

**WISCONSIN MEDICAID  
CHILDREN'S LONG-TERM SUPPORT (CLTS) WAIVER PROGRAM  
PROVIDER AGREEMENT AND ACKNOWLEDGEMENT OF TERMS OF PARTICIPATION  
FOR COUNTY WAIVER AGENCIES<sup>1</sup>**

Completion of this form is required under Federal Law by the Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, under the Code of Federal Regulations 42 CFR 431.107.

Name of County Waiver Agency (Typed or Printed)		Phone Number	Email Address
Line 1 Street Address (physical address)		Line 2 Street Address	
Mailing Address (if applicable)	City	State	ZIP Code

The county waiver agency's name, as listed above, must exactly match the name on file with the Department of Health Services (DHS), the U.S. Internal Revenue Service (IRS) and/or Wisconsin Department of Revenue. The above-referenced county waiver agency (CWA) hereby agrees and acknowledges it shall:

1. Comply with certain federal and state Medicaid home and community-based services (HCBS) laws, regulations and policies, including those relating to § 1915(c) and § 1915(b)(4) of the Social Security Act and Title XIX, those regulations pertinent to Wisconsin's Medicaid program, official written policy as transmitted through the CLTS Waiver Program's published memos, handbooks and other communicate, the standards for the specific CLTS waiver services to be delivered, and other requirements, as detailed in the *State and County Contract for Social Services and Community Programs, Children's Long-Term Support Program, Appendix #AM*. The CWA is responsible for knowing the provisions of federal and state laws, regulations, the applicable CLTS Waiver Program policies, and for complying with all applicable federal and state laws as a condition of its role as a participating provider of Wisconsin's Medicaid-funded CLTS Waiver Program services.
2. Register and submit all required data to DHS, including its National Provider Identifier (NPI). The CWA will submit information updates, as necessary, to ensure accurate data is on file with DHS. Re-registration and an updated signed *CLTS Waiver Program Medicaid Provider Agreement* form must be submitted every four years, at a minimum. The CLTS Waiver Program registration site is available at: <https://www.dhs.wisconsin.gov/clts/providers.htm>.
3. Comply with all federal and state laws regarding confidentiality and disclosure of personal health information (PHI) and personal identity information (PII) including the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for all services, transactions (including electronic transactions), privacy, and security regulations.
4. Retain any records, in accordance with 42 CFR § 431.107 of the federal Medicaid regulations, necessary to fully document services delivered to participants **for a period of seven years**. See DHS 106.02, Wis. Administrative Code for state policy related to provider record retention requirements.
5. Upon request, the CWA shall furnish to the Department of Health Services (DHS), the Wisconsin Department of Justice Medicaid Fraud Control Unit, or the U.S. Department of Health and Human Services (DHHS) any information regarding CLTS Waiver Program services delivered and claims paid to the CWA.
6. Comply with the disclosure requirements of 42 CFR Part 455, Subpart B in effect now or as may be amended. To meet those requirements and address real or potential conflicts of interest that may influence service provision, the CWA agrees to furnish the following information to DHS in writing, upon request:
  - (a) The names addresses of any subcontracted case management agencies that deliver support and service coordination or other allowable services to CLTS Waiver Program participants; and
  - (b) The identity of any person employed or sub-contracted by the CWA who has been convicted of a barring criminal offense or has a substantiated finding issued by a regulatory agency related to that person's involvement in any Medicare, Medicaid or Title XIX program service delivery.

<sup>1</sup> Note: This agreement is intended for county waiver agencies in their role as CLTS Waiver Program service providers.

7. Affirm each employed or sub-contracted support or service coordinator or other employees or sub-contractors that deliver CLTS waiver services to eligible participants, hold current licenses, registrations, certifications and/or similar entitlements, or meets the qualifications specified in the [CLTS Waiver Manual, P-02256](#), as required by federal or state statute, regulation, or rule for the provision of the service. In addition, the CWA has completed all required provider screening activities, including a search of the [U.S. DHHS Office of Inspector General's List of Excluded Individuals/Entities \(LEIE\)](#), and conducted Wisconsin caregiver background checks for all employees or sub-contractors with regular, direct access to CLTS waiver participants.
8. Consent to the use of statistical sampling and extrapolation as the means to determine the amounts owed to the Medicaid-funded CLTS Waiver Program as a result of an investigation or audit conducted by the Department of Health Services, the Department of Justice Medicaid Fraud Control Unit, the U.S. Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these entities.
9. Provide DHS with any information it requests to verify CLTS waiver covered services are included on the participant's Individual Service Plan (ISP), are prior authorized and delivered to eligible participants by screened and qualified providers. Failure to supply information as requested by DHS may result in a CLTS service payment denial, disallowance, or sanction related to the provider's continued participation in the program.
10. Affirm any statement made in this document or through the CLTS Waiver Program's registration process, constitutes a statement or representation of a material fact made for a benefit or payment, or made for use in determining rights to such benefit or payment, that is knowingly and willfully made, within the meaning of Wis. Stat. § 49.49 (1)(a) 1 and 2, which imposes criminal penalties for fraud committed in connection with a Medicaid Program.
11. Affirm under federal regulations 42 CFR § 431.301(c)(1)(vi), which pertains to federal case management conflict of interest requirements, the CWA may only bill for CLTS support and service coordination and the following services: 1) the allowable component of foster care services, 2) purchased services and supplies from third party entities (typically web-based vendors) and the CWA receives no benefit from the vendor, and 3) allowable services from sub-contracted waiver providers wherein the CWA has made prepayment to the vendor.
12. Affirm, pursuant to 42 CFR § 447.10(e), claims will only be submitted for payment for allowable CLTS services included on the participant's individual service plan (ISP), were prior authorized and delivered by qualified providers.
13. Receive payment for CLTS Waiver Program services from the DHS contracted third party administration (TPA) claims processing vendor, Wisconsin Physician Services (WPS). The TPA will pay CLTS service claims based on the CWA's approved prior authorization for each waiver service for each eligible participant.
14. Accept as payment in full, amounts paid in accordance with the CLTS rate schedule established by DHS for in-scope services: <https://www.dhs.wisconsin.gov/publications/p02184.pdf>.
15. Submit all claims with the CWA's NPI to the TPA within the timely filing business rules of 120 days from the date of service (DOS), or in the instance of a CLTS participant who is covered by Medicare or a private insurance carrier, within 120 days from the date of the third party's explanation of benefit (EOB) statement. The CWA agrees to submit refunds to WPS for any overpayment identified by the CWA, WPS or DHS.
16. Unless terminated earlier, this CLTS Waiver Program Provider Agreement for County Waiver Agencies shall remain in full force and effect for a maximum of four years. DHS will issue notification when the four-year re-registration requirement is due.

**MODIFICATIONS TO THIS CLTS WAIVER PROGRAM AGREEMENT ARE NOT PERMITTED. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE TO ANOTHER PARTY.**

<b>NAME</b> – County Waiver Agency Authorized Submitter (Typed or Printed)	Title
<b>SIGNATURE</b> – County Waiver Agency Authorized Submitter	Date Signed