above and beyond the usual spousal responsibilities. 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: 1) the service to be provided meets identified needs and outcomes in the MCP and assures the health, safety, and welfare of the member; 2) purchase of services from the spouse is cost-effective in comparison to purchase of services from another provider; and 3) 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 actually 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;
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 care giving 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: personal care, supportive home care, specialized transportation, certified 1-2 bed adult family home services, education (daily living skills training), respite care services, skilled nursing services, and supported employment 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 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. However, for services that involve intimate personal care needs or require a provider to frequently enter a member's home, the SMA-PIHP contract requires the PIHP to, upon a member's request, purchase services from any qualified provider who will accept and meet the provisions of the PIHP's subcontract.

Further, Wis. Stat. § 46.284(2)(c) requires that the SMA–PIHP contract specify that PIHPs must contract with any 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 assure that providers continually meet all licensure and/or certification standards that apply to them. Numerator: Number of providers reviewed annually through an SMA validation process that meet all licensure and/or certification standards that apply to them. Denominator: Number of providers reviewed annually through an SMA validation process.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(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**
	☐ **Other** Specify:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
The SMA verifies that PIHPs assure non-licensed/non-certified providers continually meet all the standards that apply to them. Numerator: Number of non-licensed/non-certified providers reviewed annually through an SMA validation process that meet all standards that apply to them. Denominator: Number of non-licensed/non-certified providers reviewed annually through an SMA validation process.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **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:	☒ **Annually**	☐ **Stratified** Describe Group:

PIHP / EQRO data validation		
	☒ **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.

SMA oversight teams direct the correction of individual problems. The SMA oversight team assigned to each PIHP discovers problems and issues through: reports from the EQRO related to individual member concerns; Family Care Ombudsman program reports; review of grievances and appeals; review of member incident reports; review of requests for use of isolation, seclusion, and restrictive measures; discovery of problems or issues when giving a PIHP policy clarification; complaints to the SMA; and from other sources. The oversight team also interacts with PIHP staff on a regular basis and may identify concerns through such communication and direct observation. As needed, the SMA oversight team directs remediation of individual member concerns, provider concerns, isolated operational concerns, and systemic problems or issues within the PIHP.

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

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **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) The SMA has assessed and determined that the following settings meet the requirements of 42 CFR § 441.301(c)(4):
(a) 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) Places of integrated, competitive employment.
(c) Community sites predominantly used by the general public for typical community activities, unless specifically prohibited by 42 CFR § 441.301(c)(5), including, but not limited to, retail establishments; schools; recreational and entertainment facilities; libraries; places of religious worship; public and private transportation settings, such as buses, trains, and private vehicles; restaurants; community centers; service establishments; streets; and other public accommodations.

The SMA has determined that these settings are not provider owned or controlled residential settings; are integrated in the greater community or, in the case of residences in rural settings, are the 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.

2) To assure continuing compliance with setting requirements, the SMA has done the following:
(a) Included requirements in the SMA-PIHP contract to ensure the ongoing assessment of settings in which waiver services are provided; and
(b) Informed 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.

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):*

- [x] **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)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).
  Specify qualifications:
- [x] **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) providing services to Indian members and United Community Center (UCC) providing services to Hispanic members in Milwaukee County. 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 (TADRS) is responsible to inform the potential member and/or her/his legal representative about the available service and enrollment options, including managed long term care (Family Care or Family Care Partnership), institutional services, fee-for-service Medicaid card and self-directed supports waiver (IRIS) services. If the individual is an Indian, the ADRC or TADRS informs the potential 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. If the individual is a Hispanic individual living in Milwaukee County, the ADRC informs the potential member and/or her/his legal representative of 1) the option to choose between UCC (if the selected PIHP has a care management contract with UCC) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either UCC (if available) or PIHP network providers.

IHCPs who provide care management to Indian members are required, via the SMA-PIHP-IHCP Agreement, to educate members about the full range of waiver services available to them – not just those services provided by the IHCP. The IHCP is also 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. The IHCP provider is required to ask the member to sign an attestation which will be attached to the member care plan (MCP) indicating that IHCP has provided him/her with this information every twelve (12) months as part of the annual comprehensive assessment. If the member refuses to sign the attestation, the IHCP 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 to assure this process has occurred.

If UCC provides care management to Hispanic members UCC is required, via the PIHP-UCC contract, to educate members about the full range of waiver services available to them – not just those services provided by UCC. UCC is also required to educate members that they have a right to free choice of providers and can access services through UCC (if available and UCC has the capacity) or a PIHP network provider. UCC is required to ask the member to sign an attestation which will be attached to the member care plan (MCP) indicating that UCC has provided him/her with this information every twelve (12) months as part of the annual comprehensive assessment. If the member refuses to sign the attestation, UCC will document that refusal in the MCP. The State's EQRO will, as part of its annual review, sample the MCPs of Hispanic members receiving care management from UCC 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. The Aging and Disability Resource Center (ADRC) and the Tribal Aging and Disability Resource Specialist (TADRS) inform members of the member-centered care planning process prior to enrollment. Upon enrollment, members are provided with an SMA-approved member handbook that is specific to the PIHP that describes the care planning, care management, and service authorization processes that the PIHP is required to use; the role members and their families play in these processes; and the grievance and appeal rights and procedures. In addition, the SMA-approved member handbook explains a member's rights and responsibilities as a member in the PIHP. For Indian members who choose to receive Indian Health Care Provider (IHCP) care management, the member handbook will include an insert specific to the IHCP. Likewise, members are informed by the ADRC and TADRS – prior to enrollment – and by the PIHP and IHCP (if applicable) – immediately following enrollment – of the option to self-direct supports and services. This option is also explained in the member handbook. This information and support, as with all aspects of the member-centered planning process, is communicated to the member in plain language; in a manner that reflects his or her cultural considerations; and in a way that is accessible to members with disabilities, through the provision of auxiliary aids and services at no cost to the member, and to members who are limited English proficient, through the provision of language services at no cost to the member. This process provides the necessary information and support to ensure that the member leads and directs the member-centered care planning process to the maximum extent possible and that the member is enabled to make informed choices and decisions. Information specific to Indian members receiving care management from an IHCP can be found in the SMA-IHCP-PIHP Agreement.

b. Each member has the right to include anyone he or she chooses 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. Upon enrollment, the PIHP is responsible for providing all services in the benefit package that are needed by the member. The PIHP must contact the member within three calendar days of enrollment to welcome the member to the PIHP; review the stability of current supports to identify the services necessary to sustain the member in his/her 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; and schedule a face-to-face contact at a time and location convenient to the member.

Initial service authorizations must be developed and implemented within five calendar days of enrollment and signed by the member or the member's legal decision maker within 10 calendar days of enrollment. An initial assessment must be completed within 10 calendar days of enrollment. A comprehensive assessment must be completed within 30 calendar days of enrollment. A fully developed member-centered plan (MCP) shall be finalized and signed by the member or the member's legal decision maker within 60 calendar days of enrollment.

The assessment and MCP are developed by the interdisciplinary team (IDT). The IDT always consists of the member, the member's guardian, any other persons requested by the member, a registered nurse, and a social service coordinator assigned by the PIHP. The IDT may also include, as needed, any other appropriate professionals (e.g., therapist, behavioral specialist).

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 State-IHCP-PIHP Agreement.

PIHPs must obtain the signature of all individuals and essential providers responsible for the MCP implementation. Essential providers will be defined under program policy. For non-essential providers, the PIHP will attach a copy of the provider's signed service contract, agreement, or authorization to the MCP. The PIHP will distribute a copy of the MCP to the member or the member's legal decision maker, and essential provider(s) that are responsible for the MCP's implementation, according to program policy. For non-essential providers, the PIHP will attach a copy of the provider's signed service contract, agreement, or authorization to the MCP.

b. Assessments include a face-to-face interview between the IDT and the member that comprehensively assesses and identifies the member's needs and strengths, preferences, informal supports, personal experience outcomes, and long-term care outcomes and identifies any ongoing member conditions that require a course of treatment or regular care monitoring.

The assessment must include a review of the member's functional screen, available member medical records, and any other available background information. It must also include documentation of:

i. 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;
ii. The member's medications and understanding of the desired responses, potential benefits, and side effects, and rationale for use and a detailed description of the behaviors indicating the need for any complex medication regime or behavior modifying medication; 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;
iii. Clarification and correction of any discrepancies between medications prescribed and taken;
iv. An exploration of self-directed supports and the member's desire to self-direct;
v. The member's preferences regarding privacy, services, caregivers, and daily routine;
vi. Mental health, alcohol, and substance use issues;
vii. The availability and stability of natural and community supports, and assessing how to sustain, maintain, and/or enhance existing supports;
viii. The member's preferred living situation and the stability of housing and finances to sustain housing;
ix. The member's preferences for educational and vocational activities, including supported employment;
x. The member's available financial resources;
xi. 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; and
xii. The member's vulnerability and risk of abuse or neglect.

The IHCP is required to use the PIHP's assessment protocol.

c. Members are first informed about the services available in the Family Care program by the Aging and Disability Resource Center (ADRC) or the Tribal Aging and Disability Specialist (TADRS) before enrolling. Upon enrollment, members are also provided with an SMA-approved member handbook, which describes the services available.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the State-IHCP-PIHP Agreement.

d. The MCP is developed using a member-centered process that identifies and documents the member's long-term care personal experience outcomes; the services and supports, consistent with the assessment, that will be sufficient to assure the member's health, safety, and well-being and which are satisfactory to the member in supporting his or her outcomes; and will encourage the active involvement of the member and his or her natural and community supports.

To ensure that the MCP is understandable to the member and the individuals important in supporting the member, it is written in plain language and in a manner that is accessible to members with disabilities (through the provision of auxiliary aids and services at no cost to the member) and members with limited English proficiency (through the provision of language services at no cost to the member).

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the State-IHCP-PIHP Agreement.

e. The IDT is responsible for coordinating waiver services with other services and service providers that also support the member. Managed long-term care includes all Medicaid-funded long-term care services. The coordination efforts are primarily with Medicare and Medicaid acute and primary health care providers. Most coordination efforts are conducted by the registered nurse on the IDT.

f. The IDT, which includes the member, is responsible for development of the MCP. The MCP results in service authorizations for providers that the IDT processes. The IDT is responsible for monitoring the delivery of those services and supports. The IDT is also responsible for monitoring the member's health and welfare. The IDT is required to conduct a face-to-face visit with the member each quarter of the calendar year.
Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the State-IHCP-PIHP Agreement.

g. The member and IDT must review and update the MCP periodically, but 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.

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 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 or chemical restraint; and identification of specific mechanisms to balance member needs for safety, protection, good physical health, and freedom from accidents with overall quality of life and individual choice. Indian Health Care Providers (IHCPs) providing care management are required to comply with the PIHP's safety and risk policy.

The PIHP's safety and risk policy reduces risk to members by making the interdisciplinary teams responsible for preventing unnecessary risk. PIHP procedures provide teams with appropriate tools for working with each member to identify risks and assess the level of risk that the member is willing to accept in order to allow for personal freedom.

The interdisciplinary team monitors the effectiveness of backup plans. It ensures that provider contracts include arrangements for backup for direct care providers or that a member's self-directed supports plan includes backup arrangements. Specific arrangements vary 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 its performance in the area of safety and risk issues to ensure that there are individualized supports in place to facilitate a safe environment for each member and that its performance is consistent with the understanding of the desired member outcomes and preferences. If it is consistent with the member's preferences, family members and other informal supports are included 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.

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 year, 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):

Member-centered plan (MCP) reviews are conducted on an ongoing basis and carried out concurrently as the PIHP develops and implements the member's individual MCP. For each PIHP, a sample of members is selected 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.

The MCP for each individual in the sample is made available to the SMA-designated reviewers, either onsite at the PIHP or off-site at the SMA. MCPs are reviewed by individuals who are knowledgeable about waiver target groups, services, eligibility requirements, and the service delivery system. The MCP may also be reviewed in consultation with other professionals within the SMA, including nurse consultants, therapy consultants, and others who have knowledge of services and member needs.

When a MCP identifies and addresses each of the member's needs adequately, the MCP is approved. If the reviewer finds, after collecting all relevant information, that services in a MCP do not address the member's disabilities and needs in critical areas, or if basic member needs are overlooked in the assessment, an immediate referral will be made to the SMA and the PIHP will be contacted. 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 essential needs of the member are adequately addressed. In this circumstance, the MCP will not be approved until the identified problems are corrected. The SMA will track and review findings, identify trends, and provide a periodic report to the PIHP. If a PIHP is found to have an unfavorable trend towards non-approved MCPs, the frequency of review may be increased.

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. Such reviews may be targeted to situations where quality monitoring results indicate additional review is needed, for example, specific PIHPs, specific interdisciplinary teams, specific target populations, or members with specific conditions.

These procedures also apply to MCPs developed by an IHCP providing case management. A statistical sample of those MCPs will also be 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 of the member's health and welfare.

b. As required by the SMA-PIHP contract, the IDT regularly contacts members, face-to-face and by telephone, to monitor the implementation of the MCP as well as the member's health and welfare. Further, the IDT may review provider timesheets, provider agency reports, or member contact records.

When the IDT contacts the member, it is required to document all aspects of service monitoring to ensure that the member receives services and supports as authorized, the natural and community services and supports are being provided as identified in the MCP, and the quality of services and supports received is adequate and necessary.

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 face-to-face contacts based on the complexity of the member's needs and the member's potential vulnerability/risk.

The SMA-PIHP contract requires, at a minimum, the IDT to conduct a face-to-face visit with a member every three months. Both the social services coordinator and registered nurse are required to conduct a face-to-face visit in the member's residence, at a minimum, every twelve months 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. For this exception, the following safeguards have been put in place:

The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist (TADRS) is responsible to inform the potential member and/or his or her legal representative about the available service and enrollment options. If the individual is an Indian, the ADRC or TADRS informs the potential member and/or his or her legal representative 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.

IHCPs that provide care management to Indian members are required, via the SMA-PIHP-IHCP 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.

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** Specify:	☒ **Annually**
	☐ **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**

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.

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.

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. As needed, the oversight team directs remediation of individual member concerns as well as isolated operational concerns. The oversight team also uses information gathered through direct interaction with the PIHP, and from many available sources, to identify and direct remediation of systemic problems or issues within the PIHP. Oversight teams have the ability to respond quickly to any issue that affects member health or safety.

Each oversight team documents issues and concerns as well as any resolution or remediation in the SMA's oversight team tracking system. An issue cannot be cleared in the tracking system without approval from the supervisor of the oversight team. The SMA has also developed policies and procedures for the EQRO and oversight teams to report concerns that require the SMA's immediate attention.

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. All waiver services, except care management and community residential care services, may be self-directed. In regard to the services that may be self-directed, every member is offered the opportunity to direct some or all of the services that he or she receives. PIHPs and Indian Health Care Providers (IHCPs) performing case management are required to identify the support an individual member may need in order to exercise this option and to provide training opportunities or other assistance as needed.

b. Members may exercise employer authority or budget authority or both. Members may choose to employ a support broker to assist in exercising self-directed supports (SDS) options.

c. 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. SDS is the provision of a flexible array of services provided to members that includes member direction of a specified portion of the member’s authorized services. Each PIHP must have an 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 as closely as possible;
- Planning that occurs within the limits of an individualized budget based on a standardized method to identify typical service costs for waiver members with similar needs in similar situations;
- 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 unique 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, IDT staff are required to 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 must also address 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 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 must also ensure mechanisms are in place to ensure the member's expenditures are consistent with their budget, identify any changes needed to the member's budget or related supports, exercise oversight over potential health and safety issues, exercise oversight regarding potential conflicts of interest, and validate the completion of appropriate provider training.

Annually, members must also 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 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
Assistive Technology/Communication aids	☐	☒
Specialized Medical Equipment and Supplies	☐	☒
Adaptive aids	☐	☒
Adult Day Care Services	☐	☒
Prevocational Services	☒	☒
Personal Emergency Response Systems (PERS)	☐	☒
Supportive Home Care	☒	☒
Relocation services	☒	☒
Daily Living Skills Training	☒	☒
Financial Management Services	☒	☒
Consultative Clinical and Therapeutic Services for Caregivers	☒	☒
Transportation (Specialized Transportation) - Other Transportation	☒	☒
Day Habilitation Services	☐	☒
Housing Counseling	☒	☒
Supported Employment - Individual Employment Support	☒	☒
Consumer Education and Training	☒	☒
Environmental Accessibility Adaptations (Home Modifications)	☒	☒
Home Delivered Meals	☐	☒
Transportation (Specialized Transportation) - Community Transportation	☒	☒
Skilled Nursing Services RN/LPN	☒	☒
Self-Directed Personal Care	☒	☒
Supported Employment - Small Group Employment Support	☒	☒
Vocational Futures Planning and Support	☒	☒
Consumer Directed Supports (Self-Directed Supports) Broker	☒	☐
Respite	☒	☒
Counseling and Therapeutic Resources	☐	☒
Training Services for Unpaid Caregivers	☒	☒

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 Family Care 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:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

- [x] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **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.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

1. Fiscal Management Services of the Self-Directed Support payment system:

a. This program is designed to provide a conduit for individual service funds to be held by the FMS until accessed by members and their support brokers.

b. 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.

2. Content of Report: For this program, the FMS shall submit, at a minimum, and within fifteen (15) days of the end of each period (whether monthly or quarterly), the following reports to the PIHP or IHCP that is responsible for completing all encounter reporting to the SMA:

a. Monthly, the number of financial transactions made.

b. Monthly and quarterly statements indicating all disbursements made on the member's behalf, including vendor paid, categories of payments, and amount paid to each vendor.

c. Monthly and quarterly statements indicating balance of funds in each member account.

d. Quarterly statements indicating aggregate amounts paid by vendor and payment categories and aggregate amounts held in reserve.

3. Other Features and Requirements:

a. The FMS shall maintain all individual service funds in a separate interest bearing bank account and will maintain a separate internal member account for each member.

b. The FMS shall not commingle individual service funds with any other funds that the agency holds.

c. The FMS shall not request or transfer funds from the individual services funds to any other program that it provides.

d. The FMS shall not influence the member or support broker in selecting, contracting with or terminating agreements with support brokers, service providers, FMS providers, or independent contractors.

e. The FMS and PIHP staff agree to meet quarterly to review program goals, and progress and barriers encountered in reaching those goals.

f. The FMS agrees that during the terms of the agreement the contract may be renegotiated to address changes in utilization, service delivery, or other provisions required by law, policy, or funding sources.

g. An audit of the funds held in trust may be performed as part of the FMS audit and included in the audit report submitted by the FMS. The audit of funds held in trust shall be performed on the cash basis of accounting.

4. The FMS shall submit to the PIHP by January 31 of the contract year the following:

a. Legal Name of the Organization;

b. Current street address and telephone number;

c. Chief Operating Officer/Executive Director;

d. Legal Status (Private, Not-for Profit Corporation; Private, For-Profit Corporation, LLC, etc.);

e. Number of board meetings the governing body or board of directors scheduled for the contract year (if applicable);

f. A list of the board officers and their role (President/Chair, Vice President/Chair, Treasurer, Secretary) (if applicable);

g. The address and telephone numbers of all board members, including the board officers (if applicable);

h. Listing of all hours/days and dates the fiscal management agency anticipates to be closed (holidays); and

i. Appropriate Medicaid provider registration forms.

Information regarding FMS when an IHCP is providing case management is detailed in the State- IHCP-PIHP Agreement.

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
Assistive Technology/Communication aids	☐
Specialized Medical Equipment and Supplies	☐
Adaptive aids	☐
Adult Day Care Services	☐
Prevocational Services	☐
Personal Emergency Response Systems (PERS)	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supportive Home Care	☐
Relocation services	☐
Daily Living Skills Training	☐
Financial Management Services	☒
Consultative Clinical and Therapeutic Services for Caregivers	☐
Transportation (Specialized Transportation) - Other Transportation	☐
Day Habilitation Services	☐
Housing Counseling	☐
Supported Employment - Individual Employment Support	☐
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☐
Consumer Education and Training	☐
Environmental Accessibility Adaptations (Home Modifications)	☐
Home Delivered Meals	☐
Transportation (Specialized Transportation) - Community Transportation	☐
Skilled Nursing Services RN/LPN	☐
Care Management	☒
Self-Directed Personal Care	☐
Supported Employment - Small Group Employment Support	☐
Vocational Futures Planning and Support	☐
Adult Residential Care - 3-4 Bed Adult Family Homes	☐
Consumer Directed Supports (Self-Directed Supports) Broker	☒
Respite	☐
Counseling and Therapeutic Resources	☐
Adult residential care - 1-2 bed adult family homes	☐
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☐
Training Services for Unpaid Caregivers	☐

☐ **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 (Family Care) and evidence of coverage document (Family Care-Partnership) that are provided to members upon enrollment. PIHPs are also required to use SMA templates (e.g. notice of adverse benefit determination, notice of change in level of care, etc.). The templates include contact information for the ombudsman agencies and describe the services they provide. This information is also included on SMA-issued notices of disenrollment. PIHPs are required to assist members to obtain access to ombudsman services upon member request.

In addition to the ombudsman programs, individuals who are receiving services for mental illness, a developmental disability, substance abuse, or who have been protectively placed by a court have access to an additional independent advocacy resource, a state-operated grievance system. This system is prescribed by state statute and is operated by the Client Rights Office of the Division of Mental health and Substance Abuse Services. Individuals covered by this program are required to be informed of its existence, their rights under statute and rule and must be assisted in accessing this program if they request it.

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 Family Care services or disenrolling from the program; the member is only changing how he or she obtains his or her Family Care services.

When the member decides that she or he no longer wants to self-direct services, the member notifies the 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 he or she 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 PIHP 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 use of backup providers.

The member may use any of the external member resources available for advocacy, including, but not limited to, the Family Care 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		10759
Year 2		11125
Year 3		11483
Year 4		11834

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 5		12186

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.**

- [x] **Determine staff wages and benefits subject to state limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **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*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the state's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **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 some situations where, in the absence of self-direction, the member would likely move into community residential care with a daily rate or his or her care would otherwise be paid at a daily rate, such as live-in home care, that rate may be used as the basis for calculating the member's budget. In all circumstances, the member selects the needs and outcomes for which he or she 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 will 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 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 an FMS 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.

• Daily rate
For members who choose to direct many or all of their services, a PIHP can use a member's current or projected MCP to establish a daily rate for the goods or services that the member will receive. This works well for members who need a significant amount of daily home care, up to 24 hours, especially when workers may not be providing hands-on care but need to be on the premises or when the provider lives with the member. It also can be used for members who, in the absence of self-directed supports, would be in community residential care, with the daily SDS rate based on the daily facility rate plus a daily rate for any waiver services outside of the facility rate. The daily rate is set to be sufficient to comply with applicable wage and hour requirements for member-employed home care workers.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

IDT staff use an assessment tool to estimate the number of hours needed to meet a member's stated outcomes. As a part of the individualized planning process, members receive a document showing them estimated monthly costs. The process of applying an assessment tool and completing that tool with the member ensures consistency and transparency. Fairness is ensured through the Resource Allocation Decision (RAD) making process and discussion, as well as through the availability of appeal options should a member not be satisfied with his/her member-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) retains responsibility for oversight of the member's implementation of his or her member-centered plan (MCP) and use of his or her self-directed supports (SDS) budget. Some PIHPs' contracts for fiscal agent services require regular budget authority utilization reports for 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 prescribe protocols for PIHPs to follow in carrying out these reviews.
Moreover, an SMA Member Care Quality Specialist reviews a sample of member charts for each PIHP on a rotating basis. For members who self-direct, special attention is paid to plans and associated budgets.

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.

Members are informed of the right to a fair hearing in multiple ways and at multiple times, including prior to enrollment, at the time of enrollment, and while enrolled. The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialists (TADRS) inform potential members of the right to a fair hearing prior to enrollment. This information is contained in the "Being a Full Partner" booklet produced by the SMA, which ADRCs give to all potential members. The regional income maintenance (IM) consortium determines eligibility for Medicaid and all managed long-term care programs, and processes enrollments. The IM agencies use standardized eligibility notification forms that include information about the right to a fair hearing. Once a member is enrolled, the member handbook (Family Care) or evidence of coverage document (Family Care-Partnership), given to every member by the PIHP's inter-disciplinary team (IDT), contains information about the right to a fair hearing and how to request one. PIHPs are also required to use SMA templates (e.g. notice of adverse benefit determination, notice of change in level of care, etc.). The templates include information about the right to a fair hearing and how to request one. This information is also included on SMA-issued notices of disenrollment. Copies of these notices 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 members. 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.

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.

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 EQRO tracks all grievances in a database that the SMA has access to. This database includes all timeline information. In addition, the SMA receives a monthly report from the EQRO, detailing the grievances and efforts to mediate a resolution. This report is reviewed by the SMA for consistency. The SMA uses the grievance and appeal database to monitor trends for each PIHP and trends overall.

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a. A grievance is an expression of a member's dissatisfaction about any matter other than an adverse benefit determination. Common examples of issues than can be grieved include changes in providers, concerns about the quality of care or services, and personal care workers arriving late.

Adverse benefit determinations are defined in the SMA-PIHP contract as:

1. a denial of or a reduction in functional eligibility as a result of the PIHP's administration of the long term care functional screen;
2. a denial or limited authorization of a requested service in the benefit package, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
3. the reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount or duration and that amount or duration has been completed;
4. the denial, in whole or in part, of payment for a service in the benefit package;
5. the failure to provide services and/or support items included in the member–centered plan (MCP) in a timely manner;

6. the failure of the PIHP to act within the timeframes for resolution of grievances and appeals;
7. the development of an MCP that is unacceptable to the member because:
a. the MCP is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member,
b. the MCP does not provide sufficient care, treatment, or support to meet the member's needs and/or support the member's outcomes, or
c. the MCP requires the member to accept care, treatment, or support items that are unnecessarily restrictive or unwanted by the member;
8. the involuntary disenrollment of a member from the PIHP at the PIHP's request;
9. the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities; or
10. the denial of a member's request to obtain services outside the PIHP's network when the member is a resident of a rural area with only one managed care entity.

b. Members must first file a grievance with their PIHP. The PIHP must issue a written decision on the grievance within 90 calendar days of the date of receipt. For FIDE SNP members, effective 1/1/2021, 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.

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 G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

○ **No. This Appendix does not apply** *(do not complete Items b through e)*
If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The incident types that the SMA requires to be reported for review and follow-up action are:

1. Abuse (physical, sexual, emotional, treatment without consent, unreasonable confinement or restraint);
2. Neglect and self-neglect;
3. Financial exploitation;
4. Any unplanned or unapproved use of restraints or restrictive measures;
5. Any unplanned or unapproved use of isolation/seclusion;
6. Death due to member abuse, neglect, self-neglect, exploitation, accident, restraint, seclusion, suicide, psychotropic medication(s), medication error(s), falls; unexplained, unusual, or suspicious circumstances;
7. Missing person;
8. Any unplanned (e.g. emergency) or unapproved involvement of law enforcement and/or criminal justice system (e.g. not addressed in a restrictive measures or behavior support plan);
9. Medication errors (med omission, wrong med, wrong dose, wrong time, wrong person, wrong route of administration, wrong technique); and
10. Falls

Incidents must be reported to designated PIHP staff by contracted providers or by PIHP staff no later than one (1) business day after the incident was discovered. Incidents may be reported by phone, paper form, or use of the respective PIHP's web-based incident reporting system.

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.

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 Teams (IDT) provide training regarding abuse, neglect, and exploitation to PIHP members, families, legal representatives, and/or unpaid direct caregivers. This training occurs 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.

Each PIHP is responsible for evaluating the reports. Reports are evaluated by designated PIHP managers who initiate incident investigations. Each PIHP has an incident review committee to evaluate all incidents and monitor for trends and quality improvement opportunities. The frequency of committee meetings varies by PIHP (weekly, biweekly, monthly, or quarterly).

PIHPs initiate an incident investigation to determine the cause of all incidents.

Designated PIHP staff or the provider complete an investigation of the incident and related events to determine and document whether the reported incident occurred and if it did:

a) The facts of the reported incident (including the date and location of occurrence), the type and extent of harm experienced by the member, any actions that were taken immediately to protect the member and to halt or ameliorate the harm;
b) The cause(s) of the incident;
c) Whether reasonable actions by the provider or others with responsibility for the well-being of the member would have prevented the incident; and
d) Whether any changes in the PIHP's or provider's policies or practices might prevent occurrence of similar incidents in the future.

Investigations are to be completed within thirty (30) calendar days of incident discovery. If information or findings necessary for completion of the investigation cannot be obtained within 30 calendar days for reasons beyond the PIHP's control, the investigation is to be completed as promptly as possible.

Within five (5) business days of completion of each incident investigation, the PIHP is to provide notification of the results of the investigation to the member or the member's legal representative. This notification will be documented in the member's care management record.

Indian Health Care Providers (IHCP) performing case management are required to complete the 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. In a monthly report, in a format specified by the SMA, the PIHPs must report all specified incident types.

Individual member/incident data elements are collected monthly. Data is aggregated and compiled into a monthly SMA incident report and disseminated to Oversight Teams and SMA management. Each Oversight Team reviews its respective PIHP's monthly report to monitor for incident trends and any member care-related quality issues/concerns relevant to PIHP incident management. Each SMA oversight team conducts monthly follow-up reviews with its PIHP or with the Indian Health Care provider. Remedial or corrective action is determined, as needed, by the oversight team. All findings and/or follow-up by the SMA oversight team are documented. Additional follow-up may include, but is not limited to, examination of individual member data (as provided in the PIHP's monthly report) and/or individual member record reviews, depending on the trends or concerns identified.

Annually, the EQRO will conduct a Quality Compliance Review for performance validation of each PIHP's incident management system. The SMA may also request targeted quality reviews when necessary.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Unless specifically indicated otherwise, all of the information provided applies to restraints, restrictive interventions, and seclusion.

The Restrictive Measures Guidelines and Standards are available at:

https://www.dhs.wisconsin.gov/publications/p02572.pdf

The PIHP is responsible for investigating unauthorized or emergency use of restraints in the context of incident management system investigations. Actions taken with provider deficiencies may include, but are not limited to, mandated training or re-training and additional monitoring by the 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 a similar emergency occurs more than twice in a six month period, it is no longer an emergency and the restrictive measures planning process for an approved restrictive measure is initiated.

Each request for use of a restraint must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request for the restrictive measure.

Any use of restraint that is not within the scope of the state Restrictive Measures Guidelines and Standards is prohibited under any circumstance.

Each PIHP's restrictive measures committee reviews and approves each request prior to submission for state level review and approval.

Once submitted to the SMA, review and approval of restraint requests is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. The review will be completed within 45 business days of receipt of the request.

Each Division of Medicaid Services Restrictive Measures Review Panel is comprised of the State Restrictive Measures Coordinator and 1-2 additional staff from any of the following teams:

- Best Practice Integration Resources
- Member Care Quality Specialist
- DHS Division of Quality Assurance (if the residence is licensed)
- Area Administration
- IRIS (Self-Directed Supports program)
- Children's Long Term Supports

Documentation requirements related to restraint use are specified in the Restrictive Measures Guidelines and Standards. Each restraint application must specify the monitoring and documentation plan as well as the reduction/elimination plan.

Providers are required to report the use of each approved restraint to the applicable PIHP as indicated in the application.

Quarterly each PIHP reports restrictive measures member utilization data to the SMA in accordance with the SMA's data reporting specifications.
All individuals involved in the administration of restraints/seclusion must be trained by the SMA, a restrictive measures training expert and/or designated competent PIHP (or IHCP if applicable) staff. Assurance of training of all individuals involved in the administration of restraints/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 as applicable.

Restraints may be approved for less than but no more than one year; a renewal request, review, and approval is required prior to expiration of the previous approval.

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 will collect 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 will extract aggregated data from the warehouse environment for analysis, tracking, and trending to identify potential patterns and outcomes for monitoring and possible quality improvement efforts.

The SMA is responsible for review of each PIHP's monthly incident reports. Upon request for renewal of restrictive measures approval, the member's restrictive measures utilization report will be reviewed to monitor restraint/seclusion trends and to verify the effectiveness of approved restraints/seclusion. At a minimum, follow-up consists of a review of the report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data as provided in the PIHP's monthly incident report and/or individual member record reviews, depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the SMA Oversight Team are documented.

Potential patterns concerning the unauthorized use of restraints associated with certain providers will be obtainable via analysis of the incident management system data. Unauthorized use of restraints (any type), isolation, or seclusion is captured as a member incident within the Incident Management System.

Use of approved restrictive measures is monitored and accounted for by each PIHP's restrictive measures lead. Thus, whether restraints 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.

Member record reviews could include the member-centered plan (MCP), approved restrictive measures request, PIHP tracking data concerning behavioral incidents, antecedent behavior tracking, use of restrictive measure(s), and related training documentation. The SMA would also review any appeal and grievance issues related to a restrictive measure.

During the annual 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, all of the information provided applies to restraints, restrictive interventions, and seclusion.

Each request for a restrictive intervention must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request.

Any use of a restrictive intervention that is not within the scope of the state Restrictive Measures Guidelines and Standards is prohibited under any circumstance.

Unauthorized and /or emergency use of restrictive interventions is to be reported as an incident by any person who observes such use or to whom such use is reported by the member. Any report is to be investigated as a member incident.

Review and approval of all restrictive intervention requests is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. Each PIHP's restrictive measures committee reviews and approves each request prior to submission for state level review and approval.

Documentation requirements related to restrictive interventions are specified in the Restrictive Measures Guidelines and Standards. Each restrictive intervention application must specify the monitoring and documentation plan.

Providers are required to report the use of each approved restrictive intervention to the applicable PIHP as indicated in the application.

Quarterly each PIHP reports member data (which includes IHCP data) to the SMA in accordance with the SMA's data reporting specifications.

All individuals involved in the administration of restrictive interventions must be trained by the SMA, a restrictive measures training expert and/or designated competent PIHP/IHCP staff. Restrictive interventions 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.

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:

The SMA is responsible for review of each PIHP's monthly incident reports. Upon request for renewal of restrictive measures approval, the member's restrictive measure utilization report will be reviewed to monitor restraint/seclusion trends and to verify the use and effectiveness of approved restraints/seclusion. At a minimum, follow-up consists of a review of the report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data as provided in the PIHP's monthly incident report and/or individual member record reviews, depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the SMA Oversight Team are documented.

PIHPs are required to report any unauthorized use of restraints/seclusion within their member incident management systems.

Data are aggregated to enable comparative analysis of trends/patterns across the PIHPs and data variables. Any concerning trends are examined for quality improvement opportunities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Unless specifically indicated otherwise, all of the information provided applies to restraints, restrictive interventions, and seclusion.

Each application for seclusion must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request. Any use of seclusion that is not within the scope of the state Guidelines and Standards is prohibited under any circumstance.

Unauthorized and /or emergency use of seclusion is to be reported as an incident by any person who observes such use or to whom such use is reported by the member. Any report is to be investigated as a member incident.

Review and approval of each seclusion request is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel.
Each PIHP's restrictive measures committee reviews and approves each request prior to submission for state level review and approval.

Documentation requirements related to seclusion use are specified in the Restrictive Measures Guidelines and Standards. Each seclusion application must specify the monitoring and documentation plan.

Providers are required to report the use of each approved use of seclusion to the applicable PIHP as indicated in the application.

Quarterly each PIHP reports member data (which includes IHCP data) to the SMA in accordance with the SMA's data reporting specifications.

All individuals involved in the administration of seclusion must be trained by the SMA, a restrictive measures training expert and/or designated competent PIHP/IHCP staff. 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.

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:

The SMA is responsible for review of each PIHP's monthly incident report. Upon request for renewal of restrictive measures approval, the member's restrictive measures utilization report will be reviewed to monitor restraint/seclusion trends and to verify the use and effectiveness of approved restraints/seclusion. At a minimum, follow-up consists of a review of the report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data as provided in the PIHP's monthly incident report and/or individual member record reviews, depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the SMA Oversight Team are documented.

PIHPs are required to report any unauthorized use of restraints/seclusion within their member incident management system.

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) 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 – 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 nursing staff or other appropriately licensed medical professional is responsible for monitoring the member's medication regimens as part of regular reassessment, at least every six months or more often when there is a significant change in health or functional status. This activity is part of the member's nursing assessment. It includes 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. SMA reviews monthly PIHP incident reports for medication errors, trends, and/or concerns. Identifying insufficient responses to medication errors requires a review and corrective action plan.

When medication errors are the result of nurse error, the Department of Safety and Professional Services (DSPS) completes the oversight and any sanctions. The DSPS communicates its oversight activities related to errors made by nurses to PIHPs via:
• A letter to the nurse's employer(s)
• Posting of Board of Nursing disciplinary actions in the Wisconsin Board of Nursing newsletter

Wisconsin RNs are also required to self-report to DSPS.

PIHPs are contractually required to assure all RNs are duly and fully licensed upon and throughout employment. RNs are to report any licensure changes to the PIHP; failure to do so may be cause for termination.

When specifically directed by the SMA, the EQRO will evaluate PIHP performance related to medication management.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

○ **Not applicable.** *(do not complete the remaining items)*

◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Providers are required to assess medications a member takes and the member's ability to control and self-administer medications. Providers administer medications to members who have been found incompetent or lack the physical or mental capacity to self-administer as determined by the member's physician, or to members who request in writing that the provider manage and administer medication.

When a service provider is responsible for the administration of medications to a member, there must be a written order from a physician and a properly labeled prescription, including the dosage. Medications given on an as needed basis require a clear definition of the circumstances under which the medication is given. A registered nurse affiliated with or employed by the provider is responsible to assure that staff who assist with the administration of medications are appropriately trained in administration of the medications that are specific to each member. Staff document each medication administration at the time of administration. Documentation of errors takes place as soon as discovered.

Members that have the capacity to self-administer medications do so and their medications remain under their control. The provider makes available a secure place for the storage of medications in the member's room. A member with the mental and physical capacity to develop increased independence in medication administration shall receive self-administration instruction.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Providers are required to report medication errors affecting Family Care members to the PIHP. The PIHP must report errors to the Department of Health Services, Division of Medicaid Services.

In addition, providers licensed by the Department of Health Services, Division of Quality Assurance (DQA) have reporting requirements related to the terms of their licensure. The DQA regulates licensed and certified residential facilities including annual onsite monitoring and investigation of complaints and incidents with those facilities.

Providers in a licensed profession may also have license-related reporting requirements enforced by the Department of Safety and Professional Services (DSPS). The DSPS regulates licensed professional nurses, such as LPN, RN, APNP, as well as investigation of complaints for professional misconduct.

(b) Specify the types of medication errors that providers are required to *record:*

PIHPs monitor the performance of contracted providers, including identification of potentially harmful practices. All medication errors (medication omission, wrong medication, wrong dose, wrong time, wrong person, 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:

PIHPs monitor the performance of contracted providers, including identification of potentially harmful practices. All medication errors (medication omission, wrong medication, wrong dose, wrong time, wrong person, wrong technique, and wrong route) discovered by providers must be reported to the PIHP at the time of incident discovery. Therefore providers do not report medication errors directly to the SMA; incident reports to the SMA are provided monthly by the PIHPs. Any necessary corrective action will be taken by the PIHPs per medication administration standards of practice for each particular type of provider.

The DQA and DSPS have standards for reporting specific to categories of licensure. DQA provides ongoing oversight of provider medication administration practices in regulated facilities and takes appropriate regulatory actions if a pattern of errors are discovered.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

PIHPs monitor the performance of contracted providers, including identification of potentially harmful practices. All medication errors discovered by providers must be reported to the PIHP at the time of incident discovery. Therefore providers do not report medication errors directly to the SMA. Any necessary corrective action will be taken by the PIHP per medication administration standards of practice for each particular type of provider. In addition, the 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 are discovered.

Incident data reports are provided monthly to the SMA by the PIHP. Incident data is reviewed to identify trends and patterns and support improvement strategies.

The external quality review organization (EQRO) evaluates the performance of PIHPs for appropriate medication management as part of annual quality reviews.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the 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 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**

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:

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** 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:

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 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: 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 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:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Additional information for the Performance Measure listed under sub-assurance (c) above:

SMA oversight staff will review individual case files at the PIHP to determine if restrictive interventions are being monitored by the PIHP and that the monitoring shows that the interventions are being implemented as approved. This review applies to all waiver populations.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the 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.

Providers, members, guardians, and family members are charged with reporting individual problems to the PIHP. This includes the reporting of incidents (including unapproved use of restraints, restrictive interventions, and seclusion); the use of approved restraints, restrictive interventions, and seclusion; and medication errors (these are a subset of incidents).

PIHPs are charged with investigating and remediating individual problems related to incidents; restraints, restrictive interventions, and seclusion; and medication errors as they are discovered. PIHPs are expected to remediate problems based on the nature of the incident and the potential for additional harm or reoccurrence of the problems, with rapid remediation expected in instances carrying the highest risk of harm.

As part of routine oversight, the SMA reviews the incident reports (including medication errors) and reports of incorrect use of approved restraints, restrictive interventions and seclusion submitted by PIHPs and reviews the PIHPs' response to these problems. The SMA reviews any instances discovered by the EQRO during the review process, problems identified in the annual restraints, restrictive interventions, and seclusion review and approval process and any on-site observations made by SMA staff or other potential reporters. If issues with the substance or timeliness of remediation is determined to be deficient, the SMA will review requirements and procedures with the PIHP and may request corrective action if warranted.

ii. Remediation Data Aggregation

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

Responsible Party*(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 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 regional or central office managers. Individual issues may be identified through the review of reports submitted by PIHPs, the findings of the external quality review organization (EQRO), and other sources. This process occurs on a continuous basis. 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, 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 during the discovery process, 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 issues technical assistance and policy documents as well as contract changes to address some issues that have been identified among multiple PIHPs.

4. Systemic Issues

Systemic issues that could affect member health and safety or that involve members with high risk due to complex needs are given priority, but issues that address service gaps, affect financial accountability and could impact SMA compliance with waiver assurances are also prioritized for remediation. Issues that require corrective action are identified in writing by the SMA to the PIHP and the SMA oversight team tracks and documents implementation of the corrective action. Significant issues of concern are also 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 multiple PIHPs are supervised by regional managers who can identify trends across the PIHPs for which they have responsibility. All of the SMA oversight teams meet on a periodic basis to share information about PIHP performance and best practices in relation to PIHP oversight. The SMA regional managers meet regularly with other regional and SMA managers and discuss issues they are seeing that may cross PIHPs or suggest changes to SMA policies and procedures. SMA managers coordinate with managers in the SMA's Bureau of Financial Management and with 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 within the unit and brought to management as appropriate. Issues that require an immediate response may be addressed through written policy clarifications, technical assistance documents, or contract amendments. Other issues may require more in-depth analysis and discussion within the SMA and may result in amendments or changes to future contracts.

c. Quality

i. Trending and analysis of performance metrics

The SMA has identified a number of performance metrics that it is tracking and trending over time. Those metrics are available to PIHPs and SMA oversight teams 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 are relatively new and may be modified over time. The performance metrics are not specified as such in the SMA-PIHP contract although many of them are based on reporting requirements found in the contract, such as influenza and pneumococcal vaccination rates, member survey results and financial reporting. Another group of 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

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. Adult Long Term Care Dashboard

The SMA developed a digital Adult Long Term Care Dashboard in 2018 that tracks data such as program enrollment, member living situation, incidents, admissions to institutions of mental disease, use of self-directed services, PIHP staff turnover, continuing skills scores for functional screeners, and ombudsman cases. Data in the dashboard is available to program managers and is updated on a monthly, quarterly, or annual basis as appropriate. Following the creation of the dashboard, implementation of a system for monitoring and identifying quality improvement opportunities based on the trended dashboard data will become part of the overall Quality Improvement Strategy as a tool for identifying real-time concerns requiring further investigation.

iv. Implementation of Medicaid Managed Care Quality Strategy

On June 28, 2018, the SMA submitted 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 five goals with corresponding quality measures. These goals address four domains of quality improvement: 1) access to care and member choice, 2) cost-effectiveness, 3) person-centered care and member experience, and 4) health outcomes and reducing disparities. Measures presented in the strategy include and extend beyond regulatory requirements and are operationally defined and collected through the appropriate measurement mechanisms. Enabled by health information technology and data infrastructure innovation, strategies including payment reform, delivery system transformation, and member engagement are employed to reach quality goals. The strategy will be revised and submitted to CMS every three years.

5. Methods of Implementing Quality Improvement Strategies

Quality improvement strategies can be implemented in a variety of ways including:

a. Oversight

i. 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.
ii. 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.
iii. 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 each 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, depending on the urgency.
ii. Issuance or modification of technical assistance and policy documents: The SMA issues technical assistance and policy documents on an ongoing basis, as needed, to address a range of issues including improving quality. These documents are sent to the PIHPs and are available to members and providers on the SMA's website.
iii. 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. Statewide performance improvement projects: The SMA-PIHP contract includes a provision allowing the SMA to mandate a statewide performance improvement project to address an issue that is of program-wide concern. The SMA has not required a statewide improvement project in a number of years, but it remains an option if an area of concern is identified by the SMA.
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.

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 (e.g. RN, behavioral health specialist) 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 as the information is being gathered. The processes for monitoring and assessing systems improvement vary. A major guiding principle is that the same measurement or observation by which the need for improvement was identified should be repeated. For example, the success of a systems improvement change, developed in response to a care plan review finding that identified insufficient documentation of offers of self-direction, is confirmed by another care plan review. The EQRO annual quality reviews routinely include repeat measurements of any indicators that were observed to be less than satisfactory in the previous year.

When systems improvements are implemented with organized performance improvement projects (PIPs), the specifications for monitoring and assessing the implemented change are developed and adopted in compliance with the standards set forth in the CMS protocol for PIPs. When a PIP is undertaken by a single PIHP, the PIHP develops the process and measures for monitoring and assessing system design changes, which are approved by the SMA and annually validated by the EQRO. If the PIP is a statewide project, the process and measures for monitoring and assessing system design changes are selected by the SMA, with the consultation of the EQRO and the PIHPs.

Changes to systems or processes are communicated to the PIHPs through official SMA transmittals such as technical assistance documents or 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 Family Care program to the general public, including stakeholders, such as families, providers, agencies and other interested parties. The website includes: general information; program monitoring and evaluation, including Family Care reports; program operations including the PIHP contract, and Family Care requirements.

The results of changes are communicated in many of the same ways. The communication method and frequency 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 biannual 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 (e.g., implementation of an automated system for target group identification during the functional screen process) 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 Quality Improvement Strategy is evaluated by the SMA's Quality Strategy Steering Committee on an annual basis to review performance on waiver measures and revisit high level goals linked to the SMA vision, mission, and values of adult long term care programs. The Quality Strategy Steering Committee includes representation from the quality, oversight, and compliance teams, who shape the SMA's direction of continuous improvement and operationalization of processes to measure, analyze, and improve outcomes. The Steering Committee 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.

EQRO Annual Quality Reviews and activities are periodically reviewed as they relate to the overall Quality Improvement Strategy.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ◉ **NCI Survey :**
- ○ **NCI AD Survey :**
- ○ **Other** *(Please provide a description of the survey tool used):*

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

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 include 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 three 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 and findings identified in the established 3-year cycle audits may be followed up on by the SMA through an audit to evidence correction of the finding prior to the next 3-year cycle audit if warranted.

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 conducted on the three year cycle; through required follow-up audits conducted due to identified deficiencies during annual review of the PIHP policies and procedures; and through comparison of financial reporting submissions to reported claims payments submitted to the SMA encounter reporting system.

c. The SMA defines audit requirements and the program-specific audit program is conducted by all auditors in addition to required standard audit procedures that meet the Generally Accepted Audit Standards for the entity. In place are: the three year examination (audit) cycle; targeted audits as required; and annual independent CPA audits that include program compliance audit requirements developed by the SMA. This may include qualified CPAs with expertise in the waiver program compliance requirements, such as staff from the Office of the Commissioner of Insurance, using the SMA-defined audit program requirements. Standard audit procedures and sampling methods specific to the health insurance industry are used with modifications specific to PIHP program operations and contract requirements. The SMA also uses standard sampling and audit procedures for compliance testing of claims payment systems with verification specific to PIHP program operations and contract requirements. Audit sampling uses a combination of traditional random sampling methods used in audit and auditor selection to ensure samples are representative of the area of testing.

Sampling instructions 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 currently contracted with the OCI to conduct the 3-year cycle audits and the SMA has CPA auditors with specific industry and program expertise to conduct 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***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☐ ***Annually***
	☐ ***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 Family Care 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***
☒ ***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 with the CMS managed care rate setting checklist is approved by CMS. Therefore, payment requirements identified in the SMA contract for the provision of member services are incorporated into the above rate development process. The PIHP is responsible for establishing service provider rates for waiver services for which it contracts. The incentive to negotiate and establish competitive rates that result in cost effective services to meet identified member outcomes is critical to the financial viability of the PIHP. 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. The level of provider rate increases allowed to flow into the base costs during the rate setting process has been limited, by policy decision, in prior years to support the development of the trend (this process is described in Section IV of the 2014 capitation rate report: https://www.dhs.wisconsin.gov/non-dhs/dms/fcratereport2014.pdf). This analysis and limitation, in conjunction with the contract requirement listed above, represent the SMA's primary oversight mechanisms of the provider rate setting process for waiver services.

The SMA's contract with PIHPs contains provisions with respect to the appropriate payment of providers. 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 and the CMS managed care rate setting checklist.

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 includes 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. 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:*

PIHPs' authorized waiver services and provider claims are submitted to a contracted third party administrator (TPA) or the PIHP if processing claims in-house. Claims are processed against the PIHP service authorization and against the contracted provider rates.

Each contracted PIHP must develop a compliant TPA process as outlined in the SMA contract with the PIHP. The PIHP is required to have an internal audit process to sample and verify the TPA processes claims in accordance with the authorization and the contracted rates. The SMA validates that this has been done through annual review of PIHP policies and procedures for claims processing and the process is tested during the sampling and audit of services paid during the independent annual audit, 3-year cycle audits, and periodic SMA audits of the PIHP.

Indian Health Care Providers (IHCPs) of waiver services submit claims to the PIHP or the PIHP's contracted TPA to receive payment at the rate negotiated between the PIHP and the IHCP. The IHCP separately submits a cost report to the SMA for the SMA's wraparound payment/recoupment to/from the IHCP.

DHS's Medicaid Management Information System (MMIS) fiscal agent has selected an EVV vendor for Wisconsin. This arrangement allows DHS to maximize integration between the MMIS and EVV system. A general implementation timeline is as follows:

- *Fall 2019 - Provider, payer, member, and participant trainings.*
- *Early 2020 - DHS requires providers to utilize EVV for personal care services.*
- *Late 2020 - Claims may be denied if EVV is not completed.*

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:

PIHPs can be departments within a county government, government districts, public entities, private for-profit entities, or private non-profit entities. PIHPs are direct providers of care management services. Therefore, payments for care management services can be made to government, public, and private (for profit and non-profit) providers for care management services.

The underlying entity type differs but there is no difference in the operation of the program contracted by the SMA or the contract requirements for the PIHPs. A county government PIHP would be operated by a single county but structured as a separate department of the county and operated as a separate enterprise. Although the county has taxing authority, the contracted PIHP would be at risk for the program operated by the county. There is currently not a county government PIHP under contract with the SMA.

Districts were created through statute by groups of counties with the specific purpose of operating the SMA contracted program. Districts do not have taxing authority and the counties that formed the districts do not bear financial risk at the county level. PIHPs operated under a district are risk bearing and operated as private enterprises. There are currently no districts operating PIHPs under contract with the SMA.

The public entity PIHP, a private for-profit entity, the private non-profit 501(c)(3), and the private non-profit 501(c)(4) are operated no differently from the county or district PIHPs. Regardless of entity type, all contracted PIHPs are risk bearing and required by contract to keep funds and accounting segregated from other operations, whether county, district, public, or private.

The SMA fiscal oversight function includes review of required financial reporting submissions to include both contracted PIHP operations and other operations to support the review and validation that capitation payments are segregated and used to support payments for waiver members' contracted Medicaid services and the infrastructure required to support those services.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- (●) ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ( ) ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ( ) ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- (●) ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

The monthly capitated payment to PIHPs is not reduced or returned in part to the SMA in any way that results in a disparity between the amount that is claimed to CMS and the amounts actually paid to PIHPs.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- (●) ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ( ) ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ○ ***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.***
- ○ ***not selected***

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 exclude room and board from the cost of allowable waiver services. Payments to providers for room and board are not processed through the Medicaid system and are, therefore, not included in any Medicaid cost reports. The waiver member pays the room and board obligation from the waiver member's funds.

The SMA permits PIHPs to choose one of three options for segregating room and board from service costs: an actual cost method and two flat rate methods. Each has strengths and drawbacks and because of that, the SMA has left the choice of a method to each PIHP. Each PIHP can only use one method to ensure consistency within that organization.

Actual Cost Methodology
This method requires calculation of actual room and board costs for each community residential facility with which the PIHP contracts. Facility-specific costs are split between care and supervision on the one hand and room and board on the other. Total costs attributable to room and board are divided by the number of residents licensed or certified for the living arrangement to get a room and board rate.

A. Costs Attributable to Room and Board Rent, mortgage payments, title insurance, mortgage insurance.
- *Property and casualty insurance*
- *Building and/or grounds maintenance costs*
- *Resident's food*
- *Household supplies and equipment necessary for the room and board of the individual*
- *Furnishings used by the individual (does not include office furnishings)*
- *Utilities, resident phones, cable TV, etc.*
- *Property taxes*
- *Specific individual special dietary needs*

B. Costs attributable to Care and Supervision. The following are allowable elements in residential provider rates for which FFP can be claimed:
- *Staff costs:*
  - *Salaries**
  - *FICA*
  - *Staff health insurance costs (benefits)*
  - *Worker's compensation*
  - *Unemployment compensation*
  - *Staff travel*
  - *Staff liability insurance*
  - *Staff development/education*
  - *Resident travel (includes depreciation on vehicle)*
  - *Administrative overhead-contractor's costs to do business, including:*
  - *Office Supplies and Furnishings*
  - *Percentage of administrative staff salaries*
  - *Office telephone*
  - *Recruitment*
  - *Audit fees*
  - *Operating fees/permits/licenses*
  - *Percentage of office space costs*
  - *Data processing fees*
  - *Legal fees*
  - *Agency liability insurance*

**In certain circumstances a staff person's wages and benefits may need to be apportioned between room and board costs and care and supervision. For example, a live in manager of a facility may have time apportioned for supervision and support, as well as building and ground maintenance.*

A PIHP that uses this method is responsible for assuring that each residential care provider with which it contracts uses this method for identifying the portion of the facility rate attributable to room and board, for maintaining documentation or auditing providers to verify the accuracy of these calculations, and for updating this information annually.

Flat Rate Methodologies
These methods use a standard rate as the room and board cost for every residential care facility, or depending on the method, the rate can vary by county and type of residential facility.

A. SSI-E Payment Standard - SSI–E or the SSI Exceptional Expense Supplement represents the highest combined federal and state SSI payment amount in Wisconsin. Eligibility for the supplement is based on qualifying for SSI and either residing in community residential care or needing at least 40 hours a month of supportive services in one's personal home. The flat rate equals the SSI-E payment amount ($900.77 in 2014) minus a personal needs allowance the PIHP may set at either $80 or $100 a month (must be the same for all members in community residential care in the PIHP's service area). This flat rate method is used regardless of whether the member receives SSI or her/his income comes from other sources. Since the SSI-E amount changes annually, the PIHP must update this room and board flat rate annually. A PIHP using this method with a $100 personal needs allowance would have a flat room and board rate of $800.77 in 2014.

B. HUD Fair Market Rate (FMR) Method - This method uses HUD FMR rental amounts as a proxy for housing costs. HUD FMR rents are set at the 40% percentile of surveyed rental costs reflecting modest but reasonable housing, include utilities, vary by county and apartment size, and are updated yearly. PIHPs using this method use the prior year's HUD FMR efficiency rent for owner–occupied Adult Family Homes; the one bedroom rent for corporate Adult Family Homes and Community-Based Residential Facilities; and the two bedroom rent for Residential Care Apartment Complexes. The board portion is set at a flat amount equal to the maximum Supplemental Nutrition Assistance Program (SNAP, called FoodShare in Wisconsin), allocation for one person plus a small amount for ancillary costs not included in the FMR or Foodshare figures. Figures are updated yearly.

The SMA permits PIHPs to choose from among the actual cost and two flat rate methods because each has strengths and drawbacks. The actual cost method is the most accurate when based on accurate data and calculations and reimburses real costs needed to sustain the facility and attract residential providers to serving members. However, the yearly calculations may be administratively burdensome and as a cost-based method, it lacks incentives to control room and board costs which frequently may exceed what members can afford to pay.

Flat rate methods provide more control over room and board rates. They are simple to calculate, transparent, and predictable for providers to make decisions about working with the Family Care Program. Members and potential members know prior to enrollment and/or admission to the facility what their financial obligation will be. However, flat rate methods may establish an amount which does not cover every facility's costs and members may pay more or less than the "real" room and board cost of the facility where they reside. These methods produce a reasonable proxy measure that is simpler to calculate and verify but at the expense of possible departures from actual costs.

Since each PIHP uses one method, there is consistency within each PIHP. The flat rate methods are based on widely used, available proxy data generated externally for other purposes and so verification is not necessary. If a PIHP uses actual costs, it is required to audit a sample of residential providers to verify the data used in the calculations and to make that material available to the SMA as part of any fiscal review.

EFFECTIVE FEBRUARY 1, 2021:

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.*

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	27018.64	9674.22	36692.86	75282.21	3941.75	79223.96	42531.10
2	27500.76	9905.59	37406.35	76782.13	4036.02	80818.15	43411.80
3	28091.66	10177.39	38269.05	78581.40	4146.76	82728.16	44459.11
4	28684.08	10453.83	39137.91	80401.19	4259.40	84660.59	45522.68
5	29363.18	10763.83	40127.01	82462.65	4385.71	86848.36	46721.35

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	65311	45456	19855
Year 2	67531	46738	20793
Year 3	69707	47990	21717
Year 4	71840	49212	22628
Year 5	73973	50440	23533

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average Length of Stay is calculated by dividing the total number of projected enrollment days for the year by the number of projected unduplicated participants served during the year.

The total number of enrollment days for the year is calculated by summing the product of each month's projected enrollment multiplied by the number of calendar days in each month. Monthly projected enrollment is generally based on historical enrollment experience in the Family Care and Partnership programs. Additional capacity is added to ensure Factor C is not exceeded in the event of unforeseen enrollment spikes. The Family Care waiver is available statewide as of 7/1/2018; however, there are eight counties that have not reached entitlement yet. Some of these counties have waitlists from the legacy waivers. In counties that have people on a waitlist, projected enrollment is based on the number of people remaining on the legacy waiver waitlist multiplied by the proportion of eligible individuals that have chosen to enroll in the Family Care waiver.

Persons on a waitlist are assumed to be enrolled evenly over 36 months. The State has enrolled persons from waitlists in expanding counties evenly over 36 months since May 2009. Counties are required to submit a transition plan for State approval, which includes a requirement that the waitlist population be enrolled evenly over 36 months. The Department has communicated to ADRCs the current number of individuals previously enrolled in the waivers or on the waitlist to provide an estimate of the total number of individuals who will receive enrollment counseling at the ADRC by the end of the 36 month period.

The number of unduplicated participants served during the year is calculated by adding the number of members expected to disenroll during the year to the projected participant count at the end of the year. A churn factor 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.

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 10/1/2017 - 9/30/2018 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.

Housing Counseling is based on 10/1/2018 - 12/31/2018 encounters. This is an infrequently utilized and low cost service. No encounters were reported for this service during the base period, so a different period had to be used.

The 10/1/2017 - 9/30/2018 encounter data includes data for members in all counties, which gives a more complete picture of the Family Care waiver cost structure compared with the CY2013 encounter data used as the source for the previous waiver renewal, when the program was not yet operating statewide.

All service costs are trended forward at average annual rates of 0.8% in CY2018, 4.3% in CY2019, and 2.0% in CY2020 (Year 1) - CY2024 (Year 5) based on costs and trends in the Family Care rate setting model and the State budget. Actual CY2018 and CY2019 trends are included, so projections can 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 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 percentage is based on the number of users for each service in the 10/1/2017 - 9/30/2018 base period encounter data divided by the number of unduplicated participants in the base period. 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 10/1/2017 - 9/30/2018 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 found in the Family Care rate setting model and 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 mmeber 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 10/1/2017 - 9/30/2018 service costs paid by the State Medicaid plan for Family Care members at the Nursing Home Level of Care. State plan service costs in Factor D' that are not included in the capitation payment are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. The portion of Factor D' related to State plan services included in the capitation payment is from encounter data certified by PIHPs. 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.

The average per member cost base is trended forward at an annual rate of 2.6% using the Consumer Price Index for Medical Care. The trend is applied consistently in all five years. However, changes to the average length of stay (ALOS) each year cause the Factor D' trend to fluctuate. Year 1 and Year 5 are leap years. The extra day in these years results in an additional 0.3% ALOS increase. Year 2 experiences a decrease in ALOS of roughly 0.3% relative to the previous year, which included one additional day. Independent of variations due to leap year, ALOS is projected to increase by roughly 0.1% each year.

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 10/1/2017 - 9/30/2018 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.

The average per member cost base is trended forward at an annual rate of 2.2% using the Consumer Price Index for All Items. The trend is applied consistently in all five years. However, changes to the average length of stay (ALOS) each year cause the Factor D' ***trend to fluctuate. Year 1 and Year 5 are leap years. The extra day in these years results in an additional 0.3% ALOS increase. Year 2 experiences a decrease in ALOS of roughly 0.3% relative to the previous year, which included one additional day. Independent of variations due to leap year, ALOS is projected to increase by roughly 0.1% each year.***

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 253 days. The ALOS for the wavier population is 301.9 days in CY2020 (Year 1), 301.3 days in CY2021 (Year 2), 301.7 days in CY2022 (Year 3), 302.1 days in CY2023 (Year 4), and 303.1 in CY2024 (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 19% to 20% depending on the ALOS in the waiver population for the year. Factor G is higher by $12,192 in Year 1; $12,303 in Year 2; $12,684 in Year 3; $13,054 in Year 4; and $13,634 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 10/1/2017 - 9/30/2018 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.***

The average per member cost base is trended forward at an annual rate of 2.6% using the Consumer Price Index for Medical Care. The trend is applied consistently in all five years. However, changes to the average length of stay (ALOS) each year cause the Factor D' trend to fluctuate. Year 1 and Year 5 are leap years. The extra day in these years results in an additional 0.3% ALOS increase. Year 2 experiences a decrease in ALOS of roughly 0.3% relative to the previous year, which included one additional day. Independent of variations due to leap year, ALOS is projected to increase by roughly 0.1% each year.

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 253 days. The ALOS for the wavier population is 301.9 days in CY2020 (Year 1), 301.3 days in CY2021 (Year 2), 301.7 days in CY2022 (Year 3), 302.1 days in CY2023 (Year 4), and 303.1 in CY2024 (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 19% to 20% depending on the ALOS in the waiver population for the year. Factor G' is higher by $638 in Year 1, $647 in Year 2, $669 in Year 3, $692 in Year 4, and $725 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	
Adaptive aids	
Adult residential care - 1-2 bed adult family homes	
Adult Residential Care - 3-4 Bed Adult Family Homes	
Adult Residential Care - Community-Based Residential Facilities (CBRF)	
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	
Assistive Technology/Communication aids	
Consultative Clinical and Therapeutic Services for Caregivers	
Consumer Education and Training	
Counseling and Therapeutic Resources	
Environmental Accessibility Adaptations (Home Modifications)	
Home Delivered Meals	
Housing Counseling	

Waiver Services	
Personal Emergency Response Systems (PERS)	
Relocation services	
Self-Directed Personal Care	
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	
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:							16136228.58
Adult Day Care Services	☒	Hours	2252	688.97	10.40	16136228.58	
Care Management Total:							194228221.11
Care Management	☒	Hours	50621	49.83	77.00	194228221.11	
Daily Living Skills Training Total:							3853745.75
Daily Living Skills Training	☒	Hours	841	201.51	22.74	3853745.75	
Day Habilitation Services Total:							77835806.79
Day Habilitation Services	☒	Hours	7309	800.70	13.30	77835806.79	
Prevocational Services Total:							42566575.12
Prevocational Services	☒	Hours	6239	604.31	11.29	42566575.12	

GRAND TOTAL:	1764614524.96
Total: Services included in capitation:	1764614524.96
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	65311
Factor D (Divide total by number of participants):	27018.64
Services included in capitation:	27018.64
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
Respite Total:							**9156418.58**
Respite	☒	Hours	2017	316.35	14.35	**9156418.58**	
Supported Employment - Individual Employment Support Total:							**10791221.66**
Supported Employment - Individual Employment Support	☒	Hours	2453	189.05	23.27	**10791221.66**	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							**393016.78**
Consumer Directed Supports (Self-Directed Supports) Broker	☒	Hours	610	18.19	35.42	**393016.78**	
Financial Management Services Total:							**14550946.85**
Financial Management Services	☒	Hours	22764	14.17	45.11	**14550946.85**	
Adaptive aids Total:							**1341762.52**
Adaptive aids	☒	Items	3412	6.91	56.91	**1341762.52**	
Adult residential care - 1-2 bed adult family homes Total:							**147699848.27**
Adult residential care - 1-2 bed adult family homes	☒	Days	2701	264.58	206.68	**147699848.27**	
Adult Residential Care - 3-4 Bed Adult Family Homes Total:							**368075753.16**
Adult Residential Care - 3-4 Bed Adult Family Homes	☒	Days	7375	301.69	165.43	**368075753.16**	
Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:							**414923445.63**
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☒	Days	15826	260.33	100.71	**414923445.63**	
Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:							**49883649.53**
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☒	Days	3294	241.22	62.78	**49883649.53**	
Assistive Technology/Communication aids Total:							**145908.67**
Assistive Technology/Communication aids	☒	Items	375	28.38	13.71	**145908.68**	

GRAND TOTAL:	**1764614524.96**
Total: Services included in capitation:	1764614524.96
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**65311**
Factor D (Divide total by number of participants):	**27018.64**
Services included in capitation:	27018.64
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
Consultative Clinical and Therapeutic Services for Caregivers Total:							**36989.89**
Consultative Clinical and Therapeutic Services for Caregivers	☒	Hours	49	41.73	18.09	**36989.89**	
Consumer Education and Training Total:							**677087.95**
Consumer Education and Training	☒	Hours	143	153.68	30.81	**677087.95**	
Counseling and Therapeutic Resources Total:							**1134642.17**
Counseling and Therapeutic Resources	☒	Hours	1320	29.94	28.71	**1134642.17**	
Environmental Accessibility Adaptations (Home Modifications) Total:							**1771366.15**
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	786	3.55	634.83	**1771366.15**	
Home Delivered Meals Total:							**5896684.49**
Home Delivered Meals	☒	Meals	4381	158.91	8.47	**5896684.49**	
Housing Counseling Total:							**1573.96**
Housing Counseling	☒	Hours	1	26.36	59.71	**1573.96**	
Personal Emergency Response Systems (PERS) Total:							**1942436.45**
Personal Emergency Response Systems (PERS)	☒	Month	7904	8.93	27.52	**1942436.45**	
Relocation services Total:							**231046.66**
Relocation services	☒	Projects	359	1.20	536.32	**231046.66**	
Self-Directed Personal Care Total:							**322755.77**
Self-Directed Personal Care	☒	Hours	25	975.83	13.23	**322755.77**	
Skilled Nursing Services RN/LPN Total:							**4326255.15**
Skilled Nursing Services RN/LPN	☒	Hours	193	688.87	32.54	**4326255.15**	
Specialized Medical Equipment and Supplies Total:							**2050814.49**
Specialized Medical Equipment and Supplies	☒	Items	10409	386.32	0.51	**2050814.49**	
Supported Employment -							**2010063.10**

GRAND TOTAL:	**1764614524.96**
Total: Services included in capitation:	1764614524.96
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**65311**
Factor D (Divide total by number of participants):	**27018.64**
Services included in capitation:	27018.64
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
Small Group Employment Support Total:							
Supported Employment - Small Group Employment Support	☒	Hours	501	334.90	11.98	2010063.10	
Supportive Home Care Total:							353589056.59
Supportive Home Care	☒	Hours	27736	783.07	16.28	353589056.59	
Training Services for Unpaid Caregivers Total:							158853.83
Training Services for Unpaid Caregivers	☒	Hours	812	10.34	18.92	158853.83	
Transportation (Specialized Transportation) - Community Transportation Total:							38312461.59
Community Transportation	☒	Trips	17955	162.39	13.14	38312461.59	
Transportation (Specialized Transportation) - Other Transportation Total:							530512.78
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	1018	19.71	26.44	530512.78	
Vocational Futures Planning and Support Total:							39374.93
Vocational Futures Planning and Support	☒	Hours	27	23.27	62.67	39374.93	

GRAND TOTAL:	1764614524.96
Total: Services included in capitation:	1764614524.96
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	65311
Factor D (Divide total by number of participants):	27018.64
Services included in capitation:	27018.64
Services not included in capitation:	
Average Length of Stay on the Waiver:	302

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:							**16983034.01**
Adult Day Care Services	☒	Hours	2328	687.57	10.61	**16983034.01**	
Care Management Total:							**204437080.02**
Care Management	☒	Hours	52342	49.73	78.54	**204437080.02**	
Daily Living Skills Training Total:							**4059002.40**
Daily Living Skills Training	☒	Hours	870	201.10	23.20	**4059002.40**	
Day Habilitation Services Total:							**81943421.90**
Day Habilitation Services	☒	Hours	7557	799.07	13.57	**81943421.90**	
Prevocational Services Total:							**44818203.80**
Prevocational Services	☒	Hours	6451	603.08	11.52	**44818203.80**	
Respite Total:							**9641480.32**
Respite	☒	Hours	2086	315.71	14.64	**9641480.32**	
Supported Employment - Individual Employment Support Total:							**11358501.90**
Supported Employment - Individual Employment Support	☒	Hours	2537	188.67	23.73	**11358501.90**	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							**413784.24**
Consumer Directed Supports (Self-Directed Supports) Broker	☒	Hours	631	18.15	36.13	**413784.24**	
Financial Management Services Total:							**15313384.99**
Financial Management Services	☒	Hours	23538	14.14	46.01	**15313384.99**	
Adaptive aids Total:							**1413122.76**
Adaptive aids	☒	Items	3528	6.90	58.05	**1413122.76**	
Adult residential care - 1-2 bed adult family homes Total:							**155409064.54**
Adult residential care - 1-2 bed adult family homes	☒	Days	2792	264.04	210.81	**155409064.54**	
Adult Residential Care - 3-4 Bed Adult Family Homes Total:							**387420260.03**

GRAND TOTAL:	**1857153728.64**
Total: Services included in capitation:	1857153728.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**67531**
Factor D (Divide total by number of participants):	**27500.76**
Services included in capitation:	27500.76
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
Adult Residential Care - 3-4 Bed Adult Family Homes	☒	Days	7626	301.07	168.74	387420260.03	
Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:							436673752.13
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☒	Days	16363	259.80	102.72	436673752.13	
Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:							52499886.11
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☒	Days	3406	240.73	64.03	52499886.11	
Assistive Technology/Communication aids Total:							153218.56
Assistive Technology/Communication aids	☒	Items	387	28.32	13.98	153218.56	
Consultative Clinical and Therapeutic Services for Caregivers Total:							39181.16
Consultative Clinical and Therapeutic Services for Caregivers	☒	Hours	51	41.64	18.45	39181.16	
Consumer Education and Training Total:							708555.41
Consumer Education and Training	☒	Hours	147	153.36	31.43	708555.41	
Counseling and Therapeutic Resources Total:							1194219.94
Counseling and Therapeutic Resources	☒	Hours	1365	29.88	29.28	1194219.94	
Environmental Accessibility Adaptations (Home Modifications) Total:							1863604.29
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	813	3.54	647.53	1863604.29	
Home Delivered Meals Total:							6199901.60
Home Delivered Meals	☒	Meals	4530	158.59	8.63	6199901.60	
Housing Counseling Total:							1602.54
Housing Counseling	☒	Hours	1	26.31	60.91	1602.54	
Personal Emergency Response Systems (PERS) Total:							2046391.70
Personal Emergency	☒					2046391.70	

GRAND TOTAL:	1857153728.64
Total: Services included in capitation:	1857153728.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	67531
Factor D (Divide total by number of participants):	27500.76
Services included in capitation:	27500.76
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
Response Systems (PERS)		Month	8173	8.92	28.07		
Relocation services Total:							**244203.12**
Relocation services	☒	Projects	372	1.20	547.05	**244203.12**	
Self-Directed Personal Care Total:							**341568.15**
Self-Directed Personal Care	☒	Hours	26	973.85	13.49	**341568.15**	
Skilled Nursing Services RN/LPN Total:							**4563425.86**
Skilled Nursing Services RN/LPN	☒	Hours	200	687.47	33.19	**4563425.86**	
Specialized Medical Equipment and Supplies Total:							**2157774.85**
Specialized Medical Equipment and Supplies	☒	Items	10763	385.54	0.52	**2157774.85**	
Supported Employment - Small Group Employment Support Total:							**2115599.23**
Supported Employment - Small Group Employment Support	☒	Hours	518	334.22	12.22	**2115599.23**	
Supportive Home Care Total:							**372027305.10**
Supportive Home Care	☒	Hours	28678	781.48	16.60	**372027305.10**	
Training Services for Unpaid Caregivers Total:							**167108.66**
Training Services for Unpaid Caregivers	☒	Hours	839	10.32	19.30	**167108.66**	
Transportation (Specialized Transportation) - Community Transportation Total:							**40345914.70**
Community Transportation	☒	Trips	18565	162.06	13.41	**40345914.70**	
Transportation (Specialized Transportation) - Other Transportation Total:							**558616.39**
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	1053	19.67	26.97	**558616.39**	
Vocational Futures Planning and Support Total:							**41558.23**
Vocational Futures Planning and Support	☒	Hours	28	23.22	63.92	**41558.23**	

GRAND TOTAL:	**1857153728.64**
Total: Services included in capitation:	1857153728.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**67531**
Factor D (Divide total by number of participants):	**27500.76**
Services included in capitation:	27500.76
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:							17902096.72
Adult Day Care Services	☒	Hours	2403	688.53	10.82	17902096.72	
Care Management Total:							215547506.86
Care Management	☒	Hours	54029	49.80	80.11	215547506.86	
Daily Living Skills Training Total:							4278868.89
Daily Living Skills Training	☒	Hours	898	201.39	23.66	4278868.89	
Day Habilitation Services Total:							86393185.51
Day Habilitation Services	☒	Hours	7801	800.19	13.84	86393185.51	
Prevocational Services Total:							47252663.54
Prevocational Services	☒	Hours	6659	603.92	11.75	47252663.54	
Respite Total:							10162417.28
Respite	☒	Hours	2153	316.15	14.93	10162417.28	
Supported Employment - Individual Employment Support Total:							11974719.70
Supported Employment - Individual Employment Support	☒	Hours	2618	188.93	24.21	11974719.70	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							436126.38
Consumer Directed Supports (Self-Directed Supports) Broker	☒	Hours	651	18.18	36.85	436126.38	
Financial Management Services Total:							16146056.25

GRAND TOTAL:	1958185490.65
Total: Services included in capitation:	1958185490.65
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	69707
Factor D (Divide total by number of participants):	28091.66
Services included in capitation:	28091.66
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
Financial Management Services	☒	Hours	24297	14.16	46.93	16146056.25	
Adaptive aids Total:							1490091.89
Adaptive aids	☒	Items	3642	6.91	59.21	1490091.89	
Adult residential care - 1-2 bed adult family homes Total:							163859229.19
Adult residential care - 1-2 bed adult family homes	☒	Days	2882	264.41	215.03	163859229.19	
Adult Residential Care - 3-4 Bed Adult Family Homes Total:							408435359.71
Adult Residential Care - 3-4 Bed Adult Family Homes	☒	Days	7871	301.50	172.11	408435359.72	
Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:							460415062.11
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☒	Days	16891	260.17	104.77	460415062.11	
Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:							55356894.46
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☒	Days	3516	241.07	65.31	55356894.46	
Assistive Technology/Communication aids Total:							161765.44
Assistive Technology/Communication aids	☒	Items	400	28.36	14.26	161765.44	
Consultative Clinical and Therapeutic Services for Caregivers Total:							41594.08
Consultative Clinical and Therapeutic Services for Caregivers	☒	Hours	53	41.70	18.82	41594.08	
Consumer Education and Training Total:							748413.77
Consumer Education and Training	☒	Hours	152	153.58	32.06	748413.77	
Counseling and Therapeutic Resources Total:							1258816.38
Counseling and Therapeutic Resources	☒	Hours	1409	29.92	29.86	1258816.38	
Environmental Accessibility Adaptations (Home Modifications) Total:							1967206.66

GRAND TOTAL:	1958185490.65
Total: Services included in capitation:	1958185490.65
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	69707
Factor D (Divide total by number of participants):	28091.66
Services included in capitation:	28091.66
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
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	839	3.55	660.48	1967206.66	
Home Delivered Meals Total:							6542266.88
Home Delivered Meals	☒	Meals	4676	158.81	8.81	6542266.88	
Housing Counseling Total:							1636.24
Housing Counseling	☒	Hours	1	26.34	62.12	1636.24	
Personal Emergency Response Systems (PERS) Total:							2156797.53
Personal Emergency Response Systems (PERS)	☒	Month	8436	8.93	28.63	2156797.53	
Relocation services Total:							257121.79
Relocation services	☒	Projects	384	1.20	557.99	257121.79	
Self-Directed Personal Care Total:							348891.13
Self-Directed Personal Care	☒	Hours	26	975.21	13.76	348891.13	
Skilled Nursing Services RN/LPN Total:							4801979.15
Skilled Nursing Services RN/LPN	☒	Hours	206	688.44	33.86	4801979.15	
Specialized Medical Equipment and Supplies Total:							2273354.86
Specialized Medical Equipment and Supplies	☒	Items	11110	386.08	0.53	2273354.86	
Supported Employment - Small Group Employment Support Total:							2226906.77
Supported Employment - Small Group Employment Support	☒	Hours	534	334.69	12.46	2226906.77	
Supportive Home Care Total:							392425893.15
Supportive Home Care	☒	Hours	29602	782.57	16.94	392425893.15	
Training Services for Unpaid Caregivers Total:							176312.92
Training Services for Unpaid Caregivers	☒	Hours	866	10.34	19.69	176312.92	
Transportation (Specialized Transportation) - Community Transportation Total:							42513197.90
Community Transportation	☒					42513197.90	

GRAND TOTAL:	1958185490.65
Total: Services included in capitation:	1958185490.65
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	69707
Factor D (Divide total by number of participants):	28091.66
Services included in capitation:	28091.66
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
		Trips	19163	162.29	13.67		
Transportation (Specialized Transportation) - Other Transportation Total:							**589096.39**
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	1087	19.70	27.51	**589096.39**	
Vocational Futures Planning and Support Total:							**43961.10**
Vocational Futures Planning and Support	☒	Hours	29	23.25	65.20	**43961.10**	
					GRAND TOTAL:		**1958185490.65**
					Total: Services included in capitation:		1958185490.65
					Total: Services not included in capitation:		
					Total Estimated Unduplicated Participants:		**69707**
					Factor D (Divide total by number of participants):		**28091.66**
					Services included in capitation:		28091.66
					Services not included in capitation:		
					Average Length of Stay on the Waiver:		302

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:							**18849926.40**
Adult Day Care Services	☒	Hours	2477	689.31	11.04	**18849926.40**	
Care Management Total:							**226806344.57**
Care Management	☒	Hours	55682	49.85	81.71	**226806344.57**	
Daily Living Skills Training Total:							**4500208.80**
Daily Living Skills Training	☒	Hours	925	201.62	24.13	**4500208.80**	
Day Habilitation Services Total:							**90944717.28**
					GRAND TOTAL:		**2060664589.64**
					Total: Services included in capitation:		2060664589.64
					Total: Services not included in capitation:		
					Total Estimated Unduplicated Participants:		**71840**
					Factor D (Divide total by number of participants):		**28684.08**
					Services included in capitation:		28684.08
					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
Day Habilitation Services	☒	Hours	8040	801.10	14.12	90944717.28	
Prevocational Services Total:							49710272.39
Prevocational Services	☒	Hours	6863	604.61	11.98	49710272.39	
Respite Total:							10696572.56
Respite	☒	Hours	2219	316.51	15.23	10696572.56	
Supported Employment - Individual Employment Support Total:							12599300.09
Supported Employment - Individual Employment Support	☒	Hours	2698	189.14	24.69	12599300.09	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							459056.60
Consumer Directed Supports (Self-Directed Supports) Broker	☒	Hours	671	18.20	37.59	459056.60	
Financial Management Services Total:							16985080.22
Financial Management Services	☒	Hours	25040	14.17	47.87	16985080.22	
Adaptive aids Total:							1566107.76
Adaptive aids	☒	Items	3753	6.91	60.39	1566107.76	
Adult residential care - 1-2 bed adult family homes Total:							172492826.42
Adult residential care - 1-2 bed adult family homes	☒	Days	2971	264.71	219.33	172492826.42	
Adult Residential Care - 3-4 Bed Adult Family Homes Total:							429838753.34
Adult Residential Care - 3-4 Bed Adult Family Homes	☒	Days	8112	301.84	175.55	429838753.34	
Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:							484557950.36
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☒	Days	17408	260.46	106.87	484557950.36	
Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:							58266928.58
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☒	Days	3624	241.34	66.62	58266928.58	

GRAND TOTAL:	2060664589.64
Total: Services included in capitation:	2060664589.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	71840
Factor D (Divide total by number of participants):	28684.08
Services included in capitation:	28684.08
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
Assistive Technology/Communication aids Total:							**170246.64**
Assistive Technology/Communication aids	☒	Items	412	28.40	14.55	**170246.64**	
Consultative Clinical and Therapeutic Services for Caregivers Total:							**43286.40**
Consultative Clinical and Therapeutic Services for Caregivers	☒	Hours	54	41.75	19.20	**43286.40**	
Consumer Education and Training Total:							**789337.12**
Consumer Education and Training	☒	Hours	157	153.75	32.70	**789337.12**	
Counseling and Therapeutic Resources Total:							**1324626.20**
Counseling and Therapeutic Resources	☒	Hours	1452	29.95	30.46	**1324626.20**	
Environmental Accessibility Adaptations (Home Modifications) Total:							**2066341.97**
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	864	3.55	673.69	**2066341.97**	
Home Delivered Meals Total:							**6880231.83**
Home Delivered Meals	☒	Meals	4819	158.99	8.98	**6880231.83**	
Housing Counseling Total:							**1671.07**
Housing Counseling	☒	Hours	1	26.37	63.37	**1671.07**	
Personal Emergency Response Systems (PERS) Total:							**2269551.31**
Personal Emergency Response Systems (PERS)	☒	Month	8694	8.94	29.20	**2269551.31**	
Relocation services Total:							**269777.10**
Relocation services	☒	Projects	395	1.20	569.15	**269777.10**	
Self-Directed Personal Care Total:							**370103.39**
Self-Directed Personal Care	☒	Hours	27	976.32	14.04	**370103.39**	
Skilled Nursing Services RN/LPN Total:							**5070605.32**
Skilled Nursing Services RN/LPN	☒	Hours	213	689.22	34.54	**5070605.32**	

GRAND TOTAL:	**2060664589.64**
Total: Services included in capitation:	2060664589.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**71840**
Factor D (Divide total by number of participants):	**28684.08**
Services included in capitation:	28684.08
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 Total:							**2389853.16**
Specialized Medical Equipment and Supplies	☒	Items	11450	386.52	0.54	**2389853.16**	
Supported Employment - Small Group Employment Support Total:							**2346565.57**
Supported Employment - Small Group Employment Support	☒	Hours	551	335.07	12.71	**2346565.57**	
Supportive Home Care Total:							**412784045.93**
Supportive Home Care	☒	Hours	30508	783.46	17.27	**412784045.93**	
Training Services for Unpaid Caregivers Total:							**185590.40**
Training Services for Unpaid Caregivers	☒	Hours	893	10.35	20.08	**185590.40**	
Transportation (Specialized Transportation) - Community Transportation Total:							**44762515.88**
Community Transportation	☒	Trips	19750	162.47	13.95	**44762515.88**	
Transportation (Specialized Transportation) - Other Transportation Total:							**619744.38**
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	1120	19.72	28.06	**619744.38**	
Vocational Futures Planning and Support Total:							**46450.58**
Vocational Futures Planning and Support	☒	Hours	30	23.28	66.51	**46450.58**	

GRAND TOTAL:	**2060664589.64**
Total: Services included in capitation:	2060664589.64
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**71840**
Factor D (Divide total by number of participants):	**28684.08**
Services included in capitation:	28684.08
Services not included in capitation:	
Average Length of Stay on the Waiver:	302

Appendix J: Cost Neutality 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:							**19862504.88**
Adult Day Care Services	☒	Hours	2550	691.76	11.26	**19862504.88**	
Care Management Total:							**239086978.67**
Care Management	☒	Hours	57335	50.03	83.35	**239086978.67**	
Daily Living Skills Training Total:							**4747240.46**
Daily Living Skills Training	☒	Hours	953	202.33	24.62	**4747240.46**	
Day Habilitation Services Total:							**95833412.64**
Day Habilitation Services	☒	Hours	8278	803.95	14.40	**95833412.64**	
Prevocational Services Total:							**52391614.48**
Prevocational Services	☒	Hours	7066	606.76	12.22	**52391614.48**	
Respite Total:							**11271788.92**
Respite	☒	Hours	2285	317.64	15.53	**11271788.92**	
Supported Employment - Individual Employment Support Total:							**13287971.36**
Supported Employment - Individual Employment Support	☒	Hours	2779	189.82	25.19	**13287971.36**	
Consumer Directed Supports (Self-Directed Supports) Broker Total:							**483761.08**
Consumer Directed Supports (Self-Directed Supports) Broker	☒	Hours	691	18.26	38.34	**483761.08**	
Financial Management Services Total:							**17903445.28**
Financial Management Services	☒	Hours	25784	14.22	48.83	**17903445.28**	
Adaptive aids Total:							**1652302.96**
Adaptive aids	☒	Items	3865	6.94	61.60	**1652302.96**	
Adult residential care - 1-2 bed adult family homes Total:							**181791969.63**
Adult residential care - 1-2 bed adult family homes	☒	Days	3059	265.65	223.71	**181791969.63**	
Adult Residential Care - 3-4 Bed Adult Family Homes Total:							**453084208.68**

GRAND TOTAL:	**2172082509.42**
Total: Services included in capitation:	2172082509.42
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**73973**
Factor D (Divide total by number of participants):	**29363.18**
Services included in capitation:	29363.18
Services not included in capitation:	
Average Length of Stay on the Waiver:	303

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Residential Care - 3-4 Bed Adult Family Homes	☒	Days	8353	302.91	179.07	453084208.68	
Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:							510728676.78
Adult Residential Care - Community-Based Residential Facilities (CBRF)	☒	Days	17924	261.39	109.01	510728676.78	
Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:							61402895.19
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	☒	Days	3731	242.20	67.95	61402895.19	
Assistive Technology/Communication aids Total:							179326.56
Assistive Technology/Communication aids	☒	Items	424	28.50	14.84	179326.56	
Consultative Clinical and Therapeutic Services for Caregivers Total:							45942.51
Consultative Clinical and Therapeutic Services for Caregivers	☒	Hours	56	41.90	19.58	45942.51	
Consumer Education and Training Total:							828490.70
Consumer Education and Training	☒	Hours	161	154.30	33.35	828490.70	
Counseling and Therapeutic Resources Total:							1396276.48
Counseling and Therapeutic Resources	☒	Hours	1495	30.06	31.07	1396276.48	
Environmental Accessibility Adaptations (Home Modifications) Total:							2177197.74
Environmental Accessibility Adaptations (Home Modifications)	☒	Projects	890	3.56	687.16	2177197.74	
Home Delivered Meals Total:							7252308.36
Home Delivered Meals	☒	Meals	4962	159.56	9.16	7252308.36	
Housing Counseling Total:							1710.76
Housing Counseling	☒	Hours	1	26.47	64.63	1710.76	
Personal Emergency Response Systems (PERS) Total:							2391317.32
Personal Emergency	☒					2391317.32	

GRAND TOTAL:	2172082509.42
Total: Services included in capitation:	2172082509.42
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	73973
Factor D (Divide total by number of participants):	29363.18
Services included in capitation:	29363.18
Services not included in capitation:	
Average Length of Stay on the Waiver:	303

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Systems (PERS)		Month	8952	8.97	29.78		
Relocation services Total:							**283530.85**
Relocation services	☒	Projects	407	1.20	580.53	**283530.85**	
Self-Directed Personal Care Total:							**392856.60**
Self-Directed Personal Care	☒	Hours	28	979.79	14.32	**392856.60**	
Skilled Nursing Services RN/LPN Total:							**5336489.97**
Skilled Nursing Services RN/LPN	☒	Hours	219	691.67	35.23	**5336489.97**	
Specialized Medical Equipment and Supplies Total:							**2515059.37**
Specialized Medical Equipment and Supplies	☒	Items	11789	387.89	0.55	**2515059.37**	
Supported Employment - Small Group Employment Support Total:							**2470946.08**
Supported Employment - Small Group Employment Support	☒	Hours	567	336.26	12.96	**2470946.08**	
Supportive Home Care Total:							**435200917.15**
Supportive Home Care	☒	Hours	31414	786.25	17.62	**435200917.15**	
Training Services for Unpaid Caregivers Total:							**195575.81**
Training Services for Unpaid Caregivers	☒	Hours	920	10.38	20.48	**195575.81**	
Transportation (Specialized Transportation) - Community Transportation Total:							**47183617.70**
Community Transportation	☒	Trips	20336	163.05	14.23	**47183617.70**	
Transportation (Specialized Transportation) - Other Transportation Total:							**653047.44**
Transportation (Specialized Transportation) - Other Transportation	☒	Trips	1153	19.79	28.62	**653047.44**	
Vocational Futures Planning and Support Total:							**49127.01**
Vocational Futures Planning and Support	☒	Hours	31	23.36	67.84	**49127.01**	

GRAND TOTAL:	**2172082509.42**
Total: Services included in capitation:	2172082509.42
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**73973**
Factor D (Divide total by number of participants):	**29363.18**
Services included in capitation:	29363.18
Services not included in capitation:	
Average Length of Stay on the Waiver:	303