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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

Request for 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:
This renewal application includes a number of changes from the content previously approved by CMS.

The Wisconsin Department of Health Services (DHS) has been developing and refining a standardized, statewide Medicaid Management Information System (MMIS) claims processing and data collection process for the three Children''s Long-Term Support Home and Community-Based Services (HCBS) Waivers (CLTS Waiver Program.) In 2010 Wisconsin began piloting a Third Party Administration (TPA) claims process for the CLTS Waivers in five counties, and phased in an expanded TPA claims process until it was fully implemented on a statewide basis as of December 31, 2011.

During 2015, as directed by the Centers for Medicaid and Medicare Services (CMS), the Department began transitioning the Early Intensive Behavior Intervention, Consultative Behavior Intervention and ongoing autism treatment as covered services under the CLTS Waivers to a behavior treatment benefit under Wisconsin's Medicaid State Plan. This transition is expected to be complete by December 31, 2016.

With this renewal application, Wisconsin is also phasing out any CLTS Waiver covered service that is also a required benefit under the Early and Periodic, Screening, Diagnostic and Treatment EPSDT)benefit for children enrolled in Medicaid up to age 21 years. Additional CLTS Waiver Program services that will be impacted by the elimination of any EPSDT covered benefits include:

- Adaptive Aids
- Community Integration Services
- Counseling and Therapeutic Services
- Nursing Services
- Specialized Medical and Therapeutic Services
- Supportive Home Care - personal care

In addition, the Department is proposing to add three new services to provide enhanced support to better meet the needs of families and children with signification disabilities. These services include the following:

- Child Care
- Relocation Services
- Training Support for Parents/Guardians and Families (Training for Unpaid Caregivers)

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*):
Children's Long-Term Support Waiver Program

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: WI.0414
Draft ID: WI.036.03.00

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

E. Proposed Effective Date: *(mm/dd/yy)*
01/01/17

1. Request Information (2 of 3)

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

☑ **Hospital**
Select applicable level of care
◉ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
Children from birth through age 21 years.
○ **Inpatient psychiatric facility for individuals age 21 and under as provided 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:
Children from birth through age 21 years.
○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

☑ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**
If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:
Children from birth through age 21 years.

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**
- [x] **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:
  A 1915(b)(4)Fee-for-Service Selective Contracting Program application is being submitted concurrent with the CLTS Waiver Program 1915(c) application for the purpose of obtaining approval for the county waiver agencies to be the sole provider to deliver Support and Service Coordination (case management) services.

  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)**
  - [x] **§1915(b)(4) (selective contracting/limit number of providers)**
- [ ] **A program operated under §1932(a) of the Act.**

  Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:
- [ ] **A program authorized under §1915(i) of the Act.**
- [ ] **A program authorized under §1915(j) of the Act.**
- [ ] **A program authorized under §1115 of the Act.**

  Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

- [x] **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
The overall purpose of Wisconsin's Children's Long-Term Support (CLTS) Waiver Program is to provide necessary supports and services to maintain a child with significant disabilities residence in the community and prevent placement in an institutional setting. The CLTS Waiver Program is a component of Wisconsin's support system for children with disabilities. The goal of the CLTS Waiver Program is to support children with substantial needs, as well as their parents/guardians, by delivering services to assure the child's health, safety and welfare needs in the community. A key tenet of the CLTS Waiver Program is that children are best served within the context of their family and community.

Wisconsin's CLTS system is guided by the following vision and principles which were developed in collaboration with families, advocates, providers and waiver agencies:
- The focus is on the child and his/her strengths and needs.
- Children remain in the home with their families whenever possible.
- Parents have a great capacity to care for their child with a disability if provided the supports they need.
- The service system enhances the natural supports received from family, friends, neighbors and volunteers.
- Competent service coordination supports culturally competent practices.
- Collaboration amongst varied providers enhances the provision of comprehensive services.
- The experiences of families contribute to system-wide improvements and cost efficiencies.

Wisconsin's CLTS organizational structure supports families to meet these objectives by working collaboratively at all levels of the service system. The Secretary appoints members to the CLTS Council to provide guidance to the Department of Health Services (DHS), the State Medicaid Agency, regarding waiver program policy and procedure decisions. The DHS has established statewide CLTS Waiver Program policies and procedures which are disseminated to county waiver agencies

and providers through manuals, numbered memos, websites and webinars. In addition, ongoing technical assistance, monitoring and oversight activities for county waiver agencies are completed by DHS assigned Children's Services Specialists and other State Medicaid Agency staff.

The Department of Health Services enters into contractual agreements with Wisconsin's county departments to act as the local agency responsible for operating the CLTS Waiver Program, which includes determining applicants' program eligibility, authorizing covered waiver supports and services, conducting annual recertifications, and operating other long-term support programs that assist in meeting the needs of children and their families. These programs include early intervention services funded under the Individuals with Disabilities Education Act (IDEA) Part C and the state-funded Children's Community Options Program. County waiver agencies are responsible for recruiting a local network of qualified and willing providers that have been screened and credentials verified to ensure compliance with the Department's established standards for training, work experience and licensure or certification, as applicable, for each covered service. The county waiver agency authorizes family-centered services and supports based on the assessed need of each child and his or her family to ensure continued health, safety, inclusion in the community and ability to reside in the least restrictive setting. With the submission of this CLTS Waiver Program renewal, several new services have been added to the benefit package to ensure the supports and services available for children and their families meet the current challenges parents face in raising children with disabilities in today's environment.

In addition, several CLTS waiver services have been eliminated to ensure there is no duplication with services covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, known as HealthCheck in Wisconsin, as well as Medicaid State Plan services. In addition, CLTS waiver services are coordinated as the payer of last resort with services that are covered under the IDEA Part B Special Education Program through Wisconsin's Department of Public Instruction, and services covered under the Rehabilitation Act of 1973 through Wisconsin's Department of Workforce Development's Division of Rehabilitation (DVR), as well as coordination with the child's private health insurance, and economic support programs, as applicable. DHS monitors the county waiver agencies' compliance with the CLTS Waiver Program's payer of last resort and coordination of benefit requirements through a comprehensive quality management and review system.

3. Components of the Waiver Request

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

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

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

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

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

E. **Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

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

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

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

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

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

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

4. Waiver(s) Requested

A. **Comparability.** The State requests a waiver of the requirements contained in §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:
The Department of Health Services ensured public input into the development of the CLTS Waiver Program renewal application through the Secretary's appointed advisory Children's Long-Term Support Council and the Governor appointed Autism Council through quarterly meetings and listening sessions, as well as the Wisconsin County Human Services Association's Long Term Care Policy Advisory Committee.

In addition, the Department issued written notice to Wisconsin's federally recognized tribes on June 13, 2016, regarding the proposed CLTS Waiver Program renewal changes, and provided the opportunity for public input 60 days prior to the renewal request submission to CMS. The State of Wisconsin and the Department of Health Services (DHS) have a unique legal relationship with each sovereign Tribal Governments located within Wisconsin as affirmed and described in state and federal law. The Department also held a face-to-face meeting on July 7, 2016, with the Tribal Health Directors to review the proposed changes to the CLTS Waiver Program and seek their input. Prior to submitting the waiver renewal request to CMS for approval, the updated CLTS Waiver Program description has been posted to the DHS website, as well as noticed in numerous local newspapers for public comment for at least

30 days. All policies and procedures, as well as the CLTS Waiver Program renewal application are available to the public through the Department's website. In addition, the document can be issued to parties by mail upon request. The authority to apply for and maintain waiver applications is made through the legislative and budgetary processes in the State of Wisconsin. Therefore, statutory authority exists for the operation of the waivers, creating an additional, formal process for public input.

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: Cunningham

First Name: Curtis

Title: Interim Adminstrator

Agency: Department of Health Services, Division of Long Term Care

Address: 1 West Wilson St. Room 550

Address 2: PO Box 7851

City: Madison

State: **Wisconsin**

Zip: 53701-7851

Phone: (608) 261-7810 **Ext:** ☐ **TTY**

Fax: (608) 266-2713

E-mail: Curtis.Cunningham@dhs.wisconsin.gov

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

Last Name: Rathermel

First Name: Deborah

Title: Director

Agency: Department of Health Services, Division of Long Term Care, Bureau of Children's Servic

Address: 1 West Wilson St. Room 418

Address 2: PO Box 7851

City: Madison

State: **Wisconsin**

Zip: 53701-7851

Phone: (608) 266-9366 **Ext:** ☐ **TTY**

Fax: (608) 267-2713

E-mail: Deborah.Rathermel@dhs.wisconsin.gov

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:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Moore

First Name:

Kevin

Title:

Administrator

Agency:

Department of Health Services, Division of Medicaid Service

Address:

1 W. Wilson Street, Room 350

Address 2:

PO Box 309

City:

Madison

State: **Wisconsin**

Zip:

53701-0309

Phone:

(608) 266-5151 **Ext:** ☐ **TTY**

Fax:

(608) 266-1096

E-mail:

Kevin.Moore@dhs.wisconsin.gove

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:

The Department of Health Services (DHS) seeks to renew its Children's Long-Term Support (CLTS) Waiver Program WI #0414 with an effective date of January 1, 2017. This renewal incorporates several changes to comply with current federal HCBS Waiver regulations and will strengthen the CLTS Waiver Program's supports and services available to children and families. The major changes in this renewal are:

COMBINING WAIVERS:
The Department currently administers HCBS waivers #0413, #0414 and #0415 via the same service delivery model and comparable service packages. The only difference among the three waivers is the target population(s) served. The county waiver agencies currently serve all CLTS Waiver participants enrolled in each of the three waivers and will continue to do so after the waivers are combined. This assures there is sufficient capacity under HCBS waiver #0414 to absorb the

participants of HCBS waiver #0413 and #0415. No system changes are required for the CLTS Waiver's contracted Third Party Administrator (TPA) claims processing vendor, as CLTS participants are identified by their target group, not by their CMS approved waiver number. The Department updated the Factor C projections in Appendix J to reflect the absorption of participants transitioning from HCBS waiver #0413 and #0415.

Upon the CMS approval and successful transition from HCBS waiver #0413 and #0415 to HCBS waiver #0414, CLTS waiver participants will experience no interruptions to the delivery of allowable covered services by authorized providers. The parents and guardians of CLTS Waiver participants will not experience any noticeable changes in their required paperwork, rights and responsibilities documents, or processes governing incident reporting, selection of willing and qualified providers, or grievances and appeals protocols. The participants will not experience any change in the content or appearance of their Individual Support Plan (ISP) as a result of combining the three waivers.

The participants in waiver #0413 and #0415 will receive a notice from the Department that provides information that the three CLTS Waivers are being combined to serve all target groups under one waiver to streamline administrative functions. The Department will send the notice detailed below to all participants served under HCBS waiver #0413 and #0415 on December 8, 2016.

"Dear Parent/Guardian of a CLTS Waiver Program Participant:

The Wisconsin Department of Health Services is required to notify you of an administrative change in the Children's Long-Term Support (CLTS) Waiver Program due to federal requirements. There will be no changes to your child's CLTS Waiver Program eligibility, assigned county waiver agency's support and service coordination, provider qualifications, or CLTS Waiver Program participant rights and responsibilities.

Currently, the CLTS Waiver Program operates three separate agreements with the federal government. These agreements are called "waivers." One waiver allows the Department to serve children with long-term support needs who have physical disabilities, one waiver allows the Department to serve children with long-term support needs who have severe emotional disturbance and the final waiver allows the Department to serve children with long-term support needs who have intellectual/developmental disabilities. All other aspects of the three waivers are identical.

The Centers for Medicare and Medicaid Services (CMS) now permits states to combine multiple waivers into one approved waiver. This allows for greater efficiencies and reduced administrative cost to better serve CLTS Waiver Program applicants and participants. This administrative change will take place on December 31, 2016. Effective January 1, 2017, all CLTS Waiver Program participants will be served under one single CLTS Waiver Program.

You will not notice any changes to your child's participation in the CLTS Waiver Program, as a result of combining the three separate waivers under one single waiver. The Department will continue to operate the single waiver in the same manner as under the multiple waivers. No interruption to your child's services or interactions with authorized providers will occur as the result of combining the waivers.

CMS requires the Department to inform CLTS Waiver Program participants of changes to the waivers including the combining of the three identical waivers. This letter is for your information only and requires no action on your part.

If you have any questions, please contact your county Support and Service Coordinator, or the Department of Health Services at 1-608-266-1865.

CENTRALIZING PROVIDER ENROLLMENT
The Department is currently centralizing its waiver provider management system. The Department is implementing a statewide web-based Wisconsin Provider Management (WPM) system for screening and enrolling qualified waiver providers, which is scheduled for implementation by January 1, 2018. The Department's centralized management of waiver providers will:
- Certify any willing and qualified provider of CLTS Waiver Program covered services
- Allow waiver program applicants, participants and waiver agencies to view a directory of certified providers
- Allow CLTS Waiver applicants and participants to select willing, qualified and certified providers
- Allow county waiver agencies to establish local networks with certified providers determined by the Department to be willing and qualified

The Department assures the implementation of the WPM system, including notification to willing providers regarding the self-registration process, Wisconsin Medicaid Waiver Provider Agreement requirements, the centralized provider

background check screening, and verification of provider training and credential requirements, will result in a public directory of willing and qualified waiver providers, eligible to receive payment upon the submission of completed claims for authorized services by the CLTS Waiver Program's third party administrator's claims processing vendor.

STATEWIDE RATE-SETTING METHODOLOGY
The Department is planning and implementing a three-year, comprehensive strategy to set consistent rates for all CLTS waiver services. This strategy includes creating a rate-setting methodology, as well as a provider management and claims processing system to ensure proper rate payments. The Department has created an external communications plan will be posting rate information on the DHS website. The Department intends to implement the statewide rate-setting strategy for additional waivers as they come up for renewal. The DHS approved rate-setting methodology will apply to all CLTS waiver allowable services. DHS will exercise direct financial oversight by ensuring that key fiscal staff works closely with the rate-setting vendor to establish a sound methodology. In addition, DHS will continue to use a contracted third party administer (TPA) claims processing vendor that will allow DHS to validate payments against the CLTS Waiver Program's fee schedule. As the Rate Structure Project moves forward, DHS will communicate progress to CMS on a quarterly basis. The Department will complete outreach activities to CLTS stakeholders to understand system needs, member and provider impacts; methodology and administrative issues; an in-depth review of current DHS systems capabilities; an analysis of needed statutory changes (if applicable); budget development; and, a funding strategy. In 2017, DHS will work with the rate-setting vendor to conduct detailed financial impact modeling. The main purpose of the financial impact modeling is to understand how rates will change throughout the state and the potential redistribution impacts of the rate-setting methodology on providers, counties and participants. Secondly, the financial impact modeling will help DHS assess the need for a phased-in approach of the new rates, beginning January 1, 2018. Once the rate-setting methodology is established, DHS will work with the rate-setting vendor to create an ongoing process to update rates as necessary.

ALIGNMENT OF THE CLTS WAIVER PROGRAM BENEFIT PACKAGE
The CMS issued guidance which directed states covering autism treatment services through their federal Home and Community-Based Services (HCBS) waiver programs to transfer coverage of these treatment services to their Medicaid State Plan benefit. As a result, the Department is in the process of successfully transitioning coverage of autism treatment services from the CLTS Waiver Program to a behavior treatment benefit under the ForwardHealth Medicaid card. Close coordination occurred between DHS, the county waiver agencies, providers and families to ensure a smooth transition. Prior to the transition of the autism treatment from the CLTS Waiver Program to the ForwardHealth behavior treatment, each affected child/family received a notice informing them of the upcoming change. Similar to the behavior treatment transition, DHS will be transitioning other services from the CLTS Waiver Program's benefit package that are covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. In Wisconsin, the EPSDT benefit is known as "HealthCheck." HealthCheck is a health screening benefit for any child under 21 years covered by Medicaid. The Department will identify children currently receiving services that are funded through the CLTS Waiver Program that are also included as a HealthCheck benefit. The Department will collaborate closely with county waiver agencies to assure families receive advance notice regarding services currently funded by the CLTS Waiver Program that will be transitioned to the ForwardHealth Medicaid benefit. Implementation of this transition is targeted for completion by December, 31, 2017.

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.

Applicability: The Statewide Transition Plan laid out in this document applies to the Medicaid Home and Community-Based Services (HCBS) waivers under s. 1915(c) of the Social Security Act that provide the authority for the Community

Options Program (COP) Waiver, the Community Integration Program (CIP), the Children's Long Term Support (CLTS) Waiver Program, the IRIS (Include, Respect, I Self-Direct) program, the Family Care program, and the Family Care Partnership program. Waiver-specific plans were submitted to the Centers for Medicare and Medicaid Services (CMS) for the COP Waiver, IRIS, and Family Care/Family Care Partnership. The CIP and CLTS programs will follow the statewide transition plan.

The Department of Health Services (DHS) intends to transition the Community Recovery Services (CRS) program currently operating under the 1915(i) authority to a 1905(a) State Plan authority effective January 1, 2015, pending CMS approval. The DHS has issued a public notice regarding this transition under the Wisconsin State Register published November 15, 2014. If CMS does not approve the transition of the CRS program from a 1915(i) to a 1905(a) State Plan service, then DHS agrees to follow the statewide transition plan for Medicaid HCBS as outlined in this plan.

Assessment of Compliance: Wisconsin will use a multi-phase process to assess compliance with the HCBS settings requirements. This approach includes:
- an assessment of all waiver settings for compliance with the rule;
- an assessment of the regulatory and policy framework for residential settings with regard to compliance with the rule;
- provider self-assessment;
- validation of the self-assessment response; and
- on-going monitoring and re-evaluation of settings.

Wisconsin DHS will use a comparable process for non-residential settings based upon the additional guidance provided by CMS.

Preliminary assessment of settings. The Wisconsin DHS conducted a preliminary assessment of existing HCBS settings for compliance with HCBS characteristics. Settings assessments were classified as:
- Yes - meets requirements,
- No - does not meet requirements, or
- Needs Provider Self-Assessment and Validation by the DHS.

The DHS considers any services provided in the waiver participant's own home, or family home, are home and community-based. Per the HCBS final rule, services provided in the following settings are not considered home and community-based:
- Nursing facility
- Institution for mental diseases
- Intermediate care facility for individuals with intellectual disabilities
- Hospital

All other settings will be assessed by the DHS through a multi-level process, using state staff and delegated entities as needed. The initial assessment of compliance with the HCBS settings requirements is focused on residential settings using the HCBS regulation and additional guidance provided to states by CMS. A similar assessment of non-residential HCBS settings will be implemented as a second phase of the process.

Assessment of regulations for residential settings. Wisconsin's initial review of residential settings is based on a cross-walk of current state regulations, standards and policies to the requirements articulated in the final federal rule. The DHS conducted a preliminary analysis of the current regulatory requirements and identified those that align with and meet specific requirements of the HCBS regulations and guidelines for residential settings. The analysis indicates that many of the requirements included in the federal rule are already incorporated in Wisconsin's policies that govern certain licensed or certified residential settings.

However, Wisconsin regulations do not specifically address every federal standard. Therefore, provider assessments are needed to determine whether requirements of the federal rule, that are not addressed through state regulations and policies, are met by individual providers.

Some of the standards, such as choice of setting, choice of roommate, and access to activities in the community are the responsibility of the entity providing care management or consultation, not the residential provider. This is true across all HCBS programs in Wisconsin. Monitoring of the quality of person-centered planning is an on-going process in all of these programs. The provider assessment does not cover the requirements that are the responsibility of the care management entity. The methods for ensuring person-centered planning are reflected in each of Wisconsin's approved HCBS waivers.

Provider self-assessment. Wisconsin will use a single standardized tool to conduct a provider self-assessment of all

residential settings. Residential providers will need to respond to the assessment for each location when the provider operates multiple sites. Providers will be required to provide documentation of the accuracy of their responses upon request of the DHS or the Waiver Agency.

The provider self-assessment tool drafted by DHS staff was based on the review of the requirements of the rule, model tools provided by CMS, and assessment tools developed by other states. The DHS released the draft tool using a public notice process and invited stakeholders to provide comments. Stakeholder comments will be compiled, reviewed and incorporated into the tool as determined necessary by the DHS.

The DHS will release the self-assessment tool to providers in both an on-line format and as a paper document. The DHS will use several methods to ensure that all covered providers have an opportunity to respond to the self-assessment. These include outreach using:
- Provider information from claims and encounter systems;
- Licensure records;
- Waiver Agency provider lists (managed care organizations, counties, IRIS Agencies); and
- Through notice on the DHS website.

Entities that do not currently provide waiver services may complete the self-assessment should the provider anticipate providing HCBS waiver services in the future. Providers must complete the self-assessment for each site that they operate, but will only need to complete the self-assessment once for a given site, even when they serve participants in more than one program in the setting. Provider responses will be compiled and evaluated by DHS staff, or other assessment entities.

Validation of self-assessment. Waiver Agencies and the DHS will validate compliance through a site visit with a stratified representative sample of the settings that respond to the provider self-assessment. Any current waiver provider that fails to submit a self-assessment will receive a site visit as part of the validation process, unless the provider indicates that it does not intend to continue to provide services to HCBS waiver program participants.

The DHS will develop a structured protocol for validation of the provider self-assessment that includes the review of supporting documents provided by the provider and interviews with people residing in the setting being assessed. Personnel from Waiver Agencies will validate self-assessment data for a stratified representative sample of settings. The DHS will validate a stratified representative sample of settings validated by Waiver Agencies. A site will only be subject to validation by one Waiver Agency even if they serve people from more than one program. The DHS will compile a list of providers that document, through self-assessment and/or validation by the Waiver Agency and/or State, that they comply with the regulations for HCBS settings and share the information with Waiver Agencies.

On-going assessment of settings. Licensed and certified settings are subject to periodic compliance site-visits by the state licensing authority, or by the entity that certified the provider. Licensing and certification standards are enforced during those visits. Sites found to have deficiencies are required to implement corrective actions and can lose their license or certification when non-compliance continues or is egregious.

Waiver Agencies operating Wisconsin's HCBS waiver programs are charged with the continuous evaluation of settings as they fulfill their care management responsibilities. New providers and settings will be subject to an assessment of compliance with the HCBS waiver settings requirements.

Remedial Actions: For settings that do not currently meet the HCBS waiver settings standards, Wisconsin DHS will conduct remediation activities at the state and provider level. The DHS does not anticipate a change in standards for licensed settings and the standards for the certification of Adult Family Homes serving one or two people since these providers also serve people who do not receive Medicaid HCBS. All HCBS waivers and accompanying program guidance will be reviewed and revised to reflect the new standards in the service descriptions and provider standards. The DHS will review all program authorities such as statutes and administrative code for compliance, as well as contracts and other guidance provided to Waiver Agencies. Participant handbooks and other materials will also be reviewed and revised as needed.

At the individual setting level, the DHS and Waiver Agencies will provide information on the HCBS waiver settings requirements to all providers and guidance, as feasible, to entities that want to revise their practices to comply with the regulation. Assistance may also be available to providers from provider associations and advocacy organizations. Compliance will be re-assessed upon request of the provider and validated through a site visit.

Description of heightened scrutiny process: The DHS anticipates that some settings that are presumed not to be home and

community-based per the regulation, may be able to document to the DHS that they meet the requirements of the regulation. These include:
- Settings in a publicly or privately-owned facility providing inpatient treatment;
- Settings on grounds of, or adjacent to, a public institution; and
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS waiver services.

Determinations on such settings will be made on a case-by-case basis. Any setting that meets the above definition will be invited to complete the provider self-assessment to begin the process to justify that the provider's setting does not have the characteristics of an institution and therefore meets the HCBS waiver setting requirements. The DHS will conduct a site visit for each such setting using the same protocols that will be used for other providers. The determination of the DHS will be provided to CMS along with evidence supporting the determination. Settings will be subject to periodic reviews of continuing compliance.

Plan to relocate participants: The DHS will only relocate HCBS waiver program participants after all attempts to assist providers to become compliant with the settings requirement have been exhausted, or the provider has declined to make changes to come into compliance. The DHS anticipates completing its assessment and remediation activities in a timely manner to allow people sufficient opportunity to choose a new setting and relocate before the CMS deadline for full statewide compliance. Care managers and inter-disciplinary teams will work with each person affected to provide a choice of compliant settings.

People who will be affected will receive a notice that they will need to select a new setting. The notice will be provided as soon as the Waiver Agency is aware that the setting has not successfully met the HCBS waiver requirements. The notice will indicate that the setting does not comply with the rule and will describe the person's right to due process. The Waiver Agency will begin the person-centered planning process to identify other options in compliant settings.

The DHS does not currently have an estimate of the number of people who will be impacted by compliance with the HCBS waiver rule and will make every effort to minimize the impact.

Timeframe and Milestones: The DHS established timeframes with the following priorities:
- to minimize avoidable member transitions;
- maximize the amount of time for providers to come into compliance;
- provide enough time for the DHS and Waiver Agencies to diligently carry out on-site provider assessments; and
- provide enough time for any necessary participant transitions so the changes happen in a planned, person-centered manner allowing for due process for each affected participant.

The Family Care, IRIS and COP Waiver programs have submitted detailed waiver specific transition plans to CMS. The plans differ on some interim steps and timelines. The following timeline encompasses that program variation. All HCBS settings must be compliant by March 17, 2019.

Milestone, Target Start Date, Target End Date
Preliminary Assessment of Services and Residential Settings - includes time for public comment March 31, 2015
Development of Residential Provider Assessment Tool - January 30, 2015
Development of Non-Residential Provider Assessment tool - April 1, 2015
Residential Provider Self Assessment 15 December 31, 2015
Non-Residential Provider Self Assessment May 2015, November 2015
Provider Self Assessment Validation May 2015, June 2016
Release results of Provider Self Assessment Process, July 15, 2016
Provider Remediation Plans Submitted June 2016, August 2016
Validation of Provider Remediation: As providers implement plans - no later than June 2017, December 31, 2017
Participant Transition As soon as Waiver Agencies are aware that provider will not comply - no later than September 30, 2018, September 30 2018
Full Compliance Achieved, March 17, 2019

Public Comment: DHS posted the Statewide Transition Plan on its public internet site on November 26, 2014. A review and comment period was open from that date through December 29, 2014. Notification of the posting was sent by e-mail to an extensive list of stakeholders on November 26, 2014. A notice regarding the plan posting and comment period was published in sixteen major state newspapers between November 28 and December 2, 2014, and again on December 12, 2014. Interested parties could submit comments in writing via e-mail or regular mail.

This statewide transition plan was approved by CMS on January 15, 2016.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

   ◉ **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   The Division of Long Term Care
   (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).*

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2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
   The Department of Health Services (DHS) is the designated Wisconsin State Medicaid Agency. The Governor appoints the DHS Secretary, and the Department utilizes a Division structure under the authority of

the Secretary to carry out the Department's mission and to assure compliance with federal and state regulations as they relate to the administration of programs within the Department.

The DHS Secretary has designated the Administrator of the Division of Health Care Access and Accountability(DHCAA) as the State Medicaid Director. The State Medicaid Director is responsible for the overall policy direction of Wisconsin's Medicaid programs, including HCBS waiver programs, and securing the financial well-being of all Medicaid programs. The State Medicaid Director is accountable to the Department Secretary. This includes coordinating the decision-making for all policies that affect Wisconsin's Medicaid State Plan and HCBS waiver services.

There are mechanisms in place for ongoing coordination of policy and procedure between the Division and with the Secretary's Office. These include bi-weekly status meetings with the Secretary for the Division Administrator; monthly Executive staff meetings that include all Division Administrators and the Secretary; and regular meetings between the Division of Health Care Access and Accountability and the Division of Long Term Care, which includes dedicated meetings with the Director of the Bureau of Children Services. Ultimately, the DHS Secretary's authority ensures coordination over all Medicaid programs.

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.:*

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

Appendix A: Waiver Administration and Operation

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

   ○ **Not applicable**

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

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

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

   In Wisconsin, designated county waiver agencies perform some of the functions of the State Medicaid Agency on behalf of, and under the guidance and supervision of, the Department. Under the Wisconsin

Constitution, a county department serves as an arm or political subdivision of the State, primarily performing delegated state operational functions at the local level. The functions of Wisconsin's county agencies to operate the approved HCBS Waiver Program's operations are specified in Wisconsin statutes and administrative rules and are consistent with the approved waivers.

The Department enters into State-County contracts with the designated county waiver agencies to operationalize the Children's Long-Term Support (CLTS) Waiver Program. The CLTS Waiver Program State-County contracts reference the Department's Home and Community-Based Waiver Program manual, numbered memos and other documents which detail the approved policies, procedures, and standards, as established by DHS, to which county waiver agencies must adhere. The Department is also in the process of publishing a dedicated Children's Long-Term Support (CLTS) Waiver Program Manual that will align with the numerous changes that will result from the CMS approval of the renewal submission which will become effective on or after January 1, 2017.

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Department of Health Services, the State Medicaid Agency, maintains direct administrative oversight of the Children's Long-Term Support Waiver Program consistent with 42 CFR§431.10(e). The DHS maintains the sole authority to provide administrative direction and issue policies, rules and regulations. County waiver agencies do not have the authority to change or disapprove any administrative decision of the State Medicaid agency or otherwise substitute their judgment with respect to the application of policies, procedures, rules, and regulations issued by the State Medicaid Agency. This requirement is defined through the State-County Contract. The contract specifies that each county waiver agency must carry out the required policies and procedures, as set forth by the State Medicaid Agency. This relationship is further detailed in the CLTS Waiver Program Manual and other DHS issued Medicaid policy and procedure documents. These documents are state authored and issued by the Department. The information contained in the manual and other policy documents is binding to all county waiver agencies and cannot be altered.

   The performance of the county waiver agencies is also evaluated through the Wisconsin Single State Audit, CLTS Waiver Program record review protocols, as well as other quality assurance and monitoring functions that are completed by the Bureau's Children's Services Specialists (CSS) who are assigned to specific county waiver agencies around the state, program integrity staff, and DHS regional staff. The DHS CSS, along with DHS regional staff, monitor the county waiver agencies that are identified as having quality issues through on-site review and audit protocols. County waiver agencies that fail to comply with the Department's established program requirements are provided technical assistance and guidance, along with direct follow-up. If the compliance factors represent broader system issues, DHS will develop a corrective action plan (CAP) with the county waiver agency, with measurable outcomes and timelines. The CAP is monitored by the Bureau's assigned CSS and program integrity quality assurance staff until the county waiver agency has achieved the required improvement and resolution.

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:
The DHS provides stringent financial and programmatic oversight of HCBS waiver programs through the State of Wisconsin's Single State Audit process, which is administered through the Department of Administration (DOA). The DOA's State Controller's Office provides overall coordination of the state's single audit activities. The State of Wisconsin has adopted the federal audit requirements in CFR Part 200 Subpart F, "Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards", hereafter known as "Uniform Guidance" for recipients of funding from the State. The State Single Audit Guidelines implement the federal audit requirements for certain state programs and federal programs passed through state agencies. The Single State Audit is performed on an annual basis. The Single State Audit are completed by designated auditors who must:
- Be licensed by the State of Wisconsin as a certified public accountant, as required by Wis. Stat. 442 and Government Auditing Standards. Mobility and Wisconsin Statute 442 (4) allows for licensees of other states to perform audits if all conditions of referenced paragraph are met.
- Possess the technical qualifications to perform an audit involving government programs, including continuing professional education, as required by auditing standards generally accepted in the United States of America and Government Auditing Standards.
- Undergo an external quality control review (peer review) at least once every three years and make the report on the quality control review available to the auditee and to granting agencies upon request, as required by Government Auditing Standards.

Audits performed under these Guidelines are due to the granting agencies nine months from the end of the fiscal period or 30 days from completion of the audit, whichever is sooner. Extensions of due dates are not allowed. A significant part of the value of the audit process is the opportunity to improve operations through taking corrective action for audit findings. The State Single Audit Guidelines require consideration of fraud in the administration of state funded programs and federal pass-through programs as part of every audit performed in accordance with the Guidelines. In addition, auditors have a responsibility to detect material misstatements of the financial statements, whether caused by error or by fraud.

The auditee shall follow up and take corrective action on audit findings and report these actions in the schedule of prior audit findings and corrective action plan. In addition, Wisconsin's Legislative Audit Bureau conducts single audits of state agencies. As part of the state single audit, the Legislative Audit Bureau tests whether state agencies are complying with the sub recipient audit responsibilities of the Uniform Guidance and the State Single Audit Guidelines.

The DHS Office of Inspector General (OIG) oversees the Department's Single State Audit process for the DHS designated programs, such as the CLTS Waiver Program. The Bureau of Children's Services issues specific CLTS Waiver Program State Single Audit criteria, specifications and guidance to the auditors. The auditors review the county waiver agency's CLTS Waiver Program records and operations, and issue any findings to the OIG Audit Section. The Department has established a DHS Audit Resolution Team, which is led by OIG and includes DHS representatives from all programs that are subject to the state single audit. This process ensures that DHS program staff (including the CLTS Waiver Program staff) conduct timely and consistent determinations on the appropriate audit finding remediation actions, including sanctions and recoupment of disallowed waiver funds. When audit findings indicate a systematic problem with the county waiver agency's procedures, a corrective action plan (CAP), including any necessary repayment, is directed by the State Medicaid Agency. The county waiver agency's CLTS Waiver Program audit results are also shared with BCS managers and DHS regional staff to determine if systemic issues need to be addressed.

The Bureau of Children's Services is also responsible for conducting other monitoring and quality assurance strategies, including the review of data system reports, and randomly selected samples of county CLTS Waiver Program records to ensure compliance with the approved performance measures, and analyze trends and systemic issues. The CLTS Waiver Program's monitoring protocol will be enhanced during 2017 to include a a record review process that is completed by a dedicated external quality review organization (EQRO), as detailed below:

A randomly selected sample of CLTS Waiver participant records are reviewed by the DHS EQRO in collaboration with the BCS, to ensure compliance with the approved performance measures, as well as the health, safety and welfare of participants. Additional system data is also reviewed, such as:
- the accuracy of the child's level of care, as determined by the CLTS Functional Screen
- Frequency and utilization of waiver services paid by the DHS third party administration (TPA) claims processing vendor

Reporting of incidents is an additional requirement of all county waiver agencies. DHS defines a "reportable incident" as "actual or alleged events, situations or conditions that pose a significant immediate and/or ongoing threat or risk to the physical or mental health, safety, well-being or continued community presence of a CLTS Waiver Program participant. Reportable incidents also include the actual or alleged misappropriation of the waiver participant's funds or property or unexpected and unusual adverse environmental conditions that pose serious danger to the participant's health or welfare. Reportable incidents are always unanticipated. Every reportable incident must be submitted to DHS within three business days (generally 72 hours) of the date when the waiver agency learns of the incident. Any incident that is current and continues to pose a risk to the waiver participant must be reported to DHS within one business day (24 hours).

Every reported incident is reviewed by the assigned DHS Children's Services Specialist, who corresponds with the county waiver agency to ensure the child's health, safety and welfare has been addressed, remediation of the situation, and action steps and protocols have been implemented to prevent the likelihood of a recurrence of the incident. The county waiver agency's written incident report must describe their actions completed to address the incident and prevent further occurrence.

The county waiver agency must comply with all the requirements, as detailed in the Wisconsin CLTS Waiver Program Manual, as well as the guidance included in the Single State Audit, which includes CLTS waiver expectations for county waiver agencies. The county waiver agency is responsible for ensuring the following CLTS Waiver Program requirements:

- Compliance with all state delegated county waiver agency requirements
- Participants meet functional and Medicaid financial and non-financial eligibility criteria
- Participant assessment and individualized service planning
- Participant annual recertifications are current and complete
- Participant freedom of choice
- Participant notification of fair hearing rights
- Provider networks are established to meet local CLTS waiver participant needs, based on willing and qualified providers as displayed on the Wisconsin Provider Management (WPM) public directory, after the DHS centralized caregiver background check screening, provider training and credentials have been verified
- CLTS Waiver services are allowable, properly authorized, coded, and coordinated with other benefits, as the program payer of last resort.

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	Local Non-State Entity
Participant waiver enrollment	☑	☑
Waiver enrollment managed against approved limits	☑	☑
Waiver expenditures managed against approved levels	☑	☑
Level of care evaluation	☑	☑
Review of Participant service plans	☑	☑
Prior authorization of waiver services	☑	☑
Utilization management	☑	☑
Qualified provider enrollment	☑	☑

Function	Medicaid Agency	Local Non-State Entity
Execution of Medicaid provider agreements	☑	☐
Establishment of a statewide rate methodology	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐
Quality assurance and quality improvement activities	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. **Methods for Discovery: Administrative Authority**
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. **Performance Measures**

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

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

Where possible, include numerator/denominator.

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

Performance Measure:
County waiver agencies respond to CLTS Waiver Program fair hearing decisions with remand orders by the Division of Hearing and Appeals within 10 day requirements. Numerator= Number of fair hearing remand orders completed within 10 days. Denominator= Number of all fair hearing decisions with remand order overturning county waiver agency's action.

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 =
☐ **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.
The performance measures in this section as it relates to administrative authority will ensure that the county waiver agencies implement their program operations as required under their DHS State-County contract, and the established policies and procedures, as detailed in the CLTS Waiver Program Manual and DHS issued numbered and informational memos. Performance measures within other appendices in this application will also be used to ensure administrative oversight in the implementation of program operations, policies and procedures, as indicated under the Department's CLTS Waiver Program established requirements, but are not

duplicated in this section. Additional discovery methods related to administrative oversight include issues that arise during the county waiver agency's program operations are those that are self-identified, or through complaints and other discovery methods employed by other sections within the Division related to oversight of related program operations such as Level of Care (LOC) determinations and Encounter data reporting.

County waiver agencies manage the CLTS Waiver Program applicant enrollment and recertification of participants' waiver eligibility within the Division of Long Term Care's Enrollment and Eligibility system, following the determination of the child's functional eligibility via the CLTS Functional Screen (CLTS FS). The Enrollment and Eligibility system will not permit a child to enroll in the CLTS Waiver Program if the CLTS FS does not display a LOC determination and the child is not enrolled in a Medicaid program (e.g., Katie Beckett Medicaid Program, Supplemental Security Income, Foster Care, BadgerCare Plus, Wisconsin Works, etc.).

Only trained and certified screeners are permitted access to the CLTS FS system. The DHS CLTS FS subject matter experts perform various quality assurance strategies to ensure children's functional eligibility was accurately determined according to the clinical instructions. The CLTS FS subject matter experts work closely with the assigned CSS, who follows up with the county waiver agency and ensures any issues are corrected. If the issue reflects systemic concerns, a corrective action plan (CAP) is issued to the county waiver agency and tracked by the Bureau of Children's Services program integrity staff to ensure the issue is remediated and compliance with the CLTS Functional Screen requirements.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Department directly monitors the county waiver agencies to correct any issues discovered through ongoing administrative oversight activities. For example, if the DHS assigned Children's Services Specialist (CSS) notes a concern while reviewing an Individual Service Plan (ISP) for a waiver participant, the CSS will contact the county waiver agency to discuss the potential issue and identify any needed remedial action. County waiver agencies are responsible for correcting any issues that are discovered and informing their assigned CSS of their actions. Issues are tracked from the county waiver agency's initial identification to the final resolution. The CSS may also recommend development of a corrective action plan (CAP) to the BCS program integrity staff in cases where a systemic issue appears to be present. The Department may also require immediate remedial action and impose CAPs to address serious or unresolved issues. The BCS CLTS Waiver Program staff report all issues to the Bureau's program integrity quality assurance staff who collects information and tracks the status to document and ensure appropriate remedial actions have been completed.

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
[x] Aged or Disabled, or Both - General					
	[ ]	Aged			[ ]
	[x]	Disabled (Physical)	0	21	
	[x]	Disabled (Other)	0	21	
[ ] Aged or Disabled, or Both - Specific Recognized Subgroups					
	[ ]	Brain Injury			[ ]
	[ ]	HIV/AIDS			[ ]
	[ ]	Medically Fragile			[ ]
	[ ]	Technology Dependent			[ ]
[x] Intellectual Disability or Developmental Disability, or Both					
	[x]	Autism	0	21	[ ]
	[x]	Developmental Disability	0	21	[ ]
	[x]	Intellectual Disability	0	21	[ ]
[x] Mental Illness					
	[ ]	Mental Illness			
	[x]	Serious Emotional Disturbance	0	21	

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

CLTS Waiver participants must meet the functional and support needs criteria, as set forth in the Children's Long-Term Support Functional Screen (CLTS FS), meet Medicaid financial and non-financial requirements, and reside in allowable living situations within the community.

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:

County waiver agencies must plan for the child's transition to adult waiver services by the time the child is 17 years and 6 months old. These transition plans must be documented within the individual's record and reasonable steps must be taken to assure continuity of services as the youth reaches adult status. If a person does not meet the eligibility criteria for adult waiver services, then transition planning to other community supports and services must be considered as well.

When a youth reaches age 17 years and 6 months of age, the county waiver agency must refer the CLTS Waiver participant and/or family to the local Aging and Disability Resource Center (ADRC) for options counseling. In counties that have implemented Family Care, Partnership and the self-directed Include, Respect, I Self-Direct (IRIS) waiver, young adult CLTS Waiver Program participants, 18 through 21 years of age, who are determined functionally and financially eligible for Family Care, Partnership or IRIS must be enrolled in those programs without delay. CLTS participants who are not eligible to transition to the Family Care, Partnership or IRIS program (e.g., child placed in foster care) remains eligible for the CLTS Waiver Program through age 21 years.

For counties that do not operate Family Care, Partnership or the IRIS waiver program, the county waiver agency must refer the participant to the local ADRC by age 21.5 years for enrollment into one of the Adult Legacy Waiver programs (Community Integration Program (CIP) Waiver or Community Options Program (COP) Waiver, if the participant meets the functional and Medicaid financial and non-financial eligibility criteria.

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)

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:

The county waiver agency develops a proposed Individual Service Plan (ISP) for the child, in collaboration with the family and participant, if applicable, that addresses the necessary waiver allowable goods, supports and services, based on the assessed needs of the child and parents/guardian to maintain the child's ability to live in the community. A comprehensive assessment and the ISP, along with anticipated cost is completed and signed by the child's parents/guardian. A selected sample of ISPs are reviewed as part of the quality assurance monitoring activities to ensure compliance. The DHS external quality review organization, in collaboration with BCS, reviews the selected ISP samples to assure the child's health, safety and welfare needs are met within the allowable cost limits.

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:

Additional services in excess of the individual cost limit may be authorized in situations where it is necessary to increase supports and services to maintain the child in a home and community-based setting. These are typically short-term services necessary to assist the family during a period of crisis in order to reach stabilization. The county waiver agency completes an individual needs assessment for the child with assistance of the parent/guardian. The waiver agency completes a proposed ISP, that addresses the allowable goods, supports and services, based on the assessed need, to assist the family in supporting their child through a period of increased need. The proposed crisis plan along with anticipated cost is submitted to the DHS Children's Services Specialist to review and approve, after assuring the proposed plan meets all the health, safety and welfare needs for the child.

.

☑ **Other safeguard(s)**

Specify:

Wisconsin's county human/social/community services system has local safeguards in place when a situation arises whereby a child's health, safety and welfare needs are at risk. Wisconsin Statutes Chapter 48, also known as "The Children's Code" mandate these local county systems to implement safeguards to respond to the health and safety needs of an individual child and family in a timely manner and assure the least adverse impact. These systems include Wisconsin's county's child protective services, child welfare services, juvenile justice, and mental health programs. The participant's county Support and Service Coordinator provides information regarding other available services or funding options to the child's family.

The county waiver agency's Support and Service Coordinator makes the necessary referral to their county agency partners and works to coordinate new services and available funding sources to ensure the child's health and safety needs are met.

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	8479
Year 2	9787
Year 3	9886
Year 4	9885
Year 5	9886

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:

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

The Department has incorporated several key principles commonly used in developing statewide policies, procedures and establishing an effective and equitable system for tracking eligible children waiting to receive CLTS Waiver Program services. The most basic principle is that children must be served in the order of their placement on the wait list -- the first-come, first-served principle. The Department currently uses the Program Participation System (PPS) to administer the CLTS Wait List requirements and track an applicant's waiver enrollment.

The Department is responsible for the equitable distribution of CLTS Waiver funds to release to county waiver agencies to enroll eligible children in the CLTS Waiver Program on a statewide first-come, first-served basis. The Department assigns a waiver allocation, or "slot" for the next applicant who is placed on the CLTS Wait List. The applicable county waiver agency must contact the child's parent/guardian to offer the opportunity to enroll in the program and receive waiver services. When serving children from the CLTS Wait List, the following requirements apply:

1. The child must receive all of the services necessary to meet assessed needs, as identified in his/her current assessment.
2. The Department will issue funding slots as CLTS Waiver allocations become available, and the designated county's Support and Service Coordinator, must complete an updated functional level of care determination via the CLTS FS, ensure the child is eligible for a Medicaid State Plan program, complete an assessment and the family-centered Individual Service Plan (ISP).
3. Once the Department confirms the waiver funds will be allocated to the county waiver agency, the county waiver agency must promptly complete the necessary steps to remove the child's name from the CLTS Wait List and enroll the child in the CLTS Waiver Program.

Procedures for Placing Persons on the CLTS Wait List
The county waiver agency must complete the following procedures when placing a child's name is placed on the CLTS Wait List:
1. Make a preliminary determination of the child's functional eligibility via the CLTS Functional Screen, financial eligibility, as well as the need for long term care services.
2. Document the contact with the child's parent/guardian or other referral source, which becomes the date of placement on the CLTS Wait List.
3. Offer to complete an assessment which, if accepted, must be completed within 45 days. If the child's parent/guardian agrees, the assessment may be delayed until a time nearer to when funds for CLTS Waiver services will become available.
4. Update the CLTS Wait List every six months and provide the parent/guardian with a notification of the child's status on the wait list, as well as an estimate of when funding for the waiver services may become available.

Exceptions to the First-Come, First-Served Medicaid Waiver Wait List Policy: Crisis Needs
The only allowable exception to the first-come, first-served CLTS Wait List policy is when a child or parent/guardian meets one of the crisis need criteria. This Department established criteria must be applied in all such circumstances and may not be modified or expanded by the county waiver agency. The following reasons are the only permissible times a child may bypass the CLTS Wait List and be served out of the first-come, first-served order:
1. Crisis conditions are present in the child's life situation. The need shall be classified as a crisis if an urgent need is identified as a result of any of the following:
a. Substantiated abuse, neglect or exploitation of the child in the current living situation; or
b. Death of the child's primary caregiver or the sudden inability of that caregiver/support person to provide necessary supervision and support and there no alternative caregiver available; or
c. Lack of an appropriate residence or placement for the child due to a loss of housing; or
d. Child has a documented terminal illness and has a life expectancy of less than six months, based upon the opinion of a medical professional appropriately qualified to make such a determination; or
e. A sudden change in the child's behavior or the discovery that the child has been behaving in a manner that places the child, or the people with whom he or she shares a residence, or the community at large at risk of harm.
2. A determination by the county waiver agency that the health and safety of the child is in jeopardy due to the primary caregiver's physical or mental health status; or
3. A determination by the county waiver agency that the child is at imminent risk of a more restrictive placement in an ICF-IID, nursing home or other institutional setting; or

4. A finding by the county waiver agency that other emergency or urgent conditions exist that place the child, family or community at risk of harm and a variance is approved by the Children's Services Specialist.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

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

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

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

  Select one:

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

  Specify percentage: [ ]

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

Specify:

• Other caretaker relatives specified in 42 CFR 435.110
• Pregnant women specified in 42 CFR 435.116
• Children specified in 42 CFR 435.118

All other mandatory and optional groups under the Wisconsin State plan are included.

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 spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount: [ ]

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

Specify:

"Medically needy with spendddown: For person who an intellectual disability, the state Medicaid Agency will use the average monthly rates charged for inpatient care in a State Center for Developmentally Disabled to reduce an individual's income to an amount at or below the medically needy income limit."

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

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

- [x] **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.** *Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

The State uses the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

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

- ( ) **The following standard included under the State plan**

  Select one:

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

(*select one*):

- ○ **300% of the SSI Federal Benefit Rate (FBR)**
- ○ **A percentage of the FBR, which is less than 300%**

  Specify the percentage:
- ○ **A dollar amount which is less than 300%.**

  Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

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

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

Specify:

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

In Fee For Service (FFS) waivers, Medicaid pays the actual cost of the s.1915(c) services a member receives.

○ **Other**

Specify:

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

- ○ **Not Applicable (see instructions)**
- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised.
- ◉ **The amount is determined using the following formula:**

  Specify:

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

In FFS waivers, Medicaid pays the actual cost of the s.1915 (c) services a member receives.

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).

Answers provided in Appendix B-5-a indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

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

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

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

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

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

- ○ **The following standard included under the State plan**

  Select one:

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

    (*select one*):

    - ○ **300% of the SSI Federal Benefit Rate (FBR)**
    - ○ **A percentage of the FBR, which is less than 300%**

      Specify the percentage: [ ]
    - ○ **A dollar amount which is less than 300%.**

      Specify dollar amount: [ ]
  - ○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the State Plan**

Specify:

○ **The following dollar amount**

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

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

Specify:

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

In FFS waivers, Medicaid pays the actual cost of the s.1915 (c) services a member receives.

○ **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 (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).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional State supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:

- ○ **The following dollar amount:**

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

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

  Specify formula:

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

  In FFS waivers, Medicaid pays the actual cost of the s.1915 (c) services a member receives.

- ○ **Other**

  Specify:

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-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:

Waiver services may be furnished on a less frequent basis than monthly, as long as monthly contact is maintained with the county's Support and Service Coordinator with the intent of assuring that the child's health, safety and welfare needs are met through formal or informal supports other than the waiver services.

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

- ○ **Directly by the Medicaid agency**
- ○ **By the operating agency specified in Appendix A**
- ◉ **By an entity under contract with the Medicaid agency.**

Specify the entity:

County waiver agencies, as contracted by the Department of Health Services.

- ○ **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:

Following the successful completion of the DHS approved web-based training program curricula and competency examination, which is administered by the University of Wisconsin-Oshkosh, Registered Nurses and State of Wisconsin Certified Social Workers are permitted access to the Department's Children's Long-Term Support Functional Screen Information Access (FSIA) system.

In addition, effective January 1, 2017, certified CLTS Functional Screeners will also be required to complete an annual refresher training program and competency examination, administered by the University of Wisconsin-Oshkosh, to maintain access to the FSIA system.

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.

County waiver agency support and service coordinators or designated screeners meet with children and their families and gather data from medical, educational and other sources in order to complete an assessment of the child''s abilities and needs. After completing the assessment, the screener enters information into Wisconsin''s web based screening tool, the Children''s Long-Term Support (CLTS) functional screen. Once the screener has completed entering all required information into the functional screen, it is programmed with logic that calculates whether or not the child meets level of care criteria for an Intermediate Care Facility/Developmental Disability Level of Care. Only screeners who have been certified are given access to view and enter information into the CLTS Functional Screen. Screeners achieve certification by completing the state managed online training program and successfully pass a comprehensive exam.

The level of care determination for the CLTS Waivers is based on Federal Medicaid institutional admission criteria for relevant institutional settings. Initially and annually thereafter a child''s Level of Care determination is established and reviewed using the Children''s Long-Term Support Functional Screen (CLTS-FS), a web-based tool. The paper copy of the CLTS-FS was submitted with Wisconsin''s original waiver applications. Information about the applicant is entered into the web-based application, which then applies the LOC process outlined within each of the individual waiver applications. Wisconsin has established that the CLTS-FS meets inter-rater reliability standards.

In addition, data from all functional screens started and/or completed by screeners is available to DHS through the Department's data warehouse. Data regarding individuals enrolled in the waiver is available from the CLTS Enrollment Database. In addition to accessing data to support the specific perfomance measures described in this section, a Functional Screen quality consultant runs reports periodically to identify potential areas of concern. Examples of these reports include:

1.multiple recalculations of the same person's screen in a short period of time.
2.using CLTS enrollment data to identify screen calculation dates for waiver participants, to ensure that screens are completed within waiver timelines;
3.using CLTS enrollment data to identify waiver participants' calculated level of care, to ensure the enrollee meets minimum LOC requirements.

These reports are generated at least quarterly but can be run at any time that the Department determines is appropriate.

Intermediate Care Facility/Intellectual Developmental Disability Level of Care

A child with an ICF/IDD Level of Care has a permanent cognitive disability, resulting in substantial functional limitations and a need for active treatment. The level of care criteria is based upon the child having needs similar to people in an intermediate care facility for children with mental retardation (ICF/MR). The intensity and frequency of required interventions to meet the child''s functional limitations must be so substantial that without the intervention, the child is at risk for institutionalization within an ICF/MR.

A child may be assigned this level of care if the child meets all three of the criteria listed below for Developmental Disability. The criteria are:

1.The child has a diagnosis of a Cognitive Disability that substantially impairs learning and that is expected to continue indefinitely; and
2.The child demonstrates Substantial Functional Limitations related to the cognitive disability when compared to age appropriate activities that are expected to last a year or longer; and
3. The child has the Need for Active Treatment.

Cognitive Disability
The child has a diagnosed Cognitive Disability that substantially impairs learning and that is expected to continue indefinitely. The child has a diagnosis that meets both of the following:

1. The child must have a diagnosis of Cognitive Disability (i.e. intellectual disability) or a similar diagnosis that substantially impairs learning.

The following diagnostic categories are considered diagnoses similar to Cognitive Disability or Mental Retardation for purposes of Criterion 1:

Autism Spectrum Disorders
Brain Injury or Brain Damage
Cerebral Palsy
Down Syndrome
Endocrine Disorders
Fetal Alcohol Syndrome/Effects
Genetic or Chromosomal Disorders
Metabolic Disorders
Prader Willi Syndrome
Rett's Syndrome
Seizure Disorder
Spina Bifida
Tuberous Sclerosis

AND

2. The diagnosis must have resulted in the child having substantial learning impairments as measured by one of the following:

A 30% (25% if the child is under one year of age) or greater delay in aggregate intellectual functioning, based on valid, standardized and norm referenced measures of aggregate intellectual functioning; OR

A score of at least 2 (1.5 if the child is under one year of age) standard deviations below the mean on valid, standardized and norm referenced measures of aggregate intellectual functioning.

The cognitive disability criterion is not met solely based on diagnosis, but must result in a substantial learning impairment as defined above. For example, children with Autism Spectrum Disorders, Cerebral Palsy or Spina Bifida without a substantial learning impairment do not meet the ICF/MR LOC. They may be evaluated against the Nursing Home level of care screen in the case of a child with Cerebral Palsy or Spina Bifida, or the Psychiatric Hospital level of care screen in the case of a child with an Autism Spectrum Disorder.

The child demonstrates substantial functional limitations when compared to the child''s age group and each limitation must be expected to last at least 12 months from the date of review. These limitations must be the direct result of the child''s cognitive disability or similar diagnosis from Criterion 1, and must place the child at risk of institutionalization in an ICF/MR in the absence of extensive, consistent, and direct adult intervention to assist the child in overcoming the limitations, significantly beyond the level of intervention similar aged peers typically require.

The child must demonstrate substantial functional limitations in one or more of the following developmental domains:

Communication: A substantial functional limitation in communication is defined as a 30% (25% if under one year) or greater delay or a standard score of 2 (1.5 if under one year) or more standard deviations below the mean on valid, standardized and norm referenced measures of BOTH expressive and receptive communication functioning. OR

Social Competency: Child must demonstrate substantial functional limitation in social skills in comparison with typically developing age cohorts. OR

Activities of Daily Living: Child must demonstrate substantial functional limitation in activities of daily living and one of the following requirements must be met:

For children under 5 years of age, such a degree of deficit must be evidenced in at least one of the following activities of daily living: Bathing, Grooming, Dressing, Toileting, Eating, Mobility, Transfers

For children 5 years of age or older, such a degree of deficit must be evidenced in at least two of the following six activities of daily living categories.

1.Bathing or Grooming
2.Dressing or Toileting
3.Eating
4.Mobility or Transfers
5.Meal Preparation (18 years old or older only)
6.Money Management (18 years old or older only)

The child must be in need of active treatment, which are the services an ICF/MR facility must provide under federal law. To meet this criterion a child must require a continuous active treatment program that includes aggressive, consistent implementation of training, therapies, health and related services designed to address the child''s substantial functional limitations resulting from her/his cognitive deficits to achieve the acquisition of the skills and behaviors necessary for the child to function with as much self determination and independence as possible; and the prevention of deceleration, regression, or loss of optimal functional status.

For treatment to be categorized as active it must be needed on a continuous and pervasive basis throughout the child''s daily routines in home, school and community. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

In summary, the child must need or be receiving planned and coordinated assistance that is individualized, intensive, interdisciplinary, implemented across environments, of extended duration, and relevant to the developmental stages associated with the child''s age.

e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- (●) **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ( ) **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Support and Service Coordinator completes the assessment. The assessment is a complete description of the applicant's status at the time the child applies for CLTS Waiver Program services as well as a review of the child and family's concerns and priorities. This information is obtained directly from the applicant, whenever feasible, as

well as the child's parents and other caregivers with experience related to meeting the child's needs. The assessment process is conducted in a manner that encourages the child and family to express needs and preferences for a living situation, daily activities and skills or supports that are needed to assure residence within their community. This child and family-centered approach assures a complete picture of the child and family's life as well as the desired outcomes of the child and family that can be met by any service, support or intervention. Assessments are continually updated as the child and family's needs change and must be completely reviewed and revised as necessary as part of the annual re-evaluation. New information obtained is used to update the assessment, review continued level of care, and is the basis for the child's individualized service plan and any needed revisions.

The assessment must contain information obtained during face-to-face interviews with the child and the family, as well as friends and other people who are significant in the child and family's lives. The assessment includes a review of pertinent records and related information obtained from medical, educational and other service providers.

The assessment includes an exploration of the potential community alternatives and places where the applicant may want to live. It should include a discussion of how these relate to the applicant's needs and preferences. The assessment must identify the informal and formal supports and/or services that are necessary to meet the child's needs. The assessment should include a statement regarding the child's preferences regarding where to live, what type of supports are preferred, the specific choice to live in the community or in an institutional setting and the child and family's preferences for a particular service or service provider. Other content areas include any lifestyle choices of the child and the degree to which the family chooses to direct and manage services. The assessment identifies the child and family's preferences for service delivery. The following list includes the topical areas that are reviewed and documented as a part of the assessment:

1. Background information, including any relevant diagnoses;
2. Social history;
3. Description of physical health and medical history;
4. Ability to perform physical activities of daily living;
5. Ability to perform instrumental activities of daily living (e.g. laundry, cooking, cleaning);
6. Emotional functioning;
7. Cognitive functioning;
8. Behaviors that positively or negatively affect lifestyle and relationships;
9. Social participation and existing formal and informal social supports;
10. Cultural, ethnic and spiritual influences including death and dying;
11. Current friendships;
12. Community participation and involvement;
13. Personal preferences for how and where to live and what to do during the day and night;
14. Risks associated with chosen behavior;
15. Future plans including ability to direct his/her own supports;
16. Preference for physical environments;
17. Economic resources available, and how they are managed;
18. Formal or informal supports that are currently available;
19. Need for long term community support services as an alternative to institutional care; and
20. Rights and the person's ability to understand them and assert them.

This assessment information is used by a certified screener to complete the Children's Long-Term Support Functional Screen. The screen provides preliminary functional eligibility related to the waiver level of care. The assessor then completes a comprehensive written narrative regarding their assessment findings per the areas noted above. This forms the basis of the proposed initial individual service plan (ISP).

As part of the Department's quality assurance protocol, the DHS external quality review organization reviews a selected sample of the CLTS FS to ensure the initial LOC, assessment and reevaluation, the assessment and plan to ensure the assessed needs, as well as health, safety and welfare have been appropriately determined for each child.

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

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

Specify the other schedule:

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

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

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

Several complementary practices assure timely CLTS Waiver reevaluations. Support and Service Coordinators have the responsibility to ensure CLTS Waiver participant reevaluations occur at least annually, and upon any substantial change in the child's or family's condition.

County waiver agencies currently submit Recertification Checklist forms to DHS for each participant after the annual redetermination has been completed to confirm that all required redetermination activities have been completed. All Recertification Checklist forms are currently logged into the CLTS enrollment database and reports are available to track timeliness. DHS CLTS Waiver Program staff contact county waiver agencies to follow up on late recertifications.

The CLTS Functional Screen is also a data source that displays the dates of screen calculations for waiver participants. This data is used to identify waiver participants whose functional eligibility has not been determined within the 12-month reevaluation timeline.

The DHS CLTS Enrollment and Eligibility Streamlining system, which is targeted for implementation by 1st quarter 2017, will track the CLTS Waiver participants' recertification due dates and will issue a monthly report to assist the Support and Service Coordinators to monitor and manage their workload and ensure timely actions. The system will also ensure each child has a CLTS FS completed within 365 days, has an eligible LOC, and is enrolled in a Medicaid program (Katie Beckett Medicaid Program, BadgerCare Plus, Supplemental Security Income, Foster Care, Wisconsin Works, etc.)

j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The county waiver agency must maintain either a paper file or electronically retrievable files of all CLTS Waiver evaluations and reevaluations on site at the agency's designated offices. The agency's file includes documents such as the participant's assessment, the child's Individual Service Plan (ISP), the Participant Rights and Responsibilities document, approved service provider(s) screening documentation, service authorization notifications, etc. Additionally, the CLTS FS maintains an electronic copy of the evaluation and reevaluation. These records are maintained for a minimum of three years, as required.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of new enrollees who had a completed initial CLTS functional screen with an eligible level of care (LOC) determination. Numerator: Number of new enrollees with a completed initial CLTS functional screen with an eligible LOC determination. Denominator: Number of new enrollees with completed CLTS functional screen determinations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data from CLTS Functional Screen matched to data from CLTS enrollment database. Enrollment & Eligibility Streamlining, following implementation which is targeted 1st quarter 2017.

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = + / - 5%
☐ **Other** Specify:	☐ **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:
All applicants enrolled in CLTS Waiver Program have an appropriate level of care based on a review of those screens with a Not Functionally Eligible result. Numerator= Number of completed CLTS functional screens with a Not Functionally Eligible result that were not overturned. Denominator= Number of all completed CLTS functional screens with a Not Functionally Eligible result.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLTS Functional Screen 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:

Performance Measure:
An applicant's initial CLTS FS was completed according to the clinical instructions resulting in an applicable LOC. Numerator = number of initial applications where the CLTS FS was completed appropriately and according to the clinical instructions resulting in applicable LOC. Denominator = total number of initial applications for which the CLTS FS was completed.

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

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

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = -/+ 5%
☐ **Other** Specify:	☑ **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.

Performance Measure:
Number & percent of annual eligibility redeterminations conducted by local waiver agency within 365 days of the person's last LOC determination. Numerator: Number of participants whose most recent screen is no older than 365 days. Denominator: Number of participants on the last day of the designated period who had been enrolled for at least 365 days.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data from CLTS Enrollment database matched with CLTS Functional Screen showing most recent screen calculation compared to date of previous screen calculation.

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:

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.

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.
Data from all functional screens started and/or completed by screeners is available to DHS through the Department's data warehouse. Data regarding individuals enrolled in the waiver is available from the CLTS Enrollment Database. In addition to accessing data to support the specific performance measures described in this section, a Functional Screen quality report is run periodically to identify potential areas of concern. Examples of these reports include:

1. multiple recalculations of the same person's screen in a short period of time;
2. using CLTS enrollment data to identify screen calculation dates for waiver participants, to ensure that screens are completed within waiver timelines;
3. using CLTS enrollment data to identify waiver participants' calculated level of care, to ensure the enrollee meets minimum LOC requirements;

These reports are generated at least quarterly but can be run at any time that the Department determines is appropriate.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
When an individual problem is identified through the process described above, DHS directly contacts the certified screener and/or the county waiver agency to gather more information and determine a solution. Specifically, in the event that DHS discovers multiple screens being calculated for an individual over a short period of time, the DHS CLTS Functional Screen Coordinator quality consultant contacts the screener directly to discuss the reasons. If it is determined that the screener is inappropriately utilizing the eligibility calculation function, the screener's certification may be revoked until the screener successfully re-completes the screener training. In other cases, the consultant is able to determine that the screener could show sufficient understanding of the process and certification revocation is not required; instead targeted technical assistance is provided to the screener. Should it appear that the county waiver agency has more systemic problems related to utilization of the functional screen by their certified screeners; a corrective action plan may be required to rectify the situation. DHS maintains documentation of all actions taken to resolve a specific individual problem. Any formal corrective action plan is developed in coordination between the waiver agency and DHS, the Bureau of Children's program integrity section tracks all actions related to the corrective action plan (CAP) . If functional screen data combined with CLTS enrollment data indicates that re-determinations of eligibility are not completed within waiver timelines, this information is shared with the designated Children's Services Specialist (CSS) assigned to the specific county and the CSS follows up with the waiver agency. County waiver agencies are responsible for correcting any individual issues discovered and informing their assigned CSS of their actions. Issues are tracked within the CLTS Enrollment database, from identification to final resolution. The CSS may recommend development of a corrective action plan in some cases where there appears to be a systems issue. The Department may also require immediate remedial action and impose corrective action plans to address these issues.

The Bureau's program integrity section tracks all issues subject to a corrective action plan, from notification to resolution, and reports that information to the BCS management team.

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 Department of Health Services is submitting a 1915(b)4 Waiver Fee for Service Selective Contracting Application to the Centers for Medicare and Medicaid Services (CMS) to modify the freedom of choice requirement as it applies to the CLTS Waiver Program's delivery of conflict free Support and Service Coordination (SSC), or case management services, which is delivered though the county waiver agencies. Under Wisconsin's Statutes Chapters 48 and 51, county departments of human/social/community services are designated as the local agencies responsible for the operations of a variety of programs that provide supports and services to adults, families and children. In addition, county human/social service agencies are statutorily responsible to ensure the health, safety and welfare of every child residing in Wisconsin.

   The Department issues contracts to the designated county waiver agencies to locally operate the CLTS Waiver Program, according to state established policies and procedures. In addition, each waiver agency must have a written description of how the agency will identify, resolve or mitigate conflicts of interest. If resolving or mitigating the conflict is not feasible, the waiver agency must take action to minimize the effect(s) of the conflict. These efforts must be reported to the appropriate state waiver contact and are subject to approval. This conflict of interest policy applies to the county waiver agency and to any other entity involved in any aspect of operating the waivers. A conflict of interest is present whenever a person or any other entity involved in operating any part of the waiver has an interest in or the potential to benefit from a particular decision, outcome or expenditure. A single individual, agency or entity occupying several roles often signals that conflict of interest may be present

   When the county waiver agency's assigned Support and Service Coordinator (SSC) assesses that a child is requires a level of care (LOC) determination for the CLTS Waiver Program, the SSC informs the child's parent/guardian of the feasible services and alternatives under the waiver, as well the choice between institutional or home and community-based services.

   The SSC informs the parents or guardian of their right to a fair hearing from the Wisconsin Division of Hearings and Appeals under 42 CFR Part 431, subpart E, if the child is not given the choice of home or community-based services as an alternative to the institutional care, or is denied the service(s) of their choice, or the provider(s) of their choice. Wisconsin's HCBS Waiver Program uses a form to document this notification, The Participant Rights and Responsibilities form, which outlines the right to freedom of choice and to a fair hearing if this right is violated, as well as the Individual Service Plan (ISP) form. The Participant Rights and Responsibilities form is issued to every CLTS Waiver applicant upon the completion of the initial assessment and evaluation, again as the first ISP is developed, and to every CLTS Waiver participant upon subsequent recertifications or revisions to the ISP.

   The county waiver agency's procedures for informing parents or guardians of the feasible alternatives under a waiver and for allowing individuals to choose either institutional or home and community-based services is discussed with the CLTS Waiver applicant's parent/guardian at intake and during initial person-centered ISP development. This is also discussed annually at the ISP review. The participant's parent/guardian is informed and the choices are explained to the parents/guardian prior to signing the ISP. The ISP includes the following verification statement: "I have been informed of and understand my choice between an ICF-IID, Psychiatric Hospital or Nursing Home and Community Services through an MA Community Waiver Program. By my signature below I indicate I have chosen to accept community services through an MA Community Waiver Program."
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.

The documentation of the Freedom of Choice documentation is maintained by the Support and Service Coordinator at the county. A copy of this documentation is available to the state CSS upon request.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
Following the "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against national Origin Discrimination Affecting Limited English Proficient Persons" the Department's Limited English Proficiency (LEP) Administrative Directive requires each Division to ensure the needs of LEP persons are met through both the interpretation and translation of materials. In addition, each program must develop and implement a plan for the written translations of vital documents after considering these four factors:
1. Number or proportion of LEP persons likely to be encountered by the program;
2. Frequency with which LEP individuals come in contact with the program;
3. Nature and importance of the program, activity, or service provided by the program to people's lives; and
4. Resources and costs available to the program.

In addition, as required by Wisconsin's Contract Compliance Law under Wis. Stat. § 16.765 and Wis. Admin. Code ch. ADM 50, the Department's State-County contract includes requirements for every grantee to agree to equal employment and affirmative action policies and civil rights and translation compliance practices in its programs. County waiver agencies operating the CLTS Waiver Program have access to an AT&T Language Line, which has 150 different languages for interpretation over the phone; the service also translates individual documents as needed. The Department has translated the following waiver program documents, which are routinely issued to CLTS Waiver Program participants, into Spanish and Hmong:

- Participant Rights and Responsibilities Notification
- Missed Services Policy
- Critical Incident Reporting Overview

The Department has also implemented following requirements for translation related to waiver services. In addition, the following guidelines apply to waiver providers and are required if a child or their family's language of origin is a language other than English. Communication must also be adapted for families who speak English but may not be literate or who have limitations affecting their understanding of language.

- Waiver providers with more than 25 employees and are expected to receive more than $25,000 in CLTS waiver funds in the year must comply with the translation requirements for LEP participants and families.
- Waiver providers must document that substantial efforts have been made to hire staff that speak the child and family's language of origin.
- If staff who speaks the language of origin cannot be hired, then translation services, or other appropriate accommodations, must be provided if needed by the family.
- If translation, or other accommodation, is needed in order for the child or the family to benefit from supports or services, then these services must be provided to the child and family at no cost.

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	**Consumer Education and Training**		
Statutory Service	**Day Services**		
Statutory Service	**Respite**		
Statutory Service	**Support and Service Coordination**		

Service Type	Service		
Statutory Service	Supported Employment – Individual		
Statutory Service	Supportive Home Care		
Supports for Participant Direction	Financial Management Services		
Other Service	Adaptive Aids		
Other Service	Adult Family Home		
Other Service	Child Care Services		
Other Service	Children's Foster Care		
Other Service	Communication Aids/Assistive Tehcnology/Interpreter Services		
Other Service	Community Integration Services		
Other Service	Counseling and Therapeutic Services		
Other Service	Daily Living Skills Training		
Other Service	Home Modification		
Other Service	Housing Counseling		
Other Service	Mentoring		
Other Service	Personal Emergency Response System (PERS)		
Other Service	Relocation Services		
Other Service	Specialized Medical and Therapeutic Supplies		
Other Service	Supported Employment - Small Group		
Other Service	Training for Parents/Guardians & Families of Children with Disabilities		
Other Service	Transportation		

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):

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):*
The provision of consumer education and training services helps the waiver participant acquire the skills needed to exercise control and responsibility over their other supportive services. Covered expenses may include enrollment fees, books and other educational materials and transportation related to participation in training courses, conferences and other similar events that address the objectives of this service category.

This service includes education and training for participants, their parents/guardians or caregivers that is directly related to building or acquiring the participant's skills as described in the definition above.

The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under the covered transportation service, but not both. When transportation is included within this service, all providers shall ensure the standards described in the transportation service are met.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service excludes payment for hotel and meal expenses while participants or their legal representatives attend allowable training/education events.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided
Agency	Any agency appropriately qualified as approved by the State and as related to the unique service being provided

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Education and Training

Provider Category:
Individual
Provider Type:
Any persons appropriately qualified as approved by the State and as related to the unique service being provided
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Training specific to the unique needs of the child's target group.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Consumer Education and Training

Provider Category:
Agency
Provider Type:
Any agency appropriately qualified as approved by the State and as related to the unique service being provided
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Only appropriately qualified providers of consumer education and training services are paid with waiver funds. Each provider must have demonstrated skills related to the specific area of training and the applicability of that information to children with disabilities and their families.
Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Day Habilitation
Alternate Service Title (if any):
Day Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation

Category 2:	Sub-Category 2:
04 Day Services	04070 community integration

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

Service Definition *(Scope)*:
Day Services are the provision of services that provide children with regularly scheduled activities for part of the day. Services include coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management. This includes services not available through public education programs that provide after school supervision, daytime services when school is not in session, and services to pre-school age children. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or in multiple environments, including natural settings in the community. Coordination activities may involve the implementation of components of the child's family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan.

Day Services for children also includes the provision of supplementary staffing necessary to meet the child's exceptional care needs. This service may include supplementary supports and supervision services to address exceptional emotional or behavioral needs, or physical needs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes the basic cost of day care unrelated to a child's disability needed by parents or regular caregivers to allow them to work or participate in educational or vocational training programs. The basic cost of day care here means the rate charged by and paid to a child care center for children who do not have special needs.

Excludes any service that falls under the definition of daily living skills training, supportive home care, vocational futures planning, mentoring or respite care.

This service excludes the basic cost of day care unrelated to a child's disability that may be needed by parents or regular caregivers to allow them to work, or participate in educational or vocational training programs. The "basic cost of day care" here means the rate charged by and paid to a child care center for children who do not have special needs. The basic cost of child care does not include the provision of supplementary staffing this cost may be covered by this service.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Group Child Care Center
Agency	Family Child Care Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Services

Provider Category:
Agency
Provider Type:
Group Child Care Center
Provider Qualifications
License *(specify):*
DCF 251
Certificate *(specify):*

Other Standard *(specify):*
Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting who works directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Services

Provider Category:
Agency
Provider Type:
Family Child Care Center
Provider Qualifications
License *(specify):*
DCF 20
Certificate *(specify):*

Other Standard *(specify):*

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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 child on a short-term basis to ease the child's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in a licensed facility such as a licensed children's foster home, or day care center.

Respite care may also be provided in a residential facility such as a certified or licensed adult family home, licensed community-based residential facility, residential care center (RCC), children's shelter care facilities, in the member's own home or the home of a respite care provider.

Services may be provided by RCCs for children who demonstrate complex needs who need support in one or more aspects of their lives including health care, personal care, supervision, behavior and social supports, daily living skills training, and transportation.

A RCC provides temporary respite care for a child or youth with a with complex behavioral or special care needs, usually on behalf of a parent or regular caregiver for the purpose of providing relief to the parent or regular caregiver from the extraordinary and intensive demands of providing ongoing care for the child or youth.
Institutional respite care services require prior approval by the Department, except in an emergency situation. Emergency situation is defined as: "a situation where the primary caregiver suddenly or unexpectedly becomes unable to provide care due to death, illness, disability or other unanticipated event."
Requests for approval of institutional respite must include the rationale for the use of respite in such settings. Respite care services in an RCC shall not extend beyond 9 days per respite episode. The request for prior approval must include the following information:

a. The reason for the request, identifying the caregiver in need of respite;
b. The anticipated length of the respite placement;
c. A description of the barriers to the use of alternative community based services;
d. A description of the proposed respite setting and the reasons that setting was chosen;
e. A plan to address the length of stay limitation in institutional respite.

Transportation services may be included under this service or billed separately under the service Specialized Transportation so long as there is no duplicate billing for any unit of service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Duration: Respite stays may not exceed 28 consecutive days without prior approval by the Bureau.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community Based Residential Facility
Agency	Foster Home, Including Level 5 Exceptional Foster Home
Agency	Respite Agency
Agency	Residential Care Center (RCC)
Individual	Certified Adult Family Home
Agency	Group Child Care Center
Individual	Other person appropriately qualified as approved by the State and as related to the unique service being provided

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Community Based Residential Facility
Provider Qualifications
License *(specify):*
Wisconsin Statute 50, Wisconsin Admin Code 83
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Foster Home, Including Level 5 Exceptional Foster Home
Provider Qualifications
License *(specify):*
Wisconsin Statute 48, DCF 56 Wisconsin Admin Code
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Respite Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Training specific to meeting the person's support and care needs. The provider shall complete required training within six months of beginning employment unless training is needed before providing service is specified in the person's individualized service plan. Persons providing respite must meet the DHS training requirements for Supportive Home Care. This includes training on at least the following subjects pertaining to the person(s) served:
1. Policies, procedures, and expectations of the contract agency including training on person and provider rights and responsibilities; record keeping and reporting; and other information deemed necessary and appropriate.
2. Information about the person(s) to be served, including information specific to disabilities, abilities, needs, functional deficits, and strengths of the population to be served. This training should be person-specific for the people to be served and generally focused.
3. Recognizing and appropriately responding to all conditions that might adversely affect the person's health and safety including how to respond to emergencies and Critical Incidents as defined in CLTS Waiver Program Manual.
4. Developing interpersonal and communications skills and appropriate attitudes for working effectively within the population to be served. These skills include: understanding the principles of person-centered services; person rights; respect for age; cultural, linguistic and ethnic differences; active listening, responding with emotional support and empathy; ethics in dealings with people including: family and other providers; conflict resolution skills; ability to deal with death and dying; and other topics relevant to the specific population to be served.
5. Understanding of all confidentiality and privacy laws and rules.
6. Understanding of procedures for handling complaints.
7. Understanding of the person who needs support, including personal hygiene needs, preferences, and techniques for assisting with activities of daily living including, where relevant, bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.
8. Understanding of the specific homemaking and household services, meal planning and preparation, shopping, housekeeping techniques and proper maintenance of a clean, safe and healthy living environment.
9. Understanding the personal health and wellness-related needs of the person needing supports including nutrition, dietary needs, exercise needs, and weight monitoring and control. In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the CLTS Waiver Program Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:
Residential Care Center (RCC)
Provider Qualifications
License *(specify):*
§48.68 Wisconsin Statute, DCF 53.59 Wisconsin Admin Code
Certificate *(specify):*

Other Standard *(specify):*
RCC respite staff shall have respite care training designed around the unique needs related to the child's mental health needs and the psychiatric/behavioral treatment plan or individual medical care plan of the child.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Certified Adult Family Home
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Wisconsin Stature 50, 82 and 88 Wisconsin Administrative Code
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
Group Child Care Center
Provider Qualifications
License *(specify):*
Wisconsin Statute 48, DCF 251, Wisconsin Admin Code
Certificate *(specify):*
Wisconsin Statute 48, DCF 250, Wisconsin Admin Code
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Other person appropriately qualified as approved by the State and as related to the unique service being provided
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Training specific to meeting the person's support and care needs. The provider shall complete required training within six months of beginning employment unless training is needed before providing service is specified in the person's individualized service plan. Persons providing respite must meet the DHS training requirements for Supportive Home Care. This includes training on at least the following subjects pertaining to the person(s) served:
1. Policies, procedures, and expectations of the contract agency including training on person and provider rights and responsibilities; record keeping and reporting; and other information deemed necessary and appropriate.
2. Information about the person(s) to be served, including information specific to disabilities, abilities, needs, functional deficits, and strengths of the population to be served. This training should be person-specific for the people to be served and generally focused.
3. Recognizing and appropriately responding to all conditions that might adversely affect the person's health and safety including how to respond to emergencies and Critical Incidents as defined in CLTS Waiver Program Manual.
4. Developing interpersonal and communications skills and appropriate attitudes for working effectively within the population to be served. These skills include: understanding the principles of person-centered services; person rights; respect for age; cultural, linguistic and ethnic differences; active listening, responding with emotional support and empathy; ethics in dealings with people including: family and other providers; conflict resolution skills; ability to deal with death and dying; and other topics relevant to the specific population to be served.
5. Understanding of all confidentiality and privacy laws and rules.
6. Understanding of procedures for handling complaints.
7. Understanding of the person who needs support, including personal hygiene needs, preferences, and techniques for assisting with activities of daily living including, where relevant, bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.
8. Understanding of the specific homemaking and household services, meal planning and preparation, shopping, housekeeping techniques and proper maintenance of a clean, safe and healthy living environment.
9. Understanding the personal health and wellness-related needs of the person needing supports including nutrition, dietary needs, exercise needs, and weight monitoring and control. In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the CLTS Waiver Program Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Support and Service Coordination

HCBS Taxonomy:

Category 1:	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):*

The Department of Health Services is submitting a § 1915(b)(4) Waiver Fee for Service Selective Contracting Program Application in conjunction with the CLTS Waiver Program renewal application to the Centers for Medicare and Medicaid Services for review and approval. Restricting support and service coordination (i.e., case management) under the CLTS Waiver Program, a § 1915(c) HCBS Waiver Program, to county human/social/community services departments is a component of Wisconsin's infrastructure for effectively serving children and families. The counties' existing service infrastructure, knowledge of local resources, and continuity of one entity being able to coordinate all aspects of case management is a key provision of efficiently and effectively meet the needs and serve children and families. Each waiver agency must have a written description of how the agency will identify, resolve or mitigate conflicts of interest. If resolving or mitigating the conflict is not feasible, the waiver agency must take action to minimize the effect(s) of the conflict. These efforts must be reported to the appropriate state waiver contact and are subject to approval. This conflict of interest policy applies to the county waiver agency and to any other entity involved in any aspect of operating the waivers. A conflict of interest is present whenever a person or any other entity involved in operating any part of the waiver has an interest in or the potential to benefit from a particular decision, outcome or expenditure. A single individual, agency or entity occupying several roles often signals that conflict of interest may be present.

CLTS Waiver Program support and service coordination is the provision of services to locate, manage, coordinate and monitor all covered supports and services, other program services, regardless of their funding source, and informal community supports for eligible children and their families. The Support and Service Coordinator, who is employed by county human/social/community departments, must assure that CLTS waiver services are delivered in accordance with program requirements.

This service also includes assisting applicants and participants with establishing Medicaid financial, nonfinancial and functional eligibility, and all other aspects of an individual's CLTS Waiver Program eligibility. Support and service coordination also includes assisting the participant to access Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit (known as HealthCheck in Wisconsin), Medicaid State Plan services, as well as school-based special education services through the Department of Public Instruction and rehabilitation or college and career ready services through the Department of Workforce Development, Division of Rehabilitation. County waiver agency's Support and Services Coordinators also refer participants and their families and help facilitate access to county administered mental health, public health, and social services programs, as well as locating resources for natural supports. Support and Service Coordinators are also mandated reporters for child abuse and neglect, and as part of the county human/social/community service infrastructure, must issue referrals to county child protection and child welfare services, when warranted.

Beyond the participant's person-centered plan development and other monthly case management activities, the Support and Service Coordinator's role includes the primary responsibility of assuring the participant's health, safety and welfare. This service includes coordinating or facilitating access to all services and supports, both formal and informal, which are needed by the child and family to meet their identified outcomes. This includes locating, managing, coordinating and monitoring a full range of services and educational assessments, as well as informal supports, consistent with the child and family's assessed needs, in a planned, coordinated, and cost-effective manner. The Support and Service Coordinator assures that services are delivered in accordance with waiver program requirements, and the child's assessed needs and outcomes. This service also includes an assessment of the family's needs so they may adequately support their child in the home or other community setting. The Support and Service Coordinator facilitates establishing and maintaining the child and family's individualized support system. Services provided to children include assuring effective implementation of the child and family's support plan; developing, implementing, and updating the family-centered transition plan, and coordinating across systems, in order to meet the assessed needs.

When support and service coordination is not a delivered service, and/or when the participant's family chooses to coordinate services and supports, the county waiver agency must document how the service plan will be managed, including a description of how participant's health, safety and welfare will be assured.

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

Minimum Frequency of Contact Requirements

(1) Monthly collateral contact;
(2) Direct contact with the family every three months;
(3) Face-to-face contact with the waiver participant at least every six months;
(4) Annually, at least one of the face-to-face contacts shall be at the child and family's place of residence; and
(5) More frequent contact may be required in response to individual needs identified in assessments or prior critical incidents to assure health and safety.

This service excludes the optional targeted case management benefit under the Medicaid State Plan.

Support and Service Coordinators are prohibited from conducting assessments and authorizing waiver services that are delivered by individuals who are employed by the county department of social/human/community services, and have a potential conflict of interest, with the following exceptions:

(1) Child foster care services
(2) Reimbursements of goods and services that have been purchased by the waiver agency (e.g., iPad or other equipment ordered through online or other vendors, such as Amazon, etc.)

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730),

and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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
Individual	Other Person appropriately qualified as approved by the State and as related to the unique service being provided.
Individual	Social Worker

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support and Service Coordination

Provider Category:
Individual

Provider Type:
Other Person appropriately qualified as approved by the State and as related to the unique service being provided.

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
A Support and Service Coordinator (SSC) shall have the skills and knowledge typically acquired through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience with the target group, or through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons of the specific target group for which they are employed, or through a minimum of four years experience as a long-term support SSC, or through an equivalent combination of training and experience that equals four years of long-term support practice in long-term support case management practice, or the completion of a course of study leading to a human services degree and one year of employment working with persons of the specific target group for which they are employed.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is responsible for verifying provider qualifications and making appropriate screening decisions upon initial agreement, and terminating service authorizations if the provider is no longer qualified. Once a CWA has verified that the provider has self-registered on the

Wisconsin Medicaid Waiver Provider Registry and submitted the signed Medicaid Waiver Provider Agreement to the Department, the CWA is responsible to verify that the provider meets the qualifications for each applicable waiver service, as defined in the HCBS Waivers Manual. The CWA verifies the appropriate licensure/certification/registration status through a credential search of the DHS or other state departmental systems (e.g., DHS Wisconsin Nurse Aide Registry and Wisconsin Personal Care Worker Registry, Wisconsin Department of Professional Services, etc.). County waiver agencies terminate their agreements and authorizations for waiver providers based on updated status information, including updated substantiated findings of abuse or neglect, licensure status changes, criminal history information, termination of business or other factors.

Frequency of Verification:

Each responsible agency must ensure provider qualifications initially and at a minimum of every four years thereafter.

As part of the CLTS Waivers annual record review audit, the Department provides oversight of the CWA's functions by verifying the CWA completed all steps necessary to ensure only screened and qualified providers are authorized to deliver waiver services. The DHS reviews the participant's ISP and ensures the CWA met all requirements for each listed provider by verifying the CWA:

• Ensured the provider is listed on the Wisconsin Provider Registry and signed the Medicaid Waiver Provider Agreement
• Conducted a credential search for the provider
• Determined the credential (licensure/certification/registration) is appropriate for each authorized waiver service
• Verified the provider is appropriately trained and experienced for the authorized waiver service, as defined in the HCBS Waivers Manual
• Conducted a caregiver background check and reviewed the results to ensure the provider has no barring crimes, licensure suspensions/revocations, or substantiated findings of abuse or neglect

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Support and Service Coordination

Provider Category:

Individual

Provider Type:

Social Worker

Provider Qualifications

License *(specify):*

Chapter 457 Wisconsin State Statutes

Certificate *(specify):*

Chapter 457.09 Wisconsin State Statutes

Other Standard *(specify):*

A minimum of one year of employment working with persons of the specific target group for which they are employed.A Support and Service Coordinator (SSC) shall have the skills and knowledge typically acquired through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience with the target group, or through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons of the specific target group for which they are employed, or through a minimum of four years' experience as a long-term support SSC, or through an equivalent combination of training and experience that equals four years of long-term support practice in long-term support case management practice, or the completion of a course of study leading to a human services degree and one year of employment working with persons of the specific target group for which they are employed.

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for verifying the Support and Service Coordinator's qualifications , making appropriate hiring decisions, and agreement, and terminating employment and if the SSC is no longer qualified.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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

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 are the ongoing supports provided to a participant, who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive, customized or self-employment in an integrated work setting in the general workforce. A participant receiving this service shall be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Individual employment support services are individualized and may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, job supports, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. Also included are other workplace support services not specifically related to job skill training that enable the youth to be successful in integrating into the job setting.

Individual employment supports may include support to maintain self-employment, including home-based self-employment. Individual employment supports may also include services and supports that assist the participant in achieving self-employment; however, Assistance for self-employment may include:
- aid to the participant in identifying potential business opportunities;
- assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business;
- identification of the supports that are necessary in order for the participant to operate the business; and
- ongoing assistance, counseling and guidance once the business has been launched.

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

The cost of transportation for a participant 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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Supported employment services may not include personal care assistance or transportation assistance as components of this service for the same period of time.
Coverage does not include incentive payments, subsidies or unrelated vocational training expenses such as the following:
- Incentive payment made to an employer to encourage or subsidize the employer's participation in supported employment; or
- Wages or other payments that are passed through to users of supported employment services.
This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **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

Provider Category:
Individual
Provider Type:
On the job support person
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

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

All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment – Individual

Provider Category:
Agency
Provider Type:
Supported Employment Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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:

Home Health Aide

Alternate Service Title (if any):

Supportive Home Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08040 companion

Category 2:	Sub-Category 2:
08 Home-Based Services	08050 homemaker

Category 3:	Sub-Category 3:
08 Home-Based Services	08060 chore

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):*

Supportive home care (SHC) 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. This may also include preparation and cleaning of areas used during provision of personal assistance such as the bathroom and kitchen.

a. Direct assistance with instrumental activities of daily living, as well as observation or cueing of the member to safely and appropriately complete activities of daily living and instrumental activities of daily living.

b. Providing supervision necessary for member safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, arranging and using transportation and personal assistance at a job site and in non-employment related community activities.

c. 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 youth's continued community living. These may include: outdoor activities such as yard work and snow removal; indoor activities such as window washing; cleaning of attics and basements; cleaning of carpets, rugs and drapery; refrigerator/freezer defrosting; the necessary cleaning of vehicles, wheelchairs and other adaptive equipment and home modifications such as ramps. This also may include assistance with packing/unpacking and household cleaning/organizing when a youth moves.

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

This service may not duplicate any service that is provided under another waiver service category.
This service excludes personal care services for the CLTS waiver participant.

Excludes training for the participant intended to improve the child's ability to independently perform routine daily living tasks, which may be provided as daily living skills training services.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal Care Worker
Individual	Nurse Aide
Individual	Registered Nurse
Agency	Home Health Agency
Individual	Other Person appropriately qualified as approved by the State and as related to the unique service being provided.
Individual	Licensed Practical Nurse

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supportive Home Care

Provider Category:
Individual
Provider Type:
Personal Care Worker
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
DHS 105.17 (3)(a) Wis. Admin Code
Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supportive Home Care

Provider Category:

Individual

Provider Type:

Nurse Aide

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Chapter 50, Wis. Stats, Admin Code 129

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supportive Home Care

Provider Category:
Individual
Provider Type:
Registered Nurse
Provider Qualifications
License *(specify):*
Chapter 441.06 Wis. Stats
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supportive Home Care

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 50.49 Wis. Stat; 42 CFR 484, Admin Rule DHS 131 and DHS 12 including Appendix A
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supportive Home Care

Provider Category:
Individual
Provider Type:
Other Person appropriately qualified as approved by the State and as related to the unique service being provided.
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Training begins prior to and during the first six months of employment. Training on critical procedures related to the participant's health and safety must be completed prior to the delivery of any services. Families also provide oversight and are responsible for monitoring the quality of care for their child The county waiver agency shall ensure that persons providing Supportive Home Care services receive training on at least the following subjects pertaining to the person(s) served:

1. Policies, procedures, and expectations of the county waiver agency and/or contract agency including training on person and provider rights and responsibilities; record keeping and reporting; and other information deemed necessary and appropriate.
2. Information about the person(s) to be served, including information specific to disabilities, abilities, needs, functional deficits, and strengths of the person. This training should be person-specific for the people to be served.
3. Information about recognizing and appropriately responding to all conditions that might adversely affect the person's health and safety, including how to respond to emergencies and Critical Incidents as defined in CLTS Waiver Program Manual.
4. Developing needed interpersonal and communications skills and appropriate attitudes for working effectively within the population to be served. These skills include: understanding the principles of family-centered services; participant rights; respect for age; cultural, linguistic and ethnic differences; active listening, responding with emotional support and empathy; ethics in dealings with people, including: family and other providers; conflict resolution skills; ability to deal with death and dying; and other topics relevant to the specific population to be served.
5. Information regarding confidentiality and privacy laws and rules.
6. Information related to procedures for handling complaints.

7. Information specifically regarding the person who needs support, including personal hygiene needs, preferences, and techniques for assisting with activities of daily living including, where relevant, bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.
8. Information related to homemaking and household services, meal planning and preparation, shopping, housekeeping techniques and proper maintenance of a clean, safe and healthy living environment.
9. Information on the personal health and wellness-related needs of the person needing supports, including nutrition, dietary needs, exercise needs, and weight monitoring and control.

In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the CLTS Waiver Program Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supportive Home Care

Provider Category:

Individual

Provider Type:

Licensed Practical Nurse

Provider Qualifications

License *(specify)*:

Chapter 441.10 Wisconsin Statutes

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is responsible for verifying provider qualifications and making appropriate screening decisions upon initial agreement, and terminating service authorizations if the provider is no longer qualified. Once a CWA has verified that the provider has self-registered on the Wisconsin Medicaid Waiver Provider Registry and submitted the signed Medicaid Waiver Provider Agreement to the Department, the CWA is responsible to verify that the provider meets the qualifications for each applicable waiver service, as defined in the HCBS Waivers Manual. The CWA verifies the appropriate licensure/certification/registration status through a credential search of

the DHS or other state departmental systems (e.g., DHS Wisconsin Nurse Aide Registry and Wisconsin Personal Care Worker Registry, Wisconsin Department of Professional Services, etc.). County waiver agencies terminate their agreements and authorizations for waiver providers based on updated status information, including updated substantiated findings of abuse or neglect, licensure status changes, criminal history information, termination of business or other factors.

Frequency of Verification:

Each responsible agency must ensure provider qualifications initially and at a minimum of every four years thereafter.

As part of the CLTS Waivers annual record review audit, the Department provides oversight of the CWA's functions by verifying the CWA completed all steps necessary to ensure only screened and qualified providers are authorized to deliver waiver services. The DHS reviews the participant's ISP and ensures the CWA met all requirements for each listed provider by verifying the CWA:

• Ensured the provider is listed on the Wisconsin Provider Registry and signed the Medicaid Waiver Provider Agreement
• Conducted a credential search for the provider
• Determined the credential (licensure/certification/registration) is appropriate for each authorized waiver service
• Verified the provider is appropriately trained and experienced for the authorized waiver service, as defined in the HCBS Waivers Manual
• Conducted a caregiver background check and reviewed the results to ensure the provider has no barring crimes, licensure suspensions/revocations, or substantiated findings of abuse or neglect

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 sel

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 are those services that assist participants and their families to manage waiver service funding. This service involves a person or agency paying service providers after the county waiver agency and/or the participant's, parent/guardian has authorized payment for delivered services included in the participant's approved Individualized Service Plan (ISP). Financial Management Service providers, sometimes referred to as fiscal intermediaries, are organizations or individuals that issue payments for personnel costs, tax withholding, unemployment insurance, worker's compensation, health insurance and other taxes and benefits appropriate for the specific provider consistent with the individuals ISP. The financial management service provider or fiscal intermediary serves upon the authorization of the county waiver agency and is made available to the participant/family to ensure appropriate compensation is issued to providers of services. The Financial Management Services provider is accountable for insuring compliance with all federal and state laws associated with tax withholding and all other employee benefits.

This service also includes paying bills authorized by the participant or their guardian, keeping an account of disbursements and assisting the participant to ensure sufficient funds are available for his or her needs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes payments to court-appointed guardians or court-appointed protective payees if the court has directed them to perform any of these functions.
Excludes payment for the cost of room and board.
This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Accountant
Agency	Fiscal Intermediary Agency

Provider Category	Provider Type Title
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Accountant
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Chapter 442 Wisconsin Statutes
Other Standard *(specify):*
Providers must be an agency, unit of an agency or individual that is qualified to provide all of the financial services involved. Providers must have training and experience in accounting or bookkeeping.
The Financial Management Services provider must be bonded
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Fiscal Intermediary Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers must be an agency, unit of an agency or individual that is qualified to provide all of the financial services involved. Providers must have training and experience in accounting or bookkeeping.
The Financial Management Services provider must be bonded.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Other persons appropriately qualified as approved by the State and as related to the unique service being provided

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers must be an agency, unit of an agency or individual that is qualified to provide all of the financial services involved. Providers must have training and experience in accounting or bookkeeping.
The Financial Management Services provider must be bonded.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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 include controls or appliances which enable people to increase their ability to perform Activities of Daily Living or control the environment in which they live. Adaptive aids also services and material benefits which enable children to access, participate and function in the community. These include the purchase of vehicle modifications (such as van lifts, hand controls for youth learning to drive, equipment modifications, etc.) that allow the vehicle to be used by the participant to access the community, or those costs associated with the maintenance of repair of these items. Examples of Adaptive Aids include:

- Hygiene/meal preparation aids
- Environmental control units

- Accessible computer keyboard
- Adaptive security systems
- Adaptive door handles and locks
- Adult tricycle
- Computer and necessary software
- Control switches
- Control switches, pneumatic devices, including sip and puff controls
- Electronic control panels
- Over the bed tables
- Portable ramps
- Standing board/frames
- Scald preventing showerhead
- Specialized clothing
- Talking alarm clocks
- Van/vehicle lift/transfer unit (manual, hydraulic or electronic)
- Vehicle hand controls

Clothing that is specialized relates to clothing or footwear that is customized to accommodate unique physical or care needs of a child. Funds may be utilized to supplement the cost of specialized clothing that is related to the child's disability and unique needs. Examples: Specialized mitts for children who use a manual wheelchair, a down sleeping bag for warmth during transportation in winter, fashionable or custom covers for helmets that are worn for cranial protection, clothing needing more frequent replacement for a child whose primary method of mobility is scooting, children who cannot manage oral secretions and require protective clothing or more frequent clothing changes.

As per the Americans with Disabilities Act, service animals are dogs (and in some cases, miniature horses) trained to perform major life tasks to assist people with physical disabilities. For a person to legally qualify to have a service dog, he/she must have a disability that substantially limits his/her ability to perform at least one major life task without assistance.
This service may also include the initial purchase of a service animal and routine veterinary costs for a service animal. Wisconsin Statute § 106.52 (1) (fm) states: "Service animal" means a guide dog, signal dog, or other animal that is individually trained or is being trained to do work or perform tasks for the benefit of a person with a disability, including the work or task of guiding a person with impaired vision, alerting a person with impaired hearing to intruders or sound, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items.
To qualify as a service dog, the dog must be individually trained to perform that major life task. All breeds and sizes of dogs can be trained as service animals. The federal American Disabilities Act (ADA) does NOT require certification or registration of service animals.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes food, grooming, and non-routine veterinary care for service animals based on DHS guidelines.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Other providers appropriately qualified
Individual	Durable Medical Equipment Provider
Agency	Pharmacy

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:
Other providers appropriately qualified
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Providers of systems or devices such as adaptive aids shall ensure that all items meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:

Individual

Provider Type:
Durable Medical Equipment Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers appropriately qualified to distribute Durable Medical Equipment.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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:
Pharmacy
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of systems or devices such as adaptive aids shall ensure that all items meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State,

centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Adult Family Home

HCBS Taxonomy:

Category 1:	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 home is a residence where one to four persons live and in which care, treatment or service above the level of room and board is provided as a primary function of the facility. The residence is the primary domicile of the Adult Family Home operator(s). Only the costs directly associated with participant care, support and supervision in the adult family home may be billed under this service. No costs associated with room and board of the residents may be billed to the CLTS Waiver Program.

Adult family home also includes “community care home” until statutory authority is established for community care homes. “Community care home” is a residence where one to four adult residents live and also where the resident(s) receives care, treatment, support or service above the level of room and board. In the community care home the operator owns, rents, or leases the residence and employs staff who provide care and service. The community care home is not the primary domicile of the provider.

One and two bed adult family homes shall be certified pursuant to the standards established by the Department of Health Services, which includes requirements regarding the age of individuals permitted to reside at the home.

Three or four person adult family homes must be licensed by the Department of Health Services, Division of Quality Assurance or another approved licensing agency. DHS 88, Licensed Adult Family Homes contains the regulations and standards governing this service, including requirements regarding the age of individuals permitted to reside at the home.

Specific target group requirements:

1. There must be documentation of the specific exceptional needs of the person and the individual psychiatric/behavioral care plan or individual medical care plan that the adult family home provider will implement.
2. There must be documentation of the specific training the adult family home provider received related to the individual’s needs and the psychiatric/behavioral treatment plan or individual medical care plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
For AFH services, transportation services may be included under this service or separately billed under the service Transportation so long as there is no duplicate billing for any unit of service.

Excludes environmental modifications to the home, adaptive equipment or communication aids under this service. Any needed environmental modification, adaptive equipment or communication aid may be covered by the waiver but must be claimed under the services “Home Modifications,” “Communication Aids" or “Adaptive Equipment” respectively.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin’s economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Family Home

Provider Category	Provider Type Title
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Home

Provider Category:
Agency
Provider Type:
Adult Family Home
Provider Qualifications
License *(specify):*
DHS 88 or DHS 82
Certificate *(specify):*

Other Standard *(specify):*
The Department of Health Services, Division of Quality Assurance or another approved licensing agency must license adult family homes for three or four persons. Wisconsin Administrative Code DHS 88, contains the regulations and standards governing this waiver service.
All one to two bed adult family homes shall be certified pursuant to standards established by the Department. Wisconsin Administrative Code DHS 82, contains the regulations and standards governing this waiver service. Adult Family Home standards are also described in the publication: Medicaid Waiver Standards for Adult Family Homes.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adult Family Home

Provider Category:
Individual
Provider Type:
Other persons appropriately qualified as approved by the State and as related to the unique service being provided.

Provider Qualifications

License *(specify):*
DHS 88 or DHS 82
Certificate *(specify):*

Other Standard *(specify):*
The Department of Health Services, Division of Quality Assurance or another approved licensing agency must license adult family homes for three or four persons. Wisconsin Administrative Code DHS 88, contains the regulations and standards governing this waiver service.
All one to two bed adult family homes shall be certified pursuant to standards established by the Department. Wisconsin Administrative Code DHS 82, contains the regulations and standards governing this waiver service. Adult Family Home standards are also described in the publication: Medicaid Waiver Standards for Adult Family Homes.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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:
Child Care Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation

Category 2:	Sub-Category 2:
04 Day Services	04070 community integration

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

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

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

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

Service Definition *(Scope):*
Child Care services for children includes the provision of supplementary staffing necessary to meet the child's exceptional care needs above and beyond the cost of basic child care that all families with children may incur.

This service may include supplementary supports and supervision services to address exceptional emotional or behavioral needs, or physical or personal care needs.

Child Care services may include, but are not limited to after school programs, licensed, certified family day care, group day care, day camps, and family chosen providers.

Funding may be used for child care costs when an older child has aged out of traditional child care settings, but continues to require care or supervision when the family is working. Examples include school and community-based settings that children of that age typically participate in (e.g., after school programs, 4-H clubs, family residence etc.). The entire cost of child care for children age 12 years and over may be covered.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes any service that falls under the definition of daily living skills training, supportive home care, vocational futures planning, mentoring or respite care.

This service excludes the basic cost of day care unrelated to a child's disability that may be needed by parents or regular caregivers to allow them to work, or participate in educational or vocational training programs. The "basic cost of day care" means the rate charged by and paid to a child care center for children who do not have special needs. The basic cost of child care does not include the provision of supplementary staffing this cost may be covered by this service.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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	Family Child Care Center
Agency	Group Child Care Center
Individual	Certified Child Care Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Care Services

Provider Category:
Agency
Provider Type:
Family Child Care Center
Provider Qualifications
License *(specify):*
DCF 20
Certificate *(specify):*

Other Standard *(specify):*
Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Care Services

Provider Category:
Agency
Provider Type:
Group Child Care Center
Provider Qualifications
License *(specify):*
DCF 251
Certificate *(specify):*

Other Standard *(specify):*
Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.
Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Child Care Services

Provider Category:
Individual
Provider Type:
Certified Child Care Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DCF 202
Other Standard *(specify):*
Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the

providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Children's Foster Care

HCBS Taxonomy:

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

Category 2:	Sub-Category 2:

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

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

Service Definition *(Scope):*
A Foster Home is a family-oriented residence operated by a person licensed under s.48.62 of the Wisconsin Statutes and DCF 56 of the Wisconsin Administrative Code as a Foster Home, or a residence licensed as a Level 5 Exceptional Foster Home. Level of care" means the intensity of services that is best able to meet the needs of a child who has been assessed with a corresponding level of need. "Level of need" means a rating of a child that is used to inform decision making on placement and service provision. The level of need is derived from an algorithm that is based on an assessment of a child's functioning. Level 5 Exceptional Foster Homes provide care and maintenance for no more than four foster children, with exceptions for more children if all the foster children are siblings. Services provided by these homes are for children who need support in one or more aspects of their lives including health care, personal care, supervision, behavior and social supports, daily living skills training, and transportation.

This service includes supplementary intensive supports and supervision services beyond the maintenance payment made to foster parents and is to address exceptional emotional or behavioral needs, or physical or personal care needs.

Transportation services may be included under this service or billed separately under the service Transportation so long as there is no duplicate billing for any unit of service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service excludes the cost of room and board provided by the foster home provider.

This service excludes environmental modifications to the foster home, adaptive equipment or communication aids. Any needed environmental modification, adaptive equipment or communication aid may be covered by the CLTS Waiver but must be claimed under the services "Home Modifications "Communication Aids or "Adaptive Equipment" respectively.

An individual who resides in a foster home generally does not also receive Supportive Home Care, as it is expected that the foster home provider services will meet all of the participants needs

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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 Family Foster Provider
Agency	Level 5 Exceptional Foster Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Children's Foster Care

Provider Category:
Individual

Provider Type:
Individual Family Foster Provider

Provider Qualifications

License *(specify):*
§48.62, Wisconsin Statutes, and DCF 56 of the Administrative Code.

Certificate *(specify):*

Other Standard *(specify):*
All foster care providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure the child's health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs, then the foster care provider must have training specific to the child's needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Children's Foster Care

Provider Category:
Agency

Provider Type:
Level 5 Exceptional Foster Home

Provider Qualifications

License *(specify):*
§48.62, Wisconsin Statutes, and DHS 56 of the Administrative Code.

Certificate *(specify):*

Other Standard *(specify):*
All foster home providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular home and to ensure the child's health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs, then the foster home provider must have training specific to the child's needs and specific psychiatric/behavioral treatment plan. If these unique needs are generally related to physical, medical and personal care the provider is responsible for implementing specific activities or treatments as outlined in a medical plan of care.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Communication Aids/Assistive Tehcnology/Interpreter Services

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):*
Communication aids/assistive technology aids means an item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain or improve functional capabilities of children at home, work and in the community. Assistive technology service means a service that directly assists a child/youth in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:
a. the evaluation of the assistive technology needs of a child, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the child in the customary environment of the child;
b. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for children;
c. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;
d. coordination and use of necessary therapies, interventions or services with assistive technology devices, such as therapies, intervention or services, associated with other services in the service plan;
e. training or technical assistance for the child/youth, or where appropriate, the family members, guardians, advocates or authorized representatives of the child; 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 children.

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

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

Interpreter services are provided to people with hearing impairments and who require sign language translation to effectively communicate with people in the community, employees or others. Interpreters provide sign language services for participants with hearing impairments.

Electronic devices must meet UL or FCC standards.
Individual interpreters must be on the state or national interpreter registry.
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.

CLTS Waiver funds may only be used for interpreter services when it is not the responsibility of the provider or another party to provide this service.

Excludes interpreter services that are otherwise available, including for communication with the county waiver agency, its contractors or other health care professionals, which are required to provide interpreter services under Wisconsin's Constitution civil right compliance requirements, as part of their rate.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Communication aids vendors
Individual	Individual Interpreters

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication Aids/Assistive Tehcnology/Interpreter Services

Provider Category:
Agency

Provider Type:
Communication aids vendors

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Communication aids vendors must be Medicaid certified providers.

Providers of systems or devices such as adaptive aids shall ensure that all items meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory and Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State,

centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication Aids/Assistive Tehcnology/Interpreter Services

Provider Category:
Individual
Provider Type:
Individual Interpreters
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Individual interpreters must be on the state or national interpreter registry.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Other Service

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

Service Title:

Community Integration Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation

Category 2:	Sub-Category 2:
04 Day Services	04070 community integration

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

Service Definition *(Scope):*

Community Integration Services include services and supports that are identified by the child/parent and the multidisciplinary team as necessary to support a child and family within a community setting based on their strengths and needs. Community Integration services programs benefits families with children who have mental health and/or behavioral concerns by providing intensive case coordination and individualized community-based services. Community Integration Services are services designed to provide a bundled array of services that extends beyond the traditional financial and geographic boundaries to develop a creative and flexible continuum of care. Typical services include; daily living skills, mentoring, parent education and training, community integration activities and behavior interventions, development and nurturing of natural supports, transportation and respite services. The outcome of this program is to assist, empower and build upon the strengths of the child and family or order that the child can be fully integrated into the community with their family.

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

1. The minimum service requirements are that providers shall attend quarterly team reviews or sooner (or more frequent if requested) if requested by the SSC that would include the child parent or responsible person and child (if deemed appropriate) relevant service provider agency staff/supervisor (when applicable), the overseeing SSC and that person's supervisor.
2. Community Integration providers shall complete a written report every six months or sooner if the child's condition changes or warrants and updated progress towards and identified outcome that details the participant's past and current level of functioning, as well as the intended outcome and obstacles that stand in the way of those outcomes. This report shall be provided to the county waiver agency SSC.
3. Excludes experimental or adverse treatments as defined by the Medicaid State Plan
4. Excludes residential services as part of the community integration program see relevant residential service definitions foster care or adult family care or institutional respite.
5. If providers are transporting a child, the county waiver agency must have written documentation on file that the provider has a current valid driver's license, current liability insurance coverage and the vehicle is mechanically sound as defined under the Transportation services standards. The cost of transportation may be

included in the rate paid to the provider of this service, or may be covered and reimbursed under transportation service, but not both. All providers shall ensure that all standards described in the Transportation service are met.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Social Worker
Agency	Daily Living Skills Training
Individual	Individual Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:
Agency
Provider Type:
Social Worker
Provider Qualifications
License *(specify)*:
Chapter 457 Wisconsin Statute
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:

Agency

Provider Type:

Daily Living Skills Training

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Providers of daily living skills training must have a minimum of two years experience working with the target population. However, the county waiver agency may employ qualified providers who are less experienced if the waiver agency ensures the provider receives comprehensive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the care plan.

In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the HCBS Waivers Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:
Individual
Provider Type:
Individual Provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of daily living skills training must have a minimum of two years experience working with the target population. However, the county waiver agency may employ qualified providers who are less experienced if the waiver agency ensures the provider receives comprehensive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the care plan.

In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the HCBS Waivers Manual.

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:

Counseling and Therapeutic Services

HCBS Taxonomy:

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

Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11020 health assessment

Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11130 other therapies

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 includes the provision of professional evaluation and consultation services to participants identified needs for physical, personal, social, cognitive, developmental, emotional, or substance abuse services. The goal of counseling and therapeutic services is to maintain or improve participant health, welfare or functioning in the community. The therapy service may be provided in a natural setting or in a service provider's office. Includes therapies provided by state licensed or certified medical professionals which are not available under the Medicaid State Plan. Providers of counseling and therapeutic services shall deliver services limited to their areas of formal education and training, as directed by their professional code of ethics.

Any counseling or therapeutic service funded by the CLTS Waiver Program must address an individual's assessed need and be directly related to a therapeutic goal.

Services may include assistance with interpersonal relationships, music therapy, art therapy, hippotherapy, equine assisted therapy, and day/summer camp. Counseling and therapeutic services must meet clearly defined outcome, be proven effective for the child's condition or outcome and be cost effective.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Counseling and therapeutic supports and services may not be experimental or aversive in nature nor may they otherwise jeopardize the health and safety of the participant.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources, or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided
Individual	Art Therapist
Individual	Music Therapist
Agency	Home Health Agency
Individual	Hippotherapist
Individual	Equine-Assisted Therapist
Agency	Other providers appropriately qualified

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Other persons appropriately qualified as approved by the State and as related to the unique service being provided

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State,

centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Art Therapist
Provider Qualifications
License *(specify):*
Chapter 440 Wisconsin Statutes
Certificate *(specify):*

Other Standard *(specify):*
Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Counseling and Therapeutic Services

Provider Category:
Individual
Provider Type:
Music Therapist
Provider Qualifications
License *(specify):*
Chapter 440 Wisconsin Statutes
Certificate *(specify):*

Other Standard *(specify):*
Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Home Health Agency
Provider Qualifications
License *(specify):*
Chapter 50.49 Wisconsin. Statutes
42 CFR 484 Code of Regulations
Administrative Rules DHS 131 and DHS 12 including Appendix A
Certificate *(specify):*

Other Standard *(specify):*

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification, must be authorized by a medical professional.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Hippotherapist

Provider Qualifications

License *(specify)*:
Chapter 440 Wisconsin Statute

Certificate *(specify)*:

Other Standard *(specify)*:
Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Equine-Assisted Therapist
Provider Qualifications
License *(specify):*
Chapter 440 Wisconsin Statute
Certificate *(specify):*

Other Standard *(specify):*
Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Other providers appropriately qualified
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.
Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.
Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Daily Living Skills Training

HCBS Taxonomy:

Category 1:	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 services provide education and skill development or training to improve an individual's ability to independently perform routine daily activities and effectively utilize community resources. Services are instructional, focused on skill development and are not intended to provide substitute task performance. This service includes funding for educational or training services that are of a direct benefit to the child. Daily living skills training may involve training the member or the natural support person to assist the child.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
This service excludes activities that are primarily recreational in nature or that are treatment oriented, including social skill training.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Providers of Daily Living Skills training
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Providers of Daily Living Skills training
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of daily living skills training must have a minimum of two years' experience working with the target population. However, the waiver agency may employ qualified providers who are less experienced if the waiver agency ensures the provider receives comprehensive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the care plan.

In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the CLTS Waiver Program Waivers Manual.

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Other persons appropriately qualified as approved by the State and as related to the unique service being provided
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of daily living skills training must have a minimum of two years' experience working with the target population.

However, providers who are less experienced that have received comprehensive participant-specific training to enable them to competently work with the participant and meet the objectives outlined in the care plan can meet the daily living skills training qualifications.

Providers shall ensure Daily Living Skills Training staff are knowledgeable in the adaptation and use of specialized equipment and in the modification of participant environments and that these staff complete regular training/continuing education coursework to maintain/update their level of expertise.

In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the CLTS Waiver Program Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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 Modification

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 include services designed to assess the need for, arrange for and provide modifications and/or improvements to a child's residence that address a need identified to improve health, safety, accessibility or provide for the maximization of independent functioning. Home modifications are generally permanent fixtures/changes to a physical structure. Home modifications include the cost of the permit to authorize the changes, the materials, and services needed to complete the installation of specific equipment, the modification of the physical structure or the reconfiguration of essential systems within the home. Home modifications are considered a one-time expense. Only the most economical approach to achieve the outcome is considered.
Home modifications may include adaptations, including, but not limited to:
- Ramps (fixed), ramp extensions and platforms
- Porch/stair lifts
- Doors/doorways, door handles/door opening devices
- Adaptive door bells, locks/security items or devices
- Plumbing, electrical modifications related to adaptations
- Medically necessary heating, cooling or ventilation systems
- Shower, sink, tub and toilet modifications
- Faucets/water controls
- Accessible cabinetry, counter tops or work surfaces
- Grab bars (see exception below), handrails, accessible closets
- Smoke/fire alarms and fire safety adaptations
- Adaptive lighting/light switches
- Flooring and/or floor covering to address health and safety
- Wall protection

Modifications not specifically described above may be approved if the item or service meets the definition and the standards for allowable home modifications. Home modifications must demonstrate how the modification addresses disability related long term care needs that increase self-reliance and independence, or to ensure safe, accessible means of ingress/egress to a participant's living quarters, or to otherwise provide safe access to rooms, facilities or equipment within the participant's living quarters, or adjacent buildings that are part of the residence.

A qualified assessor, independent of all contractors, must complete an accessibility assessment. Three viable provider estimates must be obtained and submitted with each request for a home modification. Quotations from at least three providers must be obtained and submitted with the request for the home modification for modifications with costs exceeding an amount set annually by the Department. In all cases, the provider with the most reasonable costs and the assurance of the appropriate level of quality will be selected.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- Home modifications are generally not available in rental units or licensed settings as the CLTS Waiver Program is not responsible for modifying a rental unit or corporate settings for which the cost of these items would be included in the cost of doing business. Items considered portable (portable ramp) are defined as adaptive aids.
- Modifications which increase the square footage or that enhance the general livability and value of a privately

owned residence are excluded.
- Modifications not recommended in the accessibility assessment are excluded.
- Modifications that are not the most cost effective approach to meeting the participant's long term care related outcomes are excluded.
- Home modifications made prior to a person leaving an institutional setting cannot be paid for until the person leaves the institution and is enrolled in the CLTS Waiver Program with a plan start date.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Other persons appropriately qualified as approved by the State and as related to the unique service being provided.
Individual	Plumber
Individual	Electrician
Agency	Independent Living Center
Agency	Contractor
Individual	Heating & Air Conditioning
Agency	Building Supply Company
Individual	Engineer

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Individual
Provider Type:
Other persons appropriately qualified as approved by the State and as related to the unique service being provided.
Provider Qualifications
License *(specify)*:

Certificate *(specify):*

Other Standard *(specify):*
The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Individual

Provider Type:
Plumber

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Chapter 443 Wisconsin Statute

Other Standard *(specify):*
The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Individual
Provider Type:
Electrician
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Chapter 443 Wisconsin Statute
Other Standard *(specify)*:
The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Agency
Provider Type:
Independent Living Center
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Agency
Provider Type:
Contractor
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Individual

Provider Type:
Heating & Air Conditioning

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
Chapter 443 Wisconsin Statute

Other Standard *(specify)*:
The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State,

centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Agency
Provider Type:
Building Supply Company
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Individual
Provider Type:
Engineer
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Chapter 433 Wisconsin Statute
Other Standard *(specify):*
The providers and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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 is the provision of services to waiver participants to provide comprehensive guidance on housing opportunities available to meet their needs and preferences. This service includes guidance on how a participant may gain access to available public and private resources to assist the person to obtain or retain safe, decent, accessible, and affordable housing and avoid institutionalization. Housing counseling services must be provided by an agency or person whose services are also available to the general public. Housing Counseling includes planning, guidance and assistance in accessing resources related to home ownership, financing, accessibility and architectural services and consultation, as well as health and safety evaluations of physical property.

The provider delivers consultation by meeting with the participant and their family and collecting individual specific information. This information is used to provide guidance and assistance which is appropriate to the individual situation.

The depth of knowledge required to provide this service will typically include an expertise in a housing-related field and is often found in providers who have background and expertise in housing and disabilities.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- Excludes reimbursement if this service is delivered by an agency that also provides residential support services or support/service coordination to the waiver participant.
- CLTS Waiver Program funding reimbursement is prohibited if it duplicates the service provided in targeted case management.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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	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):*
A qualified provider must be an agency or unit of an agency that provides Housing Counseling as a regular part of its mission.
Counseling must be provided by staff with specialized training and experience in any of the following housing issues; home ownership, both pre and post purchase, home financing and refinancing, home maintenance, repair and improvements including abating environmental hazards, rental counseling, not including any cash assistance, accessibility and architectural services and consultation, weatherization evaluation and assistance in accessing these services, lead-based paint abatement evaluation, low-income energy assistance evaluation, access to transitional or permanent housing, accessibility inventory design, health and safety evaluations of physical property, debt/credit counseling, and homelessness and eviction prevention counseling.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Mentoring

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04020 day habilitation

Category 2:	Sub-Category 2:
04 Day Services	04070 community integration

Category 3:	Sub-Category 3:

Category 4:	Sub-Category 4:

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

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

Service Definition *(Scope):*

Mentoring services are adult-supervised supports that are intended to improve the CLTS waiver participant's ability to interact in their community in socially appropriate ways. The mentor provides the participant with such services as peer interaction, social/recreational and employability skill-building opportunities. The mentor supports the participant by practicing, modeling, guiding and shadowing them in the community. Interventions are spontaneous and in real-life situations, rather than in a classroom-type environment. Covered expenses may include meals, admission fees, and transportation for the mentor related to participation in community events that address the objectives and meet the identified outcomes of the child's service plan.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Mentors
Agency	any agency appropriately qualified as approved by the State and as related to the unique service being provided

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Mentoring

Provider Category:
Individual

Provider Type:
Mentors

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Providers of mentoring services must be 18 years or older. The waiver agency must ensure that the provider receives child specific training provided by the agency, SSC and parent/guardian, and there must be documentation of this training in the child's record.
Individual mentors must receive child specific training provided by the case manager, service coordinator, parent, guardian, and/or other relevant professional who is knowledgeable of the participant's daily needs. Providers shall be involved in frequent and ongoing communication with the case manager/support and service coordinator, agency, and family, regarding child specific updates, information, and concerns.

In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the CLTS Waiver Program Manual.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Mentoring

Provider Category:
Agency
Provider Type:
any agency appropriately qualified as approved by the State and as related to the unique service being provided
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of mentoring services must be 18 years or older. The waiver agency must ensure that the provider receives child specific training provided by the agency, SSC and parent/guardian, and there must be documentation of this training in the child's record. Providers shall be involved in frequent and ongoing communication with the SSC, agency, and family, regarding child specific updates, information, and concerns.

In addition to the other listed qualifications and training, the provider must meet qualifications and training as described in the CLTS Waiver Program Manual.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response System (PERS)

HCBS Taxonomy:

Category 1:	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) provides a direct telephonic, global positioning system (GPS) 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. Electronic devices must meet Underwriters Laboratories® (UL) Standards. Telephonic devices must meet Federal Communications Commission (FCC) regulations.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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	Community Based Electronic Communications Unit
Individual	Telephone service including cellular

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Community Based Electronic Communications Unit

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Underwriter's Laboratory and/or Federal Communication Commission or equivelent standard.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Telephone service including cellular
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Underwriter's Laboratory and/or Federal Communication Commission or equivelent standard.
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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 children who are relocating from an institution, foster home or who are moving out of the family home to a less restrictive setting. This service includes person-specific services, supports or goods that will be put in place in preparation for the child/youth relocation to a safe, accessible and affordable community living arrangement. Relocation services may include the purchase of necessary furniture, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings and kitchen appliances not otherwise included in a rental arrangement if applicable.

Relocation services may include the payment of a security deposit, utility connection costs and telephone installation charges. This service includes payment for moving the child/youth personal belongings to the new community living arrangement and general cleaning and household organization services needed to prepare the selected community living arrangement for occupancy.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- Services or items covered by this service may not be purchased more than 180 days prior to the date the child/youth relocates to the community living arrangement.
- Exclude home modifications necessary to address safety and accessibility in the person's living arrangement, which may be provided as the waiver service home modifications.
- Excludes housekeeping services provided after occupancy which are considered the waiver service supportive home care.
- Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.).
- This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **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 contractor with Compliance history. Compliance history with Wisconsin or any other state's licensing requirements or federal certification requirements, including any license revocation or denial.
Fraud or substantial or repeated violations of applicable laws and rules in the operation of any business.
Financial history. Financial stability, including:
- Financial history and financial viability of the owner or related organization.
- Outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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):*
Provider with reputable compliance history. Compliance history with Wisconsin or any other state's licensing requirements or federal certification requirements, including any license revocation or denial.
Fraud or substantial or repeated violations of applicable laws and rules in the operation of any business.
Financial history. Financial stability, including:
- Financial history and financial viability of the owner or related organization.
- Outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines.

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:
Specialized Medical and Therapeutic Supplies

HCBS Taxonomy:

Category 1:	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 and therapeutic supplies include items necessary to maintain the child's health, manage a medical or physical condition, improve functioning or enhance independence. The cost of items, or devices provided, may be in excess of the quantity of medical equipment or supplies covered under the Medicaid state plan, when coverage of the additional items or devices is denied. Items or devices provided must demonstrate direct medical or remedial benefit to the participant. Allowable items, devices or supplies include:
- Nutritional supplements
- Vitamins
- Over-the-counter medications
- Skin conditioning lotions/lubricants.

Additional allowable items may include books and other therapy aids designed to augment a professional therapy or treatment plan. Room air conditioners, air purifiers, humidifiers and water treatment systems may be allowable when recommended or prescribed by the participant's physician.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Medical Supply Company
Individual	Other providers appropriately qualified as approved by the State and as related to the unique service being provided.
Individual	Authorized Dealers

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Medical Supply Company
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DHS 105 Wisconsin Administrative Code
Other Standard *(specify):*
Underwriter's Laboratory and/or Federal Communication Commission.

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:
Other providers appropriately qualified as approved by the State and as related to the unique service being provided.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Underwriter's Laboratory and/or Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Authorized Dealers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Underwriter's Laboratory and/or Federal Communication Commission.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State,

centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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

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 services are services and training activities provided in a regular business, industry or community setting for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small group employment support must be provided in a manner that promotes integration into the workplace and integration between members and people without disabilities in

those workplaces. The outcome of this service is sustained paid employment and work experiences leading to further career development and individual integrated community-based employment for which a member is compensated at or above the minimum wage, but not less than the customary wage level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group employment support services may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. Also included are other workplace support services not specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Small group employment support services may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker or other personnel and these individuals meet the qualifications established below for individual providers of service. Employers may be reimbursed for supported employment services provided by co-workers. Participants receiving small group employment support may also receive educational, pre-vocational, and/or day services and career planning services. However, different types of non-residential services may not be billed for the same period of time.

The cost of transportation for a participant to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider, or may be covered and reimbursed under specialized (community) transportation, but not both.

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

- Supported employment services may not include personal care assistance or transportation assistance as components of this service for the same period of time.
- Small group employment support does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business.
- This service may not duplicate any service that is provided under another waiver service category.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	On the job support person

Provider Category	Provider Type Title
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

Provider Category:
Individual
Provider Type:
On the job support person
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

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

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Supported Employment - Small Group

Provider Category:
Agency
Provider Type:
Supported Employment Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

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

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

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 for Parents/Guardians & Families of Children with Disabilities

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):*
The Training for Parents/Guardians and Families of Children with Disabilities sessions provides support and training strategies to help reduce the stress, demands and challenges to successfully raise children with disabilities. The training sessions include a focus on techniques on parenting children with and without disabilities, keeping family balance and harmony in the home, and effective communication. Parents/guardians, siblings and other family members are taught how stress affects individual family members and the family unit, and techniques that can be used to work through difficult and stressful times. Research indicates that children with disabilities may be at higher risk for abuse or neglect than children without disabilities. There are steps that parents/guardians and other family members can take to protect children with disabilities from abuse or neglect. Parents/guardians and family members of children and youth with emotional, behavioral, and mental health challenges obtain training on needed supports and services so that children grow up healthy and able to maximize their potential. These children are continually at risk of disciplinary actions at school, exclusion from family and community life, and the long-term effects of multiple negative experiences. Positive behavior support for parents/guardians and other family members assist in experience frustration in their attempt to change their children's problem behaviors by traditional methods of discipline. The training sessions offer practical parenting curriculum that teaches core strategies for engaging the child and explains how and why the strategies impact the child's development. These training sessions may also include parent support or mentoring groups. Parents who have similar information needs and educational issues can support each other while they learn about research-based best practices specific to their children's disability. Ongoing instruction and support for parents and family members who are implementing support interventions in their homes. The sessions are held in a location where parents/guardians, siblings, grandparents, and other family members can come together to support one another in their shared challenges and experiences in raising a child/youth with emotional, behavioral, or mental health issues.

The training sessions may also assist parents to gain an understanding of the dynamics of bullying, by exploring the various types of bullying and common characteristics of children who are targeted and children who exhibit bullying behaviors. Strategies to develop self-advocacy skills for the child being bullied, to develop peer advocacy skills for bystanders to speak out on behalf of others, and to modify the behavior of the child exhibiting the bullying behavior may be covered topics. Cooperative approaches for parents/guardians and family members to address and prevent bullying in the community are discussed.

This service includes, but is not limited to, in-person training, conferences, resource materials, and on-line

training sessions. Training includes the costs of registration and training fees associated with formal instruction in areas relevant to the needs identified in the child's support plan.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
- This service does not cover training to be a paid caregiver.
- This service does not cover training focused to the waiver participant's training needs.
- This service excludes payment for lodging and meal expenses incurred while attending a training event or conference.
- This service does not cover teaching self-advocacy to waiver participants which is covered under consumer education and training services.
- This service may not duplicate any service that is provided under another waiver service category.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training for Parents/Guardians & Families of Children with Disabilities

Provider Category:
Individual
Provider Type:
Professional Services
Provider Qualifications
License *(specify)*:
Licensed accredited professionals who maintain current credentials in their field of practice. For example, the training, peer-support sessions could be provided by licensed family professionals.
Certificate *(specify)*:
Certified or accredited professionals who maintain current credentials in their field of practice. For example, training or peer support sessions could be provided by certified family professionals.
Other Standard *(specify)*:
Training or experience in working with children with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training for Parents/Guardians & Families of Children with Disabilities

Provider Category:

Agency

Provider Type:

Training/Service Agency

Provider Qualifications

License *(specify):*

Licensed accredited professionals who maintain current credentials in their field of practice. For example, the training, peer-support sessions could be provided by licensed family professionals.

Certificate *(specify):*

Certified or accredited professionals who maintain current credentials in their field of practice. For example, training or peer support sessions could be provided by certified family professionals.

Other Standard *(specify):*

Training or experience in working with children with disabilities.

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	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):*

Transportation services pay for the cost to transport a child who does not have access to other transportation means. The transportation maintains, or improves, the child's mobility in the community, increases inclusion, independence and community participation, and prevents institutionalization. The term "community" is broadly defined, and is not limited to the boundaries of any particular municipality. Transportation services transport children who do not have access to unpaid transportation and are unable to safely transport themselves. The CLTS Waiver Program transportation services funds coverage of non-medical, non-emergency transportation needs.

Transportation is an allowable waiver service when unpaid transportation is not available to a child to support community access to obtain services, use necessary community resources, and to participate in community life. Transportation services may include the pre-purchase or provision of such items as bus tickets, train passes, taxi vouchers or other fare or may include a direct payment to providers covering the cost of transportation excluding parents.

Transportation may also be approved as mileage according to the Federal IRS rules related to mileage reimbursement and DHS established limits. Mileage is calculated based on the starting and ending points and is approved by the number of miles needed.

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

- Use of natural, or community supports, to provide transportation services should be the utilization priority.
- Transportation cannot be used to pay for transportation that is the obligation of the school district.
- The transportation service does not cover the participant driving himself/herself to a location.
- The mileage reimbursement rate may not be supplemented to cover vehicle operating, maintenance or repair costs.
- Vehicle adaptations and modifications are excluded. (They would be funded as adaptive aids.)
- Transportation excludes transportation mileage and other related expenses when the destination is a vacation. Renting a vehicle while on vacation is not an allowable expense.
- Transportation excludes the mileage incurred when a caregiver runs errands and the participant is not in the vehicle.
- Excludes transportation services to and from medical providers.
- Costs for the participant or their family to maintain a vehicle are excluded.

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's economic support programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

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**
- [x] **Relative**
- [x] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Transportation
Individual	Private Drivers
Agency	Public Carriers e.g. taxi cabs, mass transit

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Specialized Transportation
Provider Qualifications
License *(specify):*
Operator's License from the Department of Transportation
Certificate *(specify):*

Other Standard *(specify):*
Operator is insured
Vehicle is insured, is in good repair with all operating and safety systems functioning.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Individual

Provider Type:
Private Drivers

Provider Qualifications

License *(specify):*
Operator's License from the Department of Transportation

Certificate *(specify):*

Other Standard *(specify):*
Driver is insured
Vehicle is insured, is in good repair with all operating and safety systems functioning.

Verification of Provider Qualifications

Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.

Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Transportation

Provider Category:
Agency
Provider Type:
Public Carriers e.g. taxi cabs, mass transit
Provider Qualifications
License *(specify):*
Operator's License from the Department of Transportation
Certificate *(specify):*

Other Standard *(specify):*
Operator is insured
Verification of Provider Qualifications
Entity Responsible for Verification:
The county waiver agency is currently responsible for screening and verifying the provider's credentials and background check results.

The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider background check screening and credential verification process as part of the implementation of the Wisconsin Provider Management system, targeted for January 2018.
Frequency of Verification:
The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.

Effective January 2018, the Department will transition responsibility for the provider screening and credential checks via the WPM system, and will conduct searches on an annual basis.

Appendix C: Participant Services

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

b. **Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):
   - ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
   - ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
     Check each that applies:
     - ☑ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
     - ☐ **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
     - ☐ **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
     - ☐ **As an administrative activity.** *Complete item C-1-c.*

c. **Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The requirement for the completion of Wisconsin's caregiver background checks applies to all paid service providers who are listed on the Individual Service Plan (ISP), meet the definition of a caregiver and are authorized to deliver services to a CLTS Waiver participant. Under Wisconsin's Caregiver Law, s. 50.065, and s. 48.685, caregivers are defined as those persons who have regular, direct contact with participants. "Regular" means contact that is scheduled, planned, expected or otherwise periodic. "Direct" means face-to-face physical proximity to a participant that affords the opportunity to commit abuse or neglect or to misappropriate participant property.

Examples of service providers who meet the definition of a caregiver
include
providers, foster care providers, supportive home care providers, and respite providers. Generally, a provider who delivers outside chores and does not have access to the CLTS waiver participant, such as snow removal does not meet the definition of a caregiver.

When a request is made for a Wisconsin caregiver background check, it triggers an automated inter-departmental search via the DHS Integrated Background Information System (IBIS) of criminal, professional and paraprofessional registries and databases and produces the following:

1. Results from a search of Wisconsin's Department of Justice criminal history records
2. Results from a search of Wisconsin's Caregiver Misconduct Registry, maintained by the Wisconsin Department of Health Services regarding substantiated findings of abuse, neglect and misappropriation of property by noncredentialed caregivers
3. Results from findings of abuse, neglect or misappropriation in another state (if known)
4. Results from search of the status of professional credentials, licenses or certifications maintained by the Department of Safety and Professional Services
5. Denials of revocations of operating licenses for adult programs regulated by the DHS Division of Quality Assurance
6. Denials or revocation of operating licenses for child programs (e.g., day care centers, foster care providers, etc.) regulated by the Department of Children and Families

A search of the U.S. Department of Health and Human Services Office of Inspector General (OIG) Exclusions List (LEIE) is also required, as part of the required screening activities.

Currently, county waiver agencies and their sub-contracted agencies must ensure that a caregiver background check and LEIE search is completed for all persons working as caregivers. The required checks must be completed upon the hire of a caregiver and repeated every four years, at a minimum.

With the implementation of the Wisconsin Provider Management (WPM) system, targeted for January 2018, the Department will be the responsible entity for conducting the OIG LEIE screening and completion of caregiver background checks.

Effective January 2017, the Bureau of Children's Services will utilize the services of an external quality assurance organization to conduct record reviews for a selected sample of provider records, to ensure the completion of caregiver background checks, as required.

In addition, the State of Wisconsin oversees a Single State Audit process for county departments of human/social/community services. The CLTS Waiver Program includes requirements for the auditors to assure compliance with the caregiver background checks, as part of the CLTS Waiver Program audit requirements. The county waiver agencies must maintain documentation of all required documentation to ensure that prior to authorizing providers to deliver services to waiver participants, the agency has verified there are no barring offenses (e.g., substantiated finding of abuse or neglect or criminal history record indicating felony for the applicable waiver participant).

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 Department of Health Services (DHS) requires county waiver agencies to complete a caregiver background check for all waiver providers who meet the definition of a caregiver. The DHS maintains a caregiver misconduct registry which is available to the public. The Wisconsin Caregiver Misconduct Registry is a record of the names of nurse aides, personal care workers, and other non-credentialed caregivers with substantiated findings of caregiver misconduct (abuse or neglect of a client, or misappropriation of a client's property). This information must be reviewed regularly to determine appropriate hiring and employment decisions. The county waiver agencies must also conduct a search of the U.S. Department of Health and Human Services Office of Inspector General Exclusions Database.

(b) The requirement for the completion of caregiver background checks, which includes an automated search of both Wisconsin's criminal history record information, the Wisconsin Caregiver Misconduct Registry and several other children and adult provider licensure databases, must be conducted for all paid service providers who are authorized to deliver services listed on the waiver participant's Individual Service Plan (ISP) and meet the definition of a caregiver. Under Wisconsin's Caregiver Law, s. 50.065 and s 48.685, caregivers are defined as those persons who have regular, direct contact with waiver participants. "Regular" means contact that is scheduled, planned, expected or otherwise periodic. "Direct" means face-to-face physical proximity to a participant that affords the opportunity to commit abuse or neglect or to misappropriate participant property. Examples of service providers who meet the definition of a caregiver include supportive home care workers, respite providers, child care providers, and foster care providers.
Currently, county waiver agencies and their subcontracted entities must ensure that all persons working as caregivers have had a completed caregiver background check. The process is triggered when a request is submitted to the Wisconsin Department of Justice for a caregiver background check. The DHS Integrated Background Information System (IBIS) conducts an automated interdepartmental search of criminal, professional and paraprofessional licensing registry databases and produces the following:
1. Results from a search of Wisconsin's Department of Justice criminal history records
2. Results from a search of DHS Wisconsin Caregiver Misconduct Registry regarding substantiated findings of abuse, neglect and misappropriation of property by noncredentialed caregivers
3. Results from findings of abuse, neglect or misappropriation in another state (if known)
4. Results from search of the status of professional credentials, licenses or certifications maintained by the Department of Safety and Professional Services
5. Denials of revocations of operating licenses for adult programs
6. Denials or revocation of operating licenses for child programs (e.g., day care centers, foster care providers, etc.)

The county waiver agency must complete the required checks upon hire or contract, and the check must be repeated every four years, at a minimum. Providers are also required to report any change in their criminal history record (arrest or conviction) to their employer or contractor.

The CLTS Waiver Program, under the Single State Audit process, requires an audit review to ensure compliance with provider caregiver background check requirement. The county waiver agencies must maintain documentation of all required caregiver background checks and the provisions of contracts related to this requirement. Auditors view the results of the mandatory screening for each paid service provider who meets the definition of a caregiver.

In addition, the CLTS Waiver Program will implement a comprehensive quality review process through an external quality review organization (EQRO), to ensure the county waiver agencies are in compliance with the provider background check requirements.

Effective January 2018, with the implementation of the Department's Wisconsin Provider Management (WPM) system, DHS will be responsible for conducting a centralized provider screening and credentialing verification process as part of the enrollment for all waiver providers.

Information regarding Wisconsin's caregiver background check requirements, including links to the federal HHS Office of Inspector General Exclusion Database, is available at:
http://www.dhs.wisconsin.gov/caregiver/INDEX.HTM

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	
Shelter Care Facilities	
Residential Care Center (RCC)	

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.

RCCs in Wisconsin encourage a homelike atmosphere through such normalized procedures as family-style dining and the routine inclusion of daily chores. The presence of small spaces and furnishings similar to those found in typical family homes helps children feel a greater connection to those qualities typically found within their natural families. Many RCCs promote a homelike atmosphere through the safety, privacy and comfort of single bedrooms, spacious activity and leisure time areas, and outdoor play areas critical to skill development.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Shelter Care Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Support and Service Coordination	☐
Specialized Medical and Therapeutic Supplies	☐
Counseling and Therapeutic Services	☐
Home Modification	☐
Supported Employment – Individual	☐
Community Integration Services	☐
Adult Family Home	☐
Consumer Education and Training	☐
Communication Aids/Assistive Tehcnology/Interpreter Services	☐
Supported Employment - Small Group	☐
Personal Emergency Response System (PERS)	☐
Respite	☑
Housing Counseling	☐
Daily Living Skills Training	☐
Adaptive Aids	☐
Child Care Services	☐
Children's Foster Care	☐
Supportive Home Care	☐
Mentoring	☐
Transportation	☐
Day Services	☐
Training for Parents/Guardians & Families of Children with Disabilities	☐
Financial Management Services	☐
Relocation Services	☐

Facility Capacity Limit:

As per 2013 Wisconsin Act 335, s 48.63(1)(b), s. 958.22(2); no more than 20 days under a voluntary agreement.

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	☑

Standard	Topic Addressed
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:

Residential Care Center (RCC)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Support and Service Coordination	☐
Specialized Medical and Therapeutic Supplies	☐
Counseling and Therapeutic Services	☐
Home Modification	☐
Supported Employment – Individual	☐
Community Integration Services	☐
Adult Family Home	☐
Consumer Education and Training	☐
Communication Aids/Assistive Tehcnology/Interpreter Services	☐
Supported Employment - Small Group	☐
Personal Emergency Response System (PERS)	☐
Respite	☑
Housing Counseling	☐
Daily Living Skills Training	☐
Adaptive Aids	☐
Child Care Services	☐
Children's Foster Care	☐

Waiver Service	Provided in Facility
Supportive Home Care	☐
Mentoring	☐
Transportation	☐
Day Services	☐
Training for Parents/Guardians & Families of Children with Disabilities	☐
Financial Management Services	☐
Relocation Services	☐

Facility Capacity Limit:

Ch. DCF 52, Wisconsin, Stats. The Statutes do not limit bed capacity of RCCs. The WI Department of Children and Families has the authority to approve or deny proposed expansion of an existing RCC.

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.*

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 relative/legal guardians may perform specified waiver services if they are appropriately qualified and meet the following criteria:

- The child's assessed needs must warrant the proposed service to meet a child specific outcome; and
- The rate paid does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care attendant services including all the administrative costs associated with that service;
- The relatives/legal guardians must maintain time sheets for hours to be paid and must submit them to the fiscal support entity on a biweekly or more frequent basis. The waiver agency may make random, unannounced visits for the purpose of verification.

- ( ) **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:

The Department of Health Service's (DHS) current waiver provider screening and enrollment process, and public access to a list of wiling and qualified providers, is under a corrective action plan issued by the Centers for Medicare

and Medicaid Services (CMS). In response, DHS is developing the Wisconsin Provider Management (WPM) system to manage its enrollment of all willing and qualified providers of Medicaid home and community-based waiver services. WPM encompasses the administration and communication with providers through the Forward Health portal, managed by Hewlett Packard Enterprise, the Department's contracted Medicaid Management Information System (MMIS) vendor, for open and continuous provider enrollment and certification. A robust communication plan will be carried out by DHS to ensure that county waiver agencies, providers and program participants are aware of the new certification process for providers of home and community-based services.

WPM will allow all willing providers to access the certification process via the internet. Upon entering the WPM portal, providers will access information on:
- how to navigate through the portal,
- the steps to become a certified provider,
- the qualifications required for each service category, and
- the requirement for all willing and qualified providers to sign a Medicaid Waiver Provider Agreement during the certification process.

The portal will directed providers through a WPM process to identify and record:
- the program and type of service(s) they wish to deliver,
- the geographic area they wish to serve,
- the information they wish DHS to publish about their availability, and
- their qualifications to perform each service they wish to deliver.

With the implementation of WPM, DHS will eliminate the current paper execution of Medicaid Waiver Agreements and will conduct a centralized provider registration, screening and enrollment process. The provider certification process is expected to take approximately one week, depending on provider timeliness in providing documentation, such as proof of training or licensure qualifications required for certification. Once a willing and qualified provider signs the Medicaid Waiver Provider Agreement and is approved via the WPM certification process, the provider's information will be published on the online directory as an available willing and qualified provider. There will be no further barriers to prevent a provider from being selected by a waiver program participant to deliver authorized waiver services for which the provider is qualified. No provider will be enrolled or be included on the public provider directory until all background check screening and credential qualifications are verified.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. **Sub-Assurances:**

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

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

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

Performance Measure:
Providers initially and continually meet required licensure and/or certification. Numerator = number of providers reviewed who meet required initial and continuous licensure and/or certification. Denominator = the number of providers reviewed in the sample.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Wisconsin Provider Management system, once implemented (targeted in January 2018).

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

		☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☑ **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 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:
Non-licensed/non-certified providers meet applicable credentialing requirements. Numerator = number of non-licensed/non-certified providers reviewed in the sample who have met applicable credentialing requirements. Denominator = number of all non-licensed/non-certified providers reviewed in the sample.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Wisconsin Provider Management system, once implemented (targeted in January 2018).

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

		☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☑ **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:

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:
Providers of waiver services meet State and waiver training requirements. Numerator = number of waiver providers in the sample who meet state and waiver requirements. Denominator = all waiver providers reviewed in the sample.

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

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

Data Source (Select one):
Other
If 'Other' is selected, specify:
Wisconsin Provider Management system, once implemented (targeted in January 2018).

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

		Confidence Interval = +/- 5%
☐ **Other** Specify:	☑ **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.
All CLTS Waiver Program service providers must meet minimum training, work experience and/or licensure or certification credentialing requirements prior to the delivery of any services to the waiver participant and their family. These requirements vary based upon the type of service and the skill level needed for the specified service. These qualifications are defined by service type in the waiver application.

Upon the full implementation of the Department's Wisconsin Provider Management (WPM) system, targeted for January 1, 2018, interested and willing waiver providers will self-register via a web-based portal, electronically sign a Medicaid Waiver Provider Agreement, complete a Background Information Disclosure form, and upload their training, work experience, and licensure or certification credentials. DHS will

implement a centralized provider background check screening process and verify the provider's credentials to ensure all qualified provider standards have been met. Once the provider is enrolled as a qualified provider, the provider details are posted on a public directory, and the data file is submitted to the contracted third party administrated for claim payment processing.

The Department enters into a State-County contract with each county waiver agency which details the CLTS Waiver Program's requirements. The contracts reference the DHS Home and Community-Based Services Waivers Manual which indicates the DHS established statewide policies and procedures to which the county waiver agencies must adhere.

All county waiver agencies are subject to the annual Single State Audit, in accordance with federal audit requirements. The CLTS Waiver Program has been identified as a state program that is subject to the Single State Audit. This audit guidance addresses CLTS Waiver Program requirements to ensure that waiver providers comply with all the training, work experience and licensure/certification standards, and that required caregiver background checks have been completed in a timely manner.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Bureau of Children's Services' Children Service Specialists (CSS), along with regional area administration staff, monitor and follow up with county waiver agencies that have been identified as having compliance issues related to willing and qualified providers. County waiver agencies that fail to comply with the qualified provider requirements receive technical assistance and guidance from their DHS assigned CSS when individual problems are discovered. The CSS works directly with the county waiver agency and other entities as appropriate (e.g., the provider agency, Department or legal staff, etc.) to ensure that the specific issue is resolved. The county waiver agency currently retains documentation in the waiver participant's file. County waiver agencies are responsible for correcting any individual issues discovered and informing their assigned CSS of their actions. Issues related to specific waiver participants are tracked within the CLTS enrollment database, from identification to final resolution.

If it appears that there is a systems issue of concern, or if performance and compliance does not approve as a result of technical assistance and training, the CSS may recommend that a Corrective Action Plan (CAP) be developed with measurable outcomes, including timelines. This CAP is monitored by the BCS program integrity staff until compliance is achieved. Any formal corrective action plan is developed in coordination with DHS, and the department tracks all actions related to the CAP. The Department may also require immediate remedial action and impose CAPs to address these issues. The DHS CLTS team reports all tracked issues to the BCS program integrity section, which collects information and tracks information to ensure appropriate actions have occurred.

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 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.
The CLTS Waiver Program is subject to a CMS issued corrective action plan (CAP) for the current screening and enrollment process of willing and qualified waiver providers. Every CLTS waiver service provider must meet minimum training, work experience and/or licensure or certification credentialing requirements prior to the authorized delivery of any services to the waiver participant and their family. These requirements vary based upon the type of service and the skill level needed for the specified service. These qualifications are defined by service type, as approved under the CLTS Waiver Program renewal application.

In 2015, the Department established a workgroup that includes Medicaid, HCBS Waiver Medicaid program staff, as well as IT system staff. This workgroup is currently designing the Wisconsin Provider Management (WPM) system to meet the federal and state HCBS waiver program provider screening and certification requirements. The Department is currently developing a comprehensive communication and training plan for providers, county waiver agencies and participants.

The Department is planning a lengthy self-registration process for waiver providers, from the current county waiver agencies' manual review and provider verification process, to the WPM centralized provider screening and credential workflow and file submission to the CLTS Waiver Program's Third Party Administrator, to ensure a smooth and seamless transition for claim payments.

A selected stakeholder group of county waiver agencies and providers will participate in a user test group to pilot the WPM system prior to full statewide implementation. The pilot is tentatively scheduled to launch during 3rd quarter 2017.

Upon the Department's full implementation of the WPM system, targeted for January 1, 2018, interested and willing waiver providers will self-register via a web-based portal, electronically sign a Medicaid Waiver Provider Agreement, complete a Background Information Disclosure form, and upload their training, work experience, and licensure or certification credentials. The WPM workflow will implement a DHS centralized provider background check screening process and verify the provider's training and credentials to ensure all provider qualification standards have been met. Once the it is determined the provider meets all the standards, the following WPM actions shall occur:
Enrollment as a qualified provider
Issuance of a formal enrollment notice and packet on ongoing WPM provide requirements
Provider's name and contact information is posted on the public Waiver Provider Directory
Provider's name is added to the daily file submitted to the DHS TPA claims vendor

The Department enters into a State-County contract with each county waiver agency which will detail the CLTS Waiver Program's provider enrollment requirements via the WPM . The State-County contracts will be updated to reference the DHS CLTS Waiver Program Manual, which will include the established requirements for selecting willing and qualified waiver providers, to which the county waiver agencies must adhere.

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.

HCBS Waiver Final Rule Transition Plan is located in Attachment #2.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Service Plan (ISP)

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [x] **Registered nurse, licensed to practice in the State**
- [x] **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:

  Licensed or Certified under Chapter 457.09 of Wisconsin State Statute. This includes the following:
  A minimum of one year of employment working with persons of the specific target group for which they are employed. A Support and Service Coordinator (SSC) shall have the skills and knowledge typically acquired through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience with the target group, or through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons of the specific target group for which they are employed, or through a minimum of four years experience as a long-term support SSC, or through an equivalent combination of training and experience that equals four years of long-term support practice in long-term support case management practice, or the completion of a course of study leading to a human services degree and one year of employment working with persons of the specific target group for which they are employed.

- [x] **Other**

  Specify the individuals and their qualifications:

  To date, no Wisconsin family has declined service coordination on their child's Individual Service Plan. DHS requires specific minimum contacts between a participant/family and their service coordinator, and some families have requested a model of service coordination that allows for reduced contact requirements between the participant/family and the waiver agency.

  - The participant/family, in collaboration with the county waiver agency representative, maintains the overall plan to ensure identified services continue to meet their outcomes.

  - The participant/family is responsible to notify the waiver agency if/when the child's needs change and services and outcomes need to be changed to meet those needs

  - The participant/family is responsible to notify the waiver agency when a health and safety event has occurred so services can be adjusted to ensure health and safety

  Support and Service Coordination may include any of the following activities:

  a. Assistance to establish and maintain program functional and financial eligibility
  b. Establishment and reevaluation of the participant's level of care

c. Ongoing assessment and periodic reassessment of participant health, safety and functional capacity
d. Person-centered, family-centered service planning and service plan development, service coordination and plan review,
e. Contracting for services: establishing, contracting for and monitoring service systems specific to the participant's ISP,
f. Reviewing or completing individual service/support plans at required intervals
g. Identify participant outcomes, arrange services; coordinate and manage multiple service providers and between programs (e.g., county agency staff, including, economic support for Medicaid eligibility coordination, Birth to 3 Program, child welfare, juvenile justice, mental health, public health, school special education staff, Division of Vocation Rehabilitation staff, court system, multiple waiver providers, volunteers, etc.) to meet individual outcomes
h. Ongoing evaluation of the effectiveness of the waiver services and service providers
I. Monitoring and review of participant progress toward meeting CLTS waiver service goals and objectives and outcomes in service plans
j. Compiling and maintaining required documentation
k. Quality assurance and follow along services to assure participant health and safety, including the use of outcome based methods as applicable
l. Communicating orally and in writing with participants, appropriate family, guardians, service providers, DHS administration and interested members of the community
m. Providing advocacy, information and referral, crisis and critical incident intervention and resolution, protective and guardianship services
n. Assistance to participants to locate safe and appropriate housing including the determination of the efficacy of substitute care settings
o. Assistance to participants to access necessary medical care and treatment
p. Assistance to participants, as appropriate, to pursue vocational and/or educational opportunities
q. Creation and development of effective local provider networks
r. Supporting participant programmatic and developmental transitions including transition-planning processes
s. Providing instruction to participants, families/advocates to independently obtain access to services and supports, regardless of funding source
t. Providing institutional discharge-related care management/support and service coordination services up to thirty days prior to discharge that do not duplicate discharge planning services that a hospital, ICF-IID or nursing home is expected to provide
u. Provide transitional care management/support and service coordination for children and adults relocating to the community from an institution beginning up to 90 days prior to discharge and completed on the date of relocation

DHS would require the family, or the waiver agency upon request of the family, to identify a qualified person who meets the exact same minimum requirements of a SSC who is acceptable to the family, and this representative would work with the family to develop a plan for Self Directed Services for the child. The HCBS Waiver Manual, on page 62 of Ch. IV, outlines the process for developing a plan for Self-Directed Services, which is kept in the child's record at the waiver agency.

Under this plan, the family would work with their Financial Management Services provider and the waiver agency representative to ensure that a qualified provider is identified for each service on the child's ISP. The Self-Directed plan would identify the representative who retains responsibility for activities related to ensuring the waiver participant's continuing functional and financial eligibility for the CLTS Waiver Program as well as ensuring participant health and safety. The representative would be responsible for assisting in development of the child's ISP and maintenance of all required paperwork in the waiver agency file system.

The Department is implementing a statewide web-based Wisconsin Provider Management (WPM) system which is scheduled to be implemented by January 1, 2018. The DHS-managed system of certification of providers will:
- Certify any willing and qualified provider of waiver services
- Allow waiver applicants, participants and waiver agencies to view certified providers
- Allow participants to select certified providers via the public director
- Allow waiver agencies to establish local provider networks based on willing and qualified certified providers via the public directory.

DHS assures that its WPM web-based system implementation, based on the policies and procedures for self-

registration of waiver providers, along with the centralized processes for background check screening and verification of training and credentials will result in a public directory of certified providers who are willing and qualified.

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:*

The safeguards established by the State of Wisconsin to ensure that service plan development is conducted in the best interests of the participant are outlined in the Wisconsin HCBS Medicaid Waivers Manual.

Each county waiver agency must have a written plan describing how the agency will identify and resolve potential or perceived conflicts of interest that exist when the Support and Service Coordinator who has responsibility for service plan development is employed by an agency that may provide other direct services to the participant. The county waiver agency policy to address conflict of interest must be submitted to the DHS Bureau of Children's Services for review and approval.

The only waiver services county waiver agencies will be permitted to deliver to a CLTS waiver participant, in addition to support an service coordination, are the following:

- Allowable foster care services (the foster care program must be administered by a different agency within the county department).
- Purchased products and supplies from third party entities and vendors, typically from web-based vendors, and the county waiver agency receives no benefit from the vendor.

The Support and Service Coordinator must inform the parent/guardian and participant of any potential conflict of interest, as well as their right to use other providers to obtain needed direct services. If the parent/guardian and participant choose to receive direct services from the county waiver agency, the Support and Service Coordinator works in partnership with them to develop a plan to monitor the situation. A document specifying the conflict of interest, outlining the plan to monitor the situation and signed by the participant, guardian and service coordinator must be submitted with the waiver application to verify that all parties are aware of the conflict and approve of the plan to monitor the situation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Individual Service Plan (ISP) is developed through a person-centered and family-centered assessment focused on identifying the child's needs and learning about the desired child and family's outcomes. Families are critical partners in the development of the desired outcomes for the child and the necessary supports and services required to achieve these outcomes in the home and community settings. The Support and Service Coordinator gathers information for the ISP by involving the people who know the child well, such as parents, other family members, friends, and other caregivers to gain a clear understanding of the child's strengths and needs. The child and family invite and include anyone they believe will be helpful in the ISP development process.

The Support and Service Coordinator provides information regarding the application process, waiver participation,

freedom of choice, rights and responsibilities, and allowable supports and services under the CLTS Waiver Program, as well as other formal and informal community supports. Families are also able to access information regarding the CLTS Waiver Program requirements and covered services on the DHS Website: https://www.dhs.wisconsin.gov/clts/index.htm

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):

The ISP is developed by the waiver agency's Support and Service Coordinator or the designated family representative for those families who choose to self-direct, in partnership with the child's parents or guardian, and the child as appropriate to the child's age and ability. The purpose of the assessment is to gather current, comprehensive information about the person and their strengths and needs, including any unique to the child's environment to determine which services, supports and environmental modifications are necessary to enable the child or the child's family to meet or maintain their individual outcomes, and to safely and independently participate in the life of their community.

The content of the assessment must be family-centered and individualized. This includes identifying the child and family's needs as well as desired individual outcomes. The individual outcomes identified are child specific, based on the child and family's lifestyle, goals, ambitions, values, personal preferences and priorities.

The Support and Service Coordinator ore representative completing the assessment must have the skills needed to facilitate the child and family's identification of individual outcomes. This includes a focus on the whole child, not solely on functional deficits. An understanding of the child and family is essential to helping to translate a stated wish or goal or personal priority into an attainable individual outcome. The Support and Service Coordinator assists the child and family to identify and include those with an important role in their life or knowledge of their situation to participate in the process.

The assessment process is structured to explore the applicant's preferences in such areas as service delivery, living arrangement, medical care, and community participation. The process also gathers information on abilities, needs, desired outcomes, current supports, and the range of choices and services that may be beneficial. The assessment forms the basis for the service plan development. This ensures that the ISP is tailored to meet child and family's outcomes and the identified needs of the child. The service and supports provide an alternative to institutional care.

The following topical areas are explored and documented as a result of this assessment:

- Background and social history,
- Physical and medical health history,
- Individual outcomes important to the child and family,
- Ability to perform physical activities of daily living,
- Ability to perform instrumental activities of daily living,
- Emotional and cognitive function,
- Behaviors that positively or negatively affect lifestyle or relationships,
- Social participation, friendships, existing formal and informal social supports,
- Cultural, ethnic and spiritual influences,
- Community participation and involvement
- Personal preferences, preferred daily activities/routines and their environment,
- Risks associated with choices made in living arrangement, activities and relationships and behaviors,

- Economic resources available and how they are managed,
- Formal and informal supports available to the child and family,
- Review of participant rights and responsibilities, and
- A review of the child and family's interest and ability to self-direct supports.

A completed Individual Service Plan (ISP), the F-20445, is required for every CLTS waiver participant. The ISP is a summary of the child's proposed package of formal and informal supports and services. It includes information related to the services provided, the identified provider, service costs, frequency, and funding sources. The service plan results from the assessment, utilizing the most cost-effective waiver and non-waiver funded resources available to bridge the gap between the needs identified in the assessment and the desired individual outcomes.

The services and service providers listed on the ISP reflect the child and family's desired individual outcomes and preferences chosen by the family and to the extent possible the child through the course of an informed decision-making process. The ISP integrates the services listed with the individual outcomes.

The completed F-20445 summarizes the individualized supports and services for each child and family. The service plan contains individual demographic information and the services designed to address individual outcomes. The plan establishes the program and service start dates, lists all service providers, service frequency, service costs and their respective funding source. The following information is required on the Individual Service Plan:

a. The plan type (new, recertification, update, etc.);
b. Date of plan development with the child and family;
c. The cost share amount and level of care;
d. The parental fee if applicable;
e. Personal discretionary funds available;
f. The estimated Medicaid card costs/day;
g. The total start up/one time waiver costs;
h. The daily waiver service costs;
i. All of the Medicaid waiver, medical, formal and informal support services, necessary to maintain the child in the community including identification of those services that are preferred by the child and family;
j. The identified individual outcomes that the planned waiver services will address;
k. The federal procedure code for accurate waiver claim encounter reporting and name of each waiver funded service;
l. The state procedure code (if applicable) of each non-waiver funded service to be provided;
m. Each service provider's name, address, phone and e-mail;
n. Start dates of service delivery and end dates (if applicable);
o. Costs per unit of service (i.e., the hourly or daily rate charged by the provider);
p. The number of units of service to be delivered, including frequency and description for each service (e.g., 2 hours per day, 10 days/month);
q. Funding sources for all services listed (e.g., Medicaid, CLTS Waiver Program, Children's Community Options Program);
r. Services covered by the Medicaid state plan (Medicaid card), including units of service;
s. The staff person and agency with Support and Service coordination responsibility;
t. The signature of the child if they are 14 years of age or older and their family indicating that they understand that there was a choice between institutional and community-based services and indicating agreement with the community service plan; and
u. The signature of the Support and Service Coordinator.

The ISP represents an agreement between the waiver agency and the child and family as to how the program will meet the identified needs of the person and in so doing, help the child reach his/her desired outcomes. The ISP is an evolving instrument that can be adapted to meet changes in the child and family needs and preferences at any time. The ISP may also be adapted to address changing conditions among formal or informal supports, including waiver service providers. The Individual Service Plan is updated to reflect a current, accurate description of the CLTS Waiver Program services interaction with the participant whenever changes occur in services provided or when there is a change in the provider of service. Updated ISPs are forwarded to the appropriate waiver program management quality assurance entity as required.

At a minimum, the ISP must be reviewed every six months by the Support and Service Coordinator during a face-to-face meeting with the child and family. This review is documented in the participant record. The case note indicates

that the plan review was conducted, current services and supports discussed and evaluated by both the participant and the Support and Service Coordinator and describe any changes that will be made such as increases in service hours, change of service provider, or addition of new service or supports. Changes are also made upon the identification of new or increased service needs that must be addressed or made as the review identifies new preferences or desired outcomes.

For participants who have a guardian, activated power of attorney, authorized representative or other legal representative, the six-month face-to-face meeting with the participant remains mandatory however, the guardian/legal representative signs the updated ISP. The contact with the guardian/legal representative should be face-to-face as well.

The ISP serves as an agreement between the agency and the participant and therefore it must list all services and supports that are currently in place. Within six months of any change to the service plan, a completed and signed updated ISP must be placed in the participant record. A copy of the updated ISP should be provided to the participant and his/her legal representative. Finally, because the ISP is a record of Medicaid waiver services subject to estate recovery, completeness and accuracy are essential.

When a child has been on a wait list, the first steps prior to service approval are for the county waiver agency to (1) confirm the family's interest in waiver services, (2) complete all financial and functional eligibility verification activities, and (3) complete a needs assessment. Typically, waiver agencies complete these steps well before funding is expected to be available. The Department expects county waiver agencies to complete this eligibility process within 30 days.

When the initial waiver eligibility activities have been completed, the county waiver agency will enroll the child in the CLTS Waiver Program via the Eligibility and Enrollment Streamlining system. The Enrollment and Eligibility Streamlining system conducts searches of the child's level of care functional eligibility determination via the CLTS Functional Screen, and his or her Medicaid eligibility status via Interchange. If these two requirements are not met, the Enrollment and Eligibility system will not permit the child to be enrolled in the CLTS Waiver Program.

The county waiver agency has up to 60 days after the enrollment to adjust and finalize the child's ISP. When there is a change in circumstances that results in a change to the child's ISP, the revised ISP must be completed before service changes are implemented. DHS expects this to be completed within 60 days of the identification of changed needs, although this timeframe may be flexible to meet the unique needs of the child and family.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Both the CLTS level of care determination and the assessment process identify possible risks and concerns related to available community support and services. Any issues identified through these processes are addressed within the development of the ISP. The county waiver agency's Support and Service Coordinator must identify any potential risk that exists for the child and/or family. The Support and Service Coordinator, in coordination with the child, family, guardian, child welfare, court system, school, medical professionals, service providers, and others, as appropriate, develops a response plan to minimize, reduce or eliminate the potential of harm to the child's health, safety and welfare whenever risks are identified.

The Support and Service Coordinator must also determine whether any service may pose a risk to the child's health, safety, and welfare if it is not provided as scheduled. Services which pose a risk if not delivered in a timely manner must be identified in the service plan and must then include back-up plans to assure the child's continued health and safety. The back-up plan may include an on-call or crisis response system as available by either the provider or waiver agency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Currently, county waiver agencies establish local waiver provider networks, and issue information to families regarding qualified providers that are available to deliver waiver supports and services to the child.

The Department of Health Services is currently developing the Wisconsin Provider Management (WPM) system to manage willing and qualified providers of CLTS Waiver Program services. The county waiver agency will provide each parent/guardian and participant with information about the WPM and how to access information about available qualified and willing providers. Families will also be able to access the WPM provider directory via the ForwardHealth portal and search for available waiver providers, by service category, in their geographic area. If parents/guardians or participants are unable to access the WPM provider directory, will be issued paper copies of qualified list of providers, if requested.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The completed CLTS Waiver Program application packet, including the assessment and ISP is submitted by the Support and Service Coordinator to the Bureau of Children Services for review. A representative sample of the CLTS Waiver Program applications is reviewed by the Children's Services Specialists (CSS) for completeness including functional and financial eligibility. The waiver application review also includes a review of the family-centered assessment, health, safety and welfare including potential risk, and the services and supports included in the service plan to meet the assessed needs and outcomes of the child and family. The CSS assess whether or not a plan is reasonably calculated to appropriately meet the child and family identified needs and outcomes. A new, updated Individual Service Plan signed by the participant, by his/her guardian or by his/her legal representative is submitted to the Bureau of Children Services at least annually and whenever substantive changes are made. The country waiver agencies must ensure that all ISP revisions and covered services are authorized on a timely basis with the TPA vendor, to ensure scheduled service provision and payment.

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 county waiver agencies employ the CLTS waiver Support and Service Coordinators, or a sub-contracted agency, and is responsible for the provision of CLTS Waiver Program covered services, and for assuring the participants' health and welfare with regard to those services. The Support and Service Coordinator is also responsible for the coordination and remediation of identified problems within a child's service plan and the timely reporting of required incidents.

Section D-1E Risk Assessment and Mitigation further describes Wisconsin's remediation of incidents and events.

(b) The support and Service Coordinator is responsible for locating, managing, coordinating and monitoring all waiver program services, and other services, (regardless of funding source) and informal community supports provided to eligible children and families. The SSC is also required to assure that services are delivered in accordance with program requirements. This ensures the child's health and safety by enabling the child and family to receive a full range of appropriate services and supports consistent with assessed needs in a planned, coordinated, efficient and cost-effective manner. The Support and Service Coordinator role includes the primary responsibility to work with the child's parents or other legally responsible person to assure participant health and safety.

This service also includes an assessment of the family's needs so they may adequately support their minor child in the family home. The Service Coordinator also assures freedom if choice of providers. The Support and Service Coordinator must document the family's choice of providers within the CLTS Waiver Program needs assessment.

Section D-2 Service Plan Implementation and Monitoring further describes the type and frequency of service coordination. The determination of the type and frequency of support and service coordination contacts with the child and family, as well as with providers, is based on the following variables:

1. The stability of the child's health;
2. The ability of the child and the family to direct their own care;
3. The strength of in-home supports and the child and family's informal support network;
4. The stability of in-home care staffing (frequency and reliability of staffing, turnover, availability of emergency back-up staff);
5. The stability of the child's support plan (e.g., history of and/or anticipated frequency of change or adjustment to the plan);
6. The absence of a critical incident or a child protective referral for three years;
7. The child's family or guardian is active, interested and involved and is not a formal service provider.

Based on the factors detailed above, the Support and Service Coordinator works with the family and chosen providers to develop and monitor a "back-up plan" if necessary. This plan is coordinated and monitored and adjusted as necessary to meet the child and family's needs. The Support and Service Coordinator is responsible to inform the assigned BCS Children's Services Specialist in a timely manner when an incident occurs and intervention is required. Wisconsin's incident reporting protocol is also described in Section D-1E of the HCBW renewal application: Risk Assessment and Mitigation Process.

(c) The minimum monitoring requirements regarding the provision of support and service coordination include:
1) Monthly collateral contact;
2) Direct contact with the family every three months;

3) Face-to-face contact with the child at least every six months;
4) Annually, at least one of the face-to-face contacts shall be at the child and family's place of residence;
5) More frequent contact may be required in response to individual needs identified in assessments or prior critical incidents to assure health and safety; and
6) Direct contact with the family includes written or electronic mail exchanges, telephone conversations, or face-to-face contact. A collateral contact includes written or electronic mail exchange, telephone conversation, or face-to-face contact with a child's family member, medical or social services provider, or other person with knowledge of the child's long-term support needs.

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:*

The Department of Health Services is submitting a 1915(b)4 Waiver Application for Fee for Services Contracting to CMS for approval to allow county waiver agencies (or their sub-contracted entities) to be the sole provider of CLTS Waiver Program Support and Service Coordination.

Any potential conflict of interest as applicable to the county waiver agency or their sub-contracted entity, in any aspect of operating the CLTS Waiver Program must be remediated. A potential conflict is present whenever an entity or person involved in operating any part of the CLTS Waiver Program has an interest in, or the potential to benefit from, a particular decision, outcome or expenditure. A single individual, agency or entity occupying several roles in the county waiver agency's process often signals that conflict of interest may be present. Conflict of interest includes both actual and perceived.

A potential conflict of interest exists when the county waiver agency's Support and Service Coordinator, who authorizes waiver services and monitors the ISP implementation, is employed or otherwise representing the same agency that provides another waiver service to the participant. Therefore, the Support and Service Coordinator who monitors the service plan may only authorize and provide the following waiver services for the same individual:
- Child Foster Care services, as detailed under that service description.
- Goods and services, generally purchased from online Internet provider

The county waiver agency must have a written plan which outlines their response to entities, issues and events surrounding conflict of interest. The county waiver agency policy surrounding conflict of interest is subject to Department approval. Section D-1.b: Service Plan Development Safeguards further describes Wisconsin's conflict of interest safeguards.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

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

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

Performance Measure:
The most recent ISP addresses assessed needs, health and safety risks, personal goals and outcomes with the provision of waiver and non-waiver services. Numerator = the number of most recent ISPs reviewed that address assessed needs, health and safety risks, personal goals and outcomes via waiver and non-waiver services. Denominator = total number of most recent ISPs reviewed in the sample.

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

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **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 participant's needs.***

Performance Measures

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

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

Performance Measure:
ISPs are updated/revised at least annually or as warranted by changes in the waiver participant needs. Numerator = ISPs reviewed that evidence they were updated at least annually or as warranted by change. Denominator = all ISPs reviewed in the sample.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☑ **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:
Participants receive waiver services in accordance to their ISP including type, scope, amount, duration and frequency. Numerator = Number of participant ISPs reviewed where evidence supports waiver services were authorized in accordance with the ISP. Denominator = all participant paid waiver service claim records reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLTS encounter service claim 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 = +/- 5%
☐ **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:

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and 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:
Participants, parents and/or guardians were afforded choice between and among waiver services and providers. Numerator = number of records reviewed in the sample with clear documentation that choice was afforded. Denominator = all records reviewed in the sample.

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

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

☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☑ **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 county waiver agency is responsible for administering all aspects of service plan initial development, update/revision at least annually, or whenever there are changes in the participant's needs or community living situation.

The county waiver agency's Support and Service Coordinator works with the parents/guardian and the CLTS waiver participant to create and ISP based on the assessed needs of the child and family. Documentation of the service planning development is stored and maintained in the participant's file at the county waiver

agency. The Department has administrative oversight of the county waiver agencies and monitors these processes through performance measures and other reporting requirements. The primary discovery method employed by DHS in overseeing ISPs is the CLTS Waiver Program record review process.

An improved CLTS Waiver Program quality assurance process is being implemented in 2017, which will include the implementation of an onsite record review and system data review process through an external quality review organization, based on established program quality performance measures. A representative sample of initial enrollment and recertification records are reviewed to ensure level of care, ISPs and other factors.

The EQRO review results will be aggregated and analyzed by the Bureau's performance integrity quality assurance staff on a quarterly and yearly basis to identify patterns and trends. The trends will be shared with BCS managers to establish a comprehensive plan for training, technical assistance or corrective action.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
DHS directly monitors county waiver agencies when the need to correct any issues is discovered through the review of service plans. For example, if a CSS notes a concern with an initial service plan submitted for a new waiver enrollee, the CSS will contact the waiver agency to discuss the potential issue and identify any needed remedial action. County waiver agencies are responsible for correcting any individual issues discovered and informing their assigned CSS of their actions. Issues are tracked from identification to final resolution. The CSS may recommend development of a corrective action plan in some cases where there appears to be a systems issue. The Department may also require immediate remedial action and impose corrective action plans to address these issues. The CLTS team reports all tracked issues to the Bureau's program integrity staff, which follows up and collects information to document the appropriate actions have occurred.

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 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.

Family-directed supports and services are designed to assist children and their families to build, strengthen or maintain informal networks of community supports. Family-Directed Supports include the specific activities noted below at the request and direction of the child or his/her family.

The types of services and supports provided through Family-Directed Supports are the same as other waiver allowable services including: adaptive aids, communication aids, consumer education and training, counseling and therapeutic resources, daily living skills training, day services, home modifications, personal emergency response, respite care, specialized medical and therapeutic supplies, specialized transportation, supported employment, and supportive home care. The provider of each service and support must meet the provider qualifications for the specific service.

The method of arranging for the provision of services and the supervision of these services include provision of support and assistance to the child and family to prevent out-of-home placement of the child and to support the child's inclusion in the community. Assistance is provided to the family to identify and access formal and informal support systems, to develop a meaningful child and family support plan; and to increase or maintain the child and family's capacity to direct formal and informal resources. This also includes completing activities that assist the child, family, and friends to determine future plans.

The goals of family-directed supports are as follows:

- Developing and implementing a family-centered support plan, which provides the direction, assistance and support to allow the child with a disability to live in the community, establish meaningful community associations, and make valued contributions to the community.
- Providing ongoing consultation, community support, training, problem-solving, and technical assistance to assure successful implementation of a family-centered plan.

- Developing and implementing community support strategies, which aid and strengthen the involvement of community members who assist the child to live in the community.

County waiver agencies must assure that providers under Family-Directed Supports have the skills and knowledge needed to carry out responsibilities assigned to them in a manner that meets the individual needs and preferences of the child and family as specified in the individual service plan and in a manner that ensures protection of the child's health and safety. Each county waiver agency will assure the following:
- Children, families and other natural supports were involved in developing the plan and are involved in ongoing oversight of the plan;
- Consumers, families and other natural supports, and providers have access to information describing Family-Directed Supports;
- A flexible array of services that provide supports to meet identified needs and that is able to provide choice as to nature, level and location of services;
- Participating children and their families, guardians and other natural supports are supported to know their rights; learn about the methods provided by the Family-Directed Supports plan to take greater control of decision-making; and develop skills to be more effective in identifying and implementing personal goals;
- Providers shall meet the standards for the Waiver-covered service they provide or meet provider qualifications that are based on the needs and characteristics of the specific individual or individuals served;
- Family-centered support plans based on individual goals and preferences that allow the child with a disability to live in the community, establish meaningful community associations, and make valued contributions to the community;
- Outcome-based quality assurance methods;
- Consultation, problem-solving, and technical assistance to assist children and families in accessing and developing the desired support(s); and
- Assist in securing administrative and financial management assistance to implement the supports(s).

County waiver agencies must establish a mechanism for allocating resources to individuals for purchasing family-directed community support services based upon identified factors. These factors may include the person's skills, his/her environment, the supports available to the person, and the specialized support needs of the person. Each child must have an annual budget document that lists total expenditures for each child by type of expense. The allocation of resources for individual budgeting that is subject to the State Medicaid agency approval and continuous public review at least annually.

The Department is currently developing a statewide electronic Wisconsin Provider Management (WPM) system which is scheduled to be implemented by CY 2018. This DHS-managed system will:
- certify any willing and qualified provider of long-term care services
- allow any waiver participant and county waiver agency to view certified providers via a public waiver provider directory
- allow participants to select qualified providers via the public waiver provider directory

DHS assures that its WPM program roll-out, policy and procedure for certification of willing and qualified providers, along with the automated processes for verification of qualifications and good standing of providers, will result in providers who are informed about the process to become certified, and will result in certified, willing and qualified providers.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

○ **Waiver is designed to support only individuals who want to direct their services.**

○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Family-Directed Supports involve a number of components related to the child and family's ability to employ workers, manage a budget, locate services, direct services, and obtain independent advice and support. Regardless of the level of family-direct supports a child and family chooses, assistance to navigate the service system is available. Each child and family has access to the services of a Support and Service Coordinator to aid in the management of their budget and securing needed supports.

Waiver participants and their legal representatives who choose to participate in family-directed services must demonstrate the following:
- The skills to direct service providers to assure quality service delivery;
- The ability to maintain quality records to document delivered services;
- The ability to manage within a specified budget;
- The ability to direct providers to meet the individual needs of their child; and
- The ability to work within a team and direct their team in an effective manner.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Information regarding family-direction is shared with the participant and their representative at the time of assessment planning. As the waiver agency's Support and Service Coordinator is working with the family to complete the needs assessment the informal and formal supports will be identified. The Support and Service Coordinator will review all possible service options available under the waiver including Family-Directed Services.

Families are also informed of the location of the link to DHS web-based Wisconsin's CLTS Waiver Program Manual. Families are encouraged to review the allowable services to assist with the service planning process. This gives families the opportunity to review all allowable services and their requirements and limitations. If families have difficulty accessing or understanding this information the Support and Service Coordinator will assist families through other methods such as verbal explanations. Families are able to actively partner in the planning process because of this knowledge. Support and service coordinators are responsible to discuss the benefits of family-direction, responsibilities and potential liabilities of this option to the child and family.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Specialized Medical and Therapeutic Supplies	☑	☑
Counseling and Therapeutic Services	☑	☑
Home Modification	☑	☑
Supported Employment – Individual	☑	☑
Community Integration Services	☑	☑
Consumer Education and Training	☑	☑
Communication Aids/Assistive Tehcnology/Interpreter Services	☑	☑
Supported Employment - Small Group	☑	☑
Personal Emergency Response System (PERS)	☑	☑
Respite	☑	☑

Waiver Service	Employer Authority	Budget Authority
Housing Counseling	☑	☑
Daily Living Skills Training	☑	☑
Adaptive Aids	☑	☑
Child Care Services	☑	☑
Supportive Home Care	☑	☑
Mentoring	☑	☑
Transportation	☑	☑
Day Services	☑	☑
Training for Parents/Guardians & Families of Children with Disabilities	☑	☑
Financial Management Services	☑	☑
Relocation Services	☑	☑

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:

This service involves a person or agency that is responsible to pay service providers after the parent/guardian or participant authorizes payment to be issued for delivered pre-approved services included on the participant's approved ISP. Financial Management Services providers, sometimes referred to as fiscal intermediaries, are organizations or individuals that write checks to pay bills for personnel costs, tax withholding, worker's compensation, health insurance and other taxes and benefits appropriate for the

specific provider consistent with the individual's ISP. This service also includes paying bills authorized by the participant or their guardian, keeping an account of disbursements and assisting the participant ensure that sufficient funds are available for needs. The Financial Management Services provider is accountable for ensuring compliance with all federal and state laws associated with tax withholding, unemployment insurance, and all other employee benefits. The Financial Management Services provider must be subject to an audit to ensure all transactions have been properly executed. This service excludes payments to court appointed guardians or court appointed representative payees if the court has directed them to perform these functions.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

FMS administrative costs are considered costs related to the delivery of services chosen by the child's family. Typically FMS agencies charge a small monthly fee that compensates the agency for costs related to processing of individual service providers time sheets and the costs related to state and federal with holdings and employee benefits. The FMS submit their waiver service claims to the CLTS Waiver Program contracted TPA vendor for payment.

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**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [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**
- [ ] **Other**

Specify:

iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) monitor and assess the performance of the FMS agency: In addition to the discovery methods DHS employs for ALL waiver services, which are outlined throughout this application, the waiver agency support and service coordinator works closely with the child's family to monitor performance of the FMS agency. The county waiver agency's Support and Service Coordinator monitors the integrity of the financial transactions on a monthly basis. This is done by reviewing submitted time sheets and confirming directly with the child's family to ensure services were delivered as expected. In addition, the CLTS Third Party Administrator (TPA) claims vendor reviews, processes, and adjudicates provider claims. The TPA vendor brings any claim anomalies or trends to the Department's attention for further investigation.

(b) entities for monitoring: the support and service coordinator as well as DHS using discovery methods described in this application for all waiver services.

(c) how frequently performance is assessed: The county waiver agency's Support and Service Coordinator monitors the integrity of the financial transactions on a monthly basis. DHS employs discovery and remediation activities as described in this application for all CLTS Waiver Program services.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☑ **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
Support and Service Coordination	☑
Specialized Medical and Therapeutic Supplies	☐
Counseling and Therapeutic Services	☐
Home Modification	☐
Supported Employment – Individual	☐
Community Integration Services	☐
Adult Family Home	☐
Consumer Education and Training	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Communication Aids/Assistive Tehcnology/Interpreter Services	☐
Supported Employment - Small Group	☐
Personal Emergency Response System (PERS)	☐
Respite	☐
Housing Counseling	☐
Daily Living Skills Training	☐
Adaptive Aids	☐
Child Care Services	☐
Children's Foster Care	☐
Supportive Home Care	☐
Mentoring	☐
Transportation	☐
Day Services	☐
Training for Parents/Guardians & Families of Children with Disabilities	☐
Financial Management Services	☐
Relocation Services	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

◉ **No. Arrangements have not been made for independent advocacy.**

○ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

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:

Voluntary termination of participant direction can occur anytime a parent/guardian determines they no longer wish to participate in this service delivery model. The Support and Service Coordinator is responsible to transition all service delivery activities to the waiver agency so that the participant can engage in a traditional service delivery model. Services are not discontinued or disrupted during this transition period, thus ensuring service continuity and participant health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. **Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of Family-Directed Supports occurs under the following circumstances:
- The child's health and safety, or another person's safety is threatened;
- Individual expenditures are inconsistent with the budget and the plan;
- The conflicting interests of another person are taking precedence over the desires and interests of the child; or
- Funds have been used for illegal purposes.

In the event that funds have been used for illegal purposes the county waiver agency's Support and Service Coordinator is required to contact their County Corporation Counsel to begin an investigation at the local level and submit an Incident Report to DHS. If the local investigation confirms a finding of fraud, the county contacts the DHS Office of Inspector General (OIG) who engages the State of Wisconsin Department of Justice in prosecution and recoupment activities regarding Medicaid fraud. Any provider found guilty of Medicaid fraud is then place on the caregiver misconduct registry and is barred from providing services.

If a county waiver agency restricts or terminates a child and family's ability to self-direct, then the child and family receive information regarding the specific steps necessary for the restrictions or termination to be withdrawn. If the level of family-direction is restricted, then the waiver agency also informs the child and family about his or her right to file a grievance, request DHS review, or request a fair hearing if he or she disagrees with the limitation. The waiver agency is required to have written policies and procedures in place as to how it would assist children and families in attaining or regaining family-directed authority.

The Support and Service Coordinator is responsible to transition all service delivery activities to the waiver agency so that the participant can engage in a traditional service delivery model. Services are not discontinued or disrupted during this transition period, thus ensuring service continuity and participant health and welfare.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1187
Year 2		1370
Year 3		

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
		1384
Year 4		1384
Year 5		1384

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*:

- [x] **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

  Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

  Private financial management agencies, local government agencies and any other appropriately qualified to provide financial management services.
- [ ] **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

- [x] **Recruit staff**
- [x] **Refer staff to agency for hiring (co-employer)**
- [x] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [x] **Obtain criminal history and/or background investigation of staff**

  Specify how the costs of such investigations are compensated:

  Caregiver background check costs are considered an administrative cost to the county waiver agency and are arranged for and reimbursed directly by the waiver agency. Upon the full implementation of the WPM system targeted for January 1, 2018, the Department will conduct caregiver background checks as part of the centralized statewide provider screening and certification process.
- [x] **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.**
- [x] **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.

The county waiver agency Support and Service Coordinator works with the family to assess the child's disability related support needs and to identify the services necessary to meet the assessed needs in order to develop the child's CLTS Individual Service Plan (ISP).

Two approaches are utilized for budget development in family-directed services.
1. If the child has received services and supports through agency-managed services, then historical data for cost under traditional service provision arrangements are used as the budget.
2. If historical data does not exist, the waiver agency will assign costs to each service based on the fiscal experience with the chosen service providers. If a particular service has not been previously provided, so the waiver agency does not have historical data, the waiver agency will work with the new provider to establish an acceptable rate as defined by the Allowable Cost Manual Guidelines.

As the child's ISP is developed in partnership with the family, the waiver agency SSC will explain what rate methodology is used by the waiver agency to determine the cost for services. Once the rate is established and final costs are determined, the SSC informs the family of the costs and the budget limits. This information is discussed verbally and written on the child's CLTS Individual Service Plan which the parent authorizes.

Once services are being delivered, the Department of Health Service's TPA claims vendor issues weekly provider claims reports to assist waiver agencies to monitor their budgets. This information helps the SSC identify and respond to increasing service utilization and costs, so that they can work with the family to both help bring expenditures under control and ensure that the changing needs of the child are adequately addressed. The SSC has the authority to adjust the budget based upon the child's unique or changing needs.

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.

Once the comprehensive assessment is completed and a service plan is developed, the waiver agency's SSC establishes a budget based on historical data for similar service and support costs. The SSC completes the Individual Service Plan document (F-20445, F-20445A) which outlines the specific budget for each service as well as for the entire plan once the budget is established. The child and family are partners in this process and are supported to take the lead on establishing needed supports and service providers. The details of service providers and other information are documented on the ISP. The child, when appropriate and possible, the parents or guardian and the SSC sign the ISP. This process serves as a formal contract between the child and family, and waiver agency.

Modifications to the participant directed budget must be preceded by a change in the service plan. When the child's family identifies a change in need or services the SSC adjusts the service plan to reflect the change in services. This is the case for participants using self-directed supports as well as those using traditional supports. DHS policy is that adjustments to a waiver participant's service plan must be based upon identified changes to the child's assessed needs. All changes or modifications to the child's services and/or budget must be reflected on the ISP and the Outcomes document. The State verifies, through the annual record review audit, that any changes to the child's ISP are identified jointly with the child and family and are documented in the child's record.

When a participant utilizing self-directed supports has changes to their service plan, the waiver agency Support and Service Coordinator works closely with the child and family to monitor ongoing costs to assure these remain within the individual budget and to ensure health and safety needs are met. Waiver agencies are expected to manage their available funding sources to meet the unique needs of their CLTS waiver participants. If an individual's budget requires adjustment in order to ensure health and safety, the waiver agency works with their fiscal staff, and with DHS fiscal staff when necessary, to determine the source of the needed funding.

During the annual record review audit, the Department looks at any participant requests or other information in the child's file to ensure that changes in the child's needs are reflected by updates and changes to the child's ISP.

If participant request for budget adjustment is denied or outcome of the budget is reduced, they have the opportunity to request a Fair Hearing as outlined in Appendix F:1. Parents, or other legal representatives, receive the document entitled, Participant Rights and Responsibilities, which explains the fair hearing process, at initial application, upon service plan development and at least annually thereafter. Parents, or other legal representatives, also receive this document whenever eligibility or services are changed, reduced or denied. The SSC has the additional obligation of explaining these rights and responsibilities and assuring that parents, or legal representative, as well as the child when appropriate, understand the information contained in the notification.

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 SSC works closely with the child and family to monitor ongoing costs to ensure these are within the individual budget and that they will not be depleted prematurely.The Department's TPA claims vendor issues a weekly provider claims reports to assist waiver agencies to monitor their budget. Each waiver agency identifies at least one staff person who will have authority to receive and review the weekly TPA claims report. In addition at least one agency staff person, identified by the agency, will have security privileges to access their agency's claims data stored in the DHS data warehouse. In addition, the SSC uses the weekly provider claims reports submitted by the Department's TPA claims vendor to monitor whether services are delivered as authorized to meet the child's needs. In addition, the TPA claims vendor flags potential over expenditure or budget underutilization to the attention of the Department; e.g., insurance coordination of benefits, authorization problems, provider claim modifiers, etc.

Providers have 90 days from the date of service provision to submit their claims to the TPA. When claims are submitted first to another funding source (e.g., private health insurance), providers have 90 days after the coordination of benefits to submit their claims for waiver reimbursement.

The SSC identify and respond to increasing service utilization and costs, and can both help bring expenditures under control and ensure that the changing needs of the child are adequately addressed and

provide real time data on underutilization or claims above the authorized amounts. The SSC also maintains regular direct contact with the child's family to monitor the quality of services provided and to verify that the level of services continues to meet the child's needs.

The waiver agency support and service coordinator is responsible to provide the necessary authorizations of services to the FMS agency to ensure the child has funding available to reimburse the child's directed services. The TPA weekly claims reports assist the support and services coordinator in tracking the expended funds and services that have been delivered. The waiver agency is responsible to ensure that the participant's funds are spent appropriately.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Specific rights protect individuals applying for the CLTS Waiver Program, as well as children and families, or other legal representatives, participating in those programs. Along with these rights, the applicant or children and families, or legal representatives, have responsibilities as a condition of participation in the Medicaid home and community-based services waiver. The CLTS Waiver Program is part of a system of long-term supports in Wisconsin which includes both Medicaid funded and state funded programs and services. The Model Rights and Responsibilities Notification document (see below) details these rights and responsibilities. Parents, or other legal representatives, receive this document at application, upon service plan development and at least annually thereafter. Parents, or other legal representatives, also receive this document whenever eligibility or services are changed, reduced or denied. The Support and Service Coordinator has the additional obligation of explaining these rights and responsibilities and assuring that parents, or legal representative, as well as the child when appropriate, understand the information contained in the notification. The child and family, or legal representative, at initial application and annually each year thereafter sign the document. The child and family, or legal representative, receive a copy and the original signed document is in the child's file with the waiver agency.

Wisconsin's Children's Long-Term Support Functional Screen (CLTS-FS) has system logic to determine functional eligibility for the CLTS Waiver Program, based on the data entered by trained screeners. If a child is determined not functionally eligible for the CLTS Waiver Program, the waiver agency screener notifies the family verbally and in writing of their right to request a Fair Hearing. If a child and family's services are terminated, reduced or changed, the SSC also notifies the family verbally and in writing of their right to request a Fair Hearing. This notice details the denial or discontinuation of eligibility and provides specific information about the hearing request process, as well as relevant timelines and the effective date of the action taken. The notification clearly details the grievance process and state appeals procedures. The information on the right to appeal includes the name and address of the Department of Administration, Division of Hearings and Appeals. The notice also informs the child and family of the right to contact the Long-Term Care Ombudsman Program and Disability Rights Wisconsin for assistance and advocacy, including the toll-free numbers.

A waiver agency may not take any adverse action on a CLTS Waiver Program participant without giving the participant a ten-day notice of the action, as well as the appeal information previously noted. When informing a participant of his/her right to a state appeal, a waiver agency must cite chapter 227 of State Statutes and 42 CFR Part 431, Subpart E. If the child has previously been determined eligible and is receiving services, then eligibility and services must continue pending an appeal, as long as the child and family, or legal representative, appeals the decision before the date of the adverse action stated in the notice letter. The waiver agency retains original documentation of the adverse action and notification of the right to a Fair Hearing, with a copy sent to the Department of Health Services.

PARTICIPANT RIGHTS AND RESPONSIBILITIES – Notification Document
As an applicant for or participant in a Medicaid (MA) waiver program, you have specific rights and responsibilities.

Applying for the MA Waivers
You have a right to be told about the MA waiver programs and other programs that can help you to live at home. You have a right to be told about services and other types of assistance the MA waiver programs can provide for you.

You have a right to apply for the MA waiver programs. You have a right not to participate in the MA waiver programs. Your refusal to participate in a MA waiver program may lead to the loss of funds from other state funded programs such as the Children's Community Options Program (CCOP).

You have a right to a written answer to your application within thirty (30) days; sooner, if it is an emergency. The answer must say one of three things: 1) Yes, you are eligible (approval); 2) No, you are not eligible (denial) and why; or 3) More information is needed (pending) and what information is needed.

If your application is denied, you have the right to file a grievance and/or file a state appeal in certain circumstances. You have the right to be told how to file a grievance or appeal.

Deciding If You Are Eligible for the MA Waivers
If your application is approved, you have the right to a meeting to help decide what you need to live at home (assessment). This assessment must be done within 45 days from the time applied (or sooner in an emergency). A qualified person must do the assessment.

You have a right to say what you think in the assessment and in developing the plan or services/assistance (individual service plan) that you will need. You have a right to have friends, relatives, or anyone you want to be with you in these meetings.

You have a right to any help you need to understand and take part in meetings. This includes interpreters, taped or Braille material or other communication aids.

You have a right to have someone explain what your assessment says and what choices you have to help you to live at home. You have a right to a written copy of your assessment if you ask for it.

You have a right to have someone explain your plan for services (individual service plan). This plan must say what problems you have and what will be done to solve them. The plan must pay attention to what you choose. You have a right to a written copy of your plan if you ask for it.

You have a right to choose from whom you will receive services. The person you choose must be qualified.

You have a right to disagree with your service plan; you have a right to ask to change the things with which you disagree. If you disagree, you have right to file a grievance.

Getting MA Waiver Services
You have a right to services if there is money available and you are eligible.

If money is not available, you have a right to be on a waiting list for services. If you are told that you have to wait for MA waiver services, you have a right to know how the waiting list works, how many others are waiting before you and when the waiver agency thinks you will get services.

You have a right to know the amount, if any, that you will have to pay for services.

You have a right to be helped by a person (Support and Service Coordinator) after you get services. The Service Coordinator helps to make sure that you are getting the services in your plan and that the services work well together. You have a right to meet with this person as often as necessary.

You have a right to a written notice, at least 10 (ten) days in advance, whenever your services are going to be reduced or stopped. You have a right to file a grievance or state appeal if you disagree.

If you file a state appeal before the termination date stated in the termination notice you receive, you have a right to keep getting the types and amounts of services until the appeal is decided.

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 DHS Area Administration (AA) is responsible for oversight of the State-County contracts and ensuring that quality services are provided by the Department of Health Services. To achieve this, AA staff conduct quality improvement reviews, complaint investigations, interact with legislators, consumers and others who raise complaints or concerns to the Department.

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).

Participants have the right to a Fair Hearing in response to any action take regarding their participation in the CLTS Waiver Program. Every waiver agency also has a local complaint/grievance process, and the participant or their guardian may choose to file a Fair Hearing, the local complaint/grievance process, or both, or neither, at any time. The Department's client rights publication, Client Rights and the Grievance Procedure for Community Services (P-23112) is available online at http://www.dhs.wisconsin.gov/publications/P2/p23112.pdf. This brochure is available in English, Spanish, and Hmong, and contains a space for a local agency to add their contact information before distributing to the public.

The brochure describes the grievance procedure in general, and it specifies that the individual "may, instead of filing a grievance or at the end of the grievance process, or any time during it, choose to take the matter to court to sue for damages or other court relief if you believe your rights have been violated."

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).

A critical incident is any actual or alleged event or situation that creates a significant risk or serious harm to the physical, mental health, safety, or well-being of a child. Incidents that must be reported to the Support and Service Coordinator include:

- Any abuse or neglect of the child known or suspected.
- Errors in medical or medication management that result in a significant adverse reaction that requires medical attention.
- The initiation of an investigation by law enforcement of an event or allegation regarding a child as either a perpetrator or victim, unless such action is a component of an approved crisis or treatment plan.
- Significant and substantial damage to the residence of the child or service provider.
- Use of isolation, seclusion, or restraint by a service provider that is not included and approved as part of a behavior support plan.
- An unexpected event or behavior that causes a serious injury or risk to the child; which may include running away, setting a fire, violence, hospitalization resulting from an accident, suspected or confirmed suicide attempts.
- The death of the child.

Incidents must be reported immediately if the child's safety was threatened to ensure that all necessary steps have been taken to protect the child. Families, other legal representatives, and providers are required to report incidents to the waiver agency's Support and Service Coordinator. This report is immediately forwarded to the assigned DHS Children's Services Specialist. Waiver agency staff, or an entity authorized by the waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of the waiver participant who is the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the waiver agency must take all reasonable steps to protect the person. A preliminary report with further details and disposition of the Incident Report (IR) form is due within seven days. If all aspects of the report are not resolved by this point, a final report is due within 30-days.

County waiver agency's Support and Service Coordinators will be required to report incidents to their DHS CSS using the web-based Children's Incident Tracking and Reporting system within the appropriate time limits. Implementation of the CITR system is targeted for 2nd quarter 2017. The county waiver agency, after gathering, reviewing and evaluating its findings, must report the incident to the State Children's Services Specialist following a comprehensive and prescribed format for waiver agency reporting. If an allegation is found not credible, the waiver agency is still encouraged to report the incident.

The DHS Children's Services Specialist reviews the waiver agency's report upon receipt and determines if the waiver agency handled the situation adequately to assure health, safety and welfare. The Children''s Services Specialist may:

- Conduct a targeted review for a first-hand assessment of the situation,
- Schedule such a review for a later time,

- Refer the allegation for further investigation to the DHS Division of Children and Families, if the accused caregiver is an unlicensed caregiver, or to the Department of Safety and Professional Services if the caregiver is a licensed professional,
- Offer technical assistance as appropriate.

When the incident involves a death under suspicious circumstances or one that might have been preventable, the Bureau of Children Services conducts a higher level of review. Deaths that involve use of restraint or are related to psychotropic medication or suicide are reviewed by the Division of Long Term Care's Death Review Committee. This committee was established by the legislature in Section 46.60 (5)(a), 50.035 (5) and 51.64 (2) of the Wisconsin statutes. At the discretion of the BCS director, suspicious deaths may also be taken to the Committee for Review of Residential Deaths, a standing committee that reviews deaths in state institutions.

All incidents are evaluated and summarized. If a waiver agency's submission of an IR indicates a pattern, or potentially preventable incidents are identified, recommendations are made for the program manager and Children's Services Specialists to take actions to decrease the number of incidents. A summary of these results is compiled on an annual basis and is part of public reporting.

In addition, any concerned individual can report suspected abuse or neglect directly to the human services agency's Child Protective Services (CPS) agency or law enforcement agency. Those individuals whose employment brings them into contact with children are mandated reporters and are required by law to report any suspected abuse or neglect or threatened abuse or neglect to a child seen in the course of their professional duties. Reports made to law enforcement agencies must be referred to the CPS agency within 12 hours of receipt. All cases of suspected sexual abuse of a child must be reported by the CPS agency to a law enforcement agency within 12 hours of receipt. Child Protective Service agencies are required to report all investigations of reported abuse and /or neglect using the Wisconsin Statewide Automated Child Welfare Information System (WiSACWIS).

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.

The Bureau of Children's Services has developed an Incident Reporting overview document that is issued to county waiver agencies and provider agencies for informing participants, families, caregivers, and providers. This document includes the definition, reporting, and evaluation requirements of incidents in the CLTS Waiver Program. County waiver agencies must provide and review this information with families during initial application and annually at recertification.

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.

County waiver agency Support and Service Coordinators (SSC) must address and resolve situations and implement systems to decrease the likelihood of a recurrence of an incident. The Department of Health Services ensures the health, safety and welfare of CLTS Waiver Program participants by following up on each reported an IR as previously noted. The Department shares this responsibility with waiver agencies in the State- Contract by requiring wavier agency compliance with the Home and Community-Based Services Waivers Manual and the CIR process. Chapter 9 of this Manual requires each waiver agency administering any of the waivers to have an adequate system to ensure waiver participants are adequately protected from physical, verbal and sexual abuse, maltreatment, neglect, financial exploitation and violations of their rights under law. Chapter 9 also requires counties to have an effective response system when incidents arise. The Manual also specifies Critical Incident Reporting requirements for waiver agencies. The contract requires waiver agency staff to submit Incident Reports as outlined below.

Immediately upon learning of an allegation of an incident, the service provider determines whether the allegation is credible. If there is reasonable cause to believe that the report may be accurate, the service provider's first responsibility is to take immediate action to protect waiver participants from the potential of harm. In doing this, they should preserve possible evidence for an investigation if one is to be conducted. The provider must notify the Support and Service Coordinator or designated waiver agency staff of the allegation and results of any action taken. Agencies are required to notify local law enforcement authorities in any situation where there is a potential violation of criminal law. Agencies are also required to notify Child Protective Services, if applicable.

The SSC must assure that the parent or legally responsible person is informed of the incident. If an incident is serious or continues to pose a threat to the health, safety or welfare of the child, the SSC must immediately contact the Children's Services Specialist or the Children's Services Section. The waiver agency staff or their agents/contractors who are involved should promptly determine if the incident occurred and if the persons with on-site responsibility have taken the necessary steps to ensure the child's health, safety and welfare as required by the waiver. Waiver agency staff should also determine if the service provider's procedures and responses were adequate. The waiver agency must take action to ensure that any remedial action needed implemented.

If the waiver agency determines that the situation or event occurred, they should next determine if a long-term, substantive response or change is warranted. Waiver agency staff must take all actions necessary to make the changes needed including termination of the provider, substitution of provider, increased supervision, or other action as appropriate. These actions may occur after the initial IR was submitted to DHS, but shall be reported in updates to the initial IR. The waiver agency uses the IR to summarize the details of the incident, the waiver agency response and actions, the participant outcomes, and any remediation. Each incident is reviewed as a test of the adequacy of the waiver agency's response system.

Waiver agency staff sends the completed/closed/final Incident Report Form to the DHS Children's Services Section within 30 days of the incident (or earlier, if warranted). If waiver agency staff are unable to gain access to certain findings or records within the 30-day period due to concurrent investigations or other extenuating circumstances beyond their control, the waiver agency is required to send in all available information, indicating that the report is incomplete, and the target date when the submission of the completed report is anticipated, if that can be predicted. Waiver agencies are responsible for "closing" all critical incident reports. Closing means submitting a report and any necessary updates so that all pertinent information about the event and the response are included in the report. Follow-up visits or future targeted reviews are usually not part of the report unless they occur within a short time frame. Waiver agency staff must complete all other required reporting procedures such as child abuse reporting and the timelines of other required reports remain in force and are not replaced or superseded by this process.

In addition, when known or suspected abuse and/or neglect has been reported to the county department's child protective services (CPS) agency, upon receiving a report, the waiver agency first determines if the information constitutes an allegation of child maltreatment or threatened harm as defined by Wisconsin law. If the report is found to meet the definition of child maltreatment, the CPS worker in the agency must initiate an initial assessment within 24 hours after receipt of the report and complete it within 60 days. Reports that suggest a child is in current or imminent danger receive an immediate response.

The focus of the CPS assessment is to assure child safety and to work with the family to determine whether the child and family are in need of any services. The assessment must be conducted in accordance with the investigation standards established by the Wisconsin Department of Health Services. Established in September of 1994, the Child Protective Service Investigation Standards recognize that the CPS role must differ in cases of familial and non-familial maltreatment.

The Ongoing Child Protective Services Standards and Practice Guidelines are in effect throughout Wisconsin's county welfare Child Protection Services Units. These standards and guidelines direct and support the case management of ongoing services to children and families in cases where children are found to be unsafe or at risk of maltreatment. In Wisconsin, child protective services staff utilize the Wisconsin Model, a specific structure for gathering, organizing and assessing relevant information in Child Protective Services (CPS) cases so it may be used most effectively to make critical decisions.

If the report is accepted by the agency for assessment, a caseworker will assess the situation and work with the family to determine what, if anything must be done to protect the child and help the family. Child welfare services available to help the family and the child include counseling, in-home services, assistance or training in home and financial management, parent education, and self-help groups. In severe situations, it may be necessary to place a child in out-of-home care temporarily. The initial assessment must be conducted in accordance with standards established by the Wisconsin Department of Health Services.

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 DHS Bureau of Children's Services staff reviews all Incident Reports. This review is intended to determine whether:

• The child's health, safety and welfare are now adequately protected;
• The response to the situation and event was reasonable and appropriate;
• The waiver agency's procedures and system for responding to such incidents were adequate;
• The child and family's service plan is adequate;
• Relevant, steps to prevent similar incidents were taken;
• All service providers or staff involved in the incident appear to be adequately trained or that additional training needed is to be provided pursuant to the report; and
• An appropriate DHS response is needed, which may include informal follow up, site visit, formal plan of correction, or a licensing referral.

DHS runs CITR reports on a scheduled basis to identify statewide or regional trends, which allows for the development of training or interventions to decrease the likelihood of recurrence.

Child Protective Services, including reporting, investigation and case management, are also delivered in Wisconsin through a state-supervised, administered system. Alleged child maltreatment is reported to local agencies in the state. Data regarding each report investigated is sent to and compiled by the Department of Children and Families to assist state policy makers, service providers and the public in understanding and effectively responding to trends in maltreatment. A Child Abuse and Neglect report is completed annually and submitted to the Legislature.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DHS allows for the use of restraint, isolation and seclusion in very limited situations. In addition to HCBS Medicaid Waiver requirements, Wisconsin Administrative Code DHS 94.10 states: "Isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s.51.61(1)(i)2., Stats. For a community placement, the use of isolation, seclusion or physical restraint shall be specifically approved by the Department on a case-by-case basis. For those children residing in Foster Care including Level 5 Exceptional Foste Care, Wisconsin Administrative Code outlines licensing requirements and restraint limitations (DCF 56 Adm. Code).

The DHS has multiple approaches to assuring safeguards are in place to prevent the use of unnecessary and/or unauthorized use of restrictive interventions. The DHS reviews a representative sample of waiver applications for restrictions on participant movement, participant access to other individuals, locations or activities, participant rights concerns or aversive methods to modify behavior. All concerns are addressed and resolved prior to approval. Incident reporting is monitored at both the waiver agency and

the DHS for patterns and trends specific to a child or more general that may suggest additional training needs.

County waiver agency Support and Service Coordinators meet with families on a regular basis to identify changing needs of the child, increases in behaviors and methods being used to address significant or challenging behaviors of the child. The waiver agency Support and Service Coordinator provides families with supports to address the needs of the child and assure that least restrictive measures are being utilized. Department regional resources are available to provide additional consultations as needed to assure that children are living and playing in the least restrictive and most integrated settings.

The county waiver agency is responsible to ensure that restrictive measures are used only as a last resort and when there is imminent danger present. The county's Support and Service Coordinators may contact their assigned Children's Services Specialist to discuss the situation and to review alternative ways to handle the child to avoid the use of restrictive measures.

When DHS becomes aware of a child with behavioral needs, it is recommended that a behavioral specialist provide an assessment and consultation for the child, the family, and the service provider to address how to handle these behavioral needs without the use of restrictive measures. A behavior support plan is typically written at this time, addressing the behavior and the methods that will be implemented to address them, as well as the training for the staff and parents and how the waiver agency will monitor this plan.

Documentation for the use of behavioral restrictive measures includes the behavior support plan, the behavior intervention plan, and the documentation sheets for tracking such. Additionally, the Incident Report form is submitted by the waiver agency to DHS via the Children's Incident Tracking and Reporting system for each use of a restrictive measure prior to its approval through the restrictive measure application process. Also a part of this is the documentation and evidence of alternatives that have been used with the child, and what preventative methods are used to avoid the use of a restrictive measure.

There are a variety of training courses available to be utilized for restrictive measures purposes (such as Crisis Prevention Institute: Non-violent Crisis Intervention, Managing Threatening Confrontations, Handle with Care, The Mandt System, and Safety Care).

All individuals who are trainers have certifications that reflect that they have met the requirements to be a trainer for this course. The State is familiar with the training courses used most often by waiver agencies and have found they meet the training standards. If a training program's quality in meeting the provider service standards is brought to the State's attention, the program is audited to assure it does meet the State's expectations.

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:

The DHS reviews new waiver applications, which includes identification of potential restrictive measures, when applicable. A CLTS Waiver Program application includes an ISP and either a separate waiver assessment document, or comprehensive assessment notes in the online Functional Screen. When the Children's Services Specialist reviews these items as part of the plan approval process, there may be references to methods or devices currently being used with the child that may meet the definition of a restrictive measure. In this case, the CSS follows up with the waiver agency to determine if it is a restrictive measure, to discuss other strategies for addressing the child's needs, and to identify how the issue is best addressed. DHS follows up on all concerns and if appropriate requires that an application for the use of a restrictive measure and behavioral support plan be submitted prior to the application being approved. The plan is not approved until these concerns have been resolved.

Incident Reports are reviewed for potential unauthorized use of restrictive measures and followed up on with the waiver agency service coordinator. The DHS has regional capacity teams (Community Behavioral Support Teams) which consist of a psychologist and nurse that are available to provide

individual consultation to families and counties, in addition to the Children's Services Specialists who are based in the regions to work with families to address challenging behaviors and reduce the potential use of restrictive measures.

When a Community Behavioral Support Team determines that there is a need for a restrictive measure, the application is submitted to the waiver agency director or designee for review. Once approved by the waiver agency director, the application with proposed restrictive measures is forwarded to the DHS for review.

The DHS conducts a panel review of all applications requesting the use of restraint, isolation or seclusion. Reviewers include a representative from the Children's Services Section and others from the Department with expertise related to the nature of the application. There are a minimum of three reviewers for each application. A representative from the Department of Children and Families jointly reviews each application if the child is in an out-of-home placement. A written letter of approval or denial is issued. All approved restrictive measures applications include the ability to demonstrate that there is adequate staff training, that less restrictive measures have been exhausted, and that the Department will be notified if the approved approaches are not effective. All approvals are time limited and include parameters requiring elimination of the need for a restrictive measure.

The Support and Service Coordinator monitors the use of the restrictive measure, assures the plan is being implemented appropriately and monitors effectiveness as well as assures training requirements are being maintained. Incident Reports are required if the use of a restrictive measure results in injury. This situation results in a target review; that is, a face-to-face contact with the child, family, provider and waiver agency service coordinator.

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.

DHS allows for the use of restraint, isolation and seclusion in very limited situations. In addition to HCBS Medicaid Waiver requirements, Wisconsin Administrative Code DHS 94.10 states: "Isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s.51.61(1)(i)2., Stats. For a community placement, the use of isolation, seclusion or physical restraint shall be specifically approved by the Department on a case-by-case basis. For those children residing in Foster Care or Treatment Foster Care, Wisconsin Administrative Code outlines licensing requirements and restraint limitations (DCF 56 Adm. Code and DCF 38 Adm. Code, respectively).

The DHS has multiple approaches to assuring safeguards are in place to prevent the use of unnecessary and/or unauthorized use of restrictive interventions. The DHS reviews a representative sample of waiver

applications for restrictions on participant movement, participant access to other individuals, locations or activities, participant rights concerns or aversive methods to modify behavior. All concerns are addressed and resolved prior to approval. Incident reporting is monitored at both the waiver agency and the DHS for patterns and trends specific to a child or more general that may suggest additional training needs.

County waiver agency Support and Service Coordinators meet with families on a regular basis to identify changing needs of the child, increases in behaviors and methods being used to address significant or challenging behaviors of the child. The waiver agency Support and Service Coordinator provides families with supports to address the needs of the child and assure that least restrictive measures are being utilized. Department regional resources are available to provide additional consultations as needed to assure that children are living and playing in the least restrictive and most integrated settings.

The county waiver agency is responsible to ensure that restrictive measures are used only as a last resort and when there is imminent danger present. The county's Support and Service Coordinators may contact their assigned Children's Services Specialist to discuss the situation and to review alternative ways to handle the child to avoid the use of restrictive measures.

When DHS becomes aware of a child with behavioral needs, it is recommended that a behavioral specialist provide an assessment and consultation for the child, the family, and the service provider to address how to handle these behavioral needs without the use of restrictive measures. A behavior support plan is typically written at this time, addressing the behavior and the methods that will be implemented to address them, as well as the training for the staff and parents and how the waiver agency will monitor this plan.

Documentation for the use of behavioral restrictive measures includes the behavior support plan, the behavior intervention plan, and the documentation sheets for tracking such. Additionally, the Incident Report form is submitted by the waiver agency to DHS via the Children's Incident Tracking and Reporting system for each use of a restrictive measure prior to its approval through the restrictive measure application process. Also a part of this is the documentation and evidence of alternatives that have been used with the child, and what preventative methods are used to avoid the use of a restrictive measure.

There are a variety of training courses available to be utilized for restrictive measures purposes (such as Crisis Prevention Institute: Non-violent Crisis Intervention, Managing Threatening Confrontations, Handle with Care, The Mandt System, and Safety Care).

All individuals who are trainers have certifications that reflect that they have met the requirements to be a trainer for this course. The State is familiar with the training courses used most often by waiver agencies and have found they meet the training standards. If a training program's quality in meeting the provider service standards is brought to the State's attention, the program is audited to assure it does meet the State's expectations.

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:

DHS assigned Children's Services Specialists review applications for the use of restrictive measures. A written letter of approval or denial is issued. All approvals are time-limited, and require data collection and updates. Applications and implementation of restrictive measures are reviewed at least annually and more frequently for very restrictive measures. Unauthorized use of restrictive interventions is identified through monitoring by the waiver agency. The Children's Services Staff review all restrictive measure applications, monitor critical incident reporting and conduct random face-to-face waiver reviews.

DHS uses incident reports and the onsite record reviews as methods for detection of unauthorized, overuse, or inappropriate use of restraint or seclusion, and to ensure that all applicable state requirements are followed. In addition, as described above in the response to G-2-a, situations may also be identified during initial plan review or when a waiver agency contacts their Children's Services Specialist directly to discuss concerns about a specific child.

If unauthorized, overuse, or inappropriate use of restraint or seclusion is detected, the CSS follows up with the waiver agency to determine if it is a restrictive measure, to discuss other strategies for addressing the child's needs, and to identify how the issue is best addressed. This may result in the need for a behavior support plan and an application for the use of restrictive measures. If the waiver agency has a pattern of unauthorized overuse or inappropriate use of restraints or seclusion, the Department issues a request for corrective action plan.

The waiver agency has 14 to 30 days to address any misuse of restrictive measures. The correction may be to discontinue the use of the restrictive measure, or to submit a restrictive measure application for review and approval. DHS notifies the waiver agency verbally of the timeline for correction, and the situation is monitored by the state restrictive measures lead. The restrictive measures lead tracks all instances of unauthorized, overuse, or inappropriate use of restraint and seclusion to determine if any trends exist.

The State currently reviews CLTS Waiver Program applications to verify that all assurances are met. The intention is to review at least a representative sample (with a +/- 5% confidence interval) of new CLTS Waiver Program applications picked at random throughout each calendar year of participants enrolled for at least 90 days. If any indication of the use of a restrictive measure is discovered during this review, the Children's Services Specialist assigned follows up with the waiver agency. In addition, 100 percent of all incident reports are reviewed by DHS CSS staff, and again, if there is any indication of use of a restrictive measure or restraint, it is followed up on with the waiver agency.

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 below applies to restraints, restrictive measures, and seclusion.

Each application for a restraint/seclusion must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request for the restrictive measure. (References: Guidelines and Requirements for the Use of Restrictive Measures, pp.1-5; Application form – DHS F-00926, pp.5-6). Any use of seclusion that is not within the scope of the state Guidelines and Requirements is prohibited under any circumstance.

Unauthorized and /or emergency use of restraints/seclusion is to be reported as an incident by any person who observes such use or to whom such use is reported by the participant. Any report is to be investigated as a member incident.

Review and approval of restraints/seclusion requests is conducted by the SMA's Division of Long Term Care's Behavior Intervention Oversight Committee and/or the Division of Quality Assurance's, Waivers, Approvals, Variances, Exceptions (WAVE) Committee depending on the target group and type of residence (regulated vs. unregulated) of the respective member. Each committee includes a representative from the SMA (References: Section 6 Guidelines and Requirements for the Use of Restrictive Measures outlines the criteria for the approval process; WAVE memo 13-016). Each restrictive measures committee reviews and approves each request prior to submission for state level review and approval.

For CLTS Waiver Program participants who reside in their own homes or in any unregulated facility, restraint/seclusion are first reviewed and approved by the respective waiver agency. Upon approval, the waiver agency submits the application to the SMA. A collaborative review and approval is completed by the SMA Behavior Specialist and the respective Oversight Team.

Documentation requirements related to restraint/seclusion use are specified in the Guidelines and Requirements for the Use of Restrictive Measures. Each restraint/seclusion application must specify the monitoring and documentation plan.

Providers are required to report use of restraint/seclusion to the applicable waiver agency according to the "individualized protocol for provider reporting" as approved in the application.
Monthly each waiver agency reports 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 Department, a restrictive measures training expert and/or designated competent waiver agency staff.
Restraints/seclusion may be approved for less than but no more than one year; a renewal request and review and approval is required.

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

On a monthly basis, the DHS Oversight Team will collect data on approved restrictive measures from each waiver agency in a standardized file format, and load this data into a data warehouse environment. The BCS will extract aggregated data from this environment for analysis, tracking, and trending to identify potential patterns and outcomes, for monitoring and possible quality improvement efforts.

Each DHS Oversight Team is responsible for review of their respective waiver agency monthly incident and restrictive measures data reports; for monitoring restraint/seclusion trends and requests and the use and effectiveness of approved restraints/seclusion. Minimum follow-up consists of review of the report with the waiver agency. Additional follow-up may include, but is not limited to, examination of individual participant data (as provided in the waiver agency monthly report) and/or individual member record reviews depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the DHS Oversight Team are documented.

Potential patterns concerning the unauthorized use of restraints associated with certain providers will be obtainable via analysis of the incident management system data. Unauthorized use of restraints (any type) or isolation/seclusion is captured as a member incident within the Incident Management System.

Use of approved restrictive measures is monitored and accounted for by each waiver agency restrictive measures lead. Thus, it could be readily assessed if restraints in use have not been approved. In the context of child-centered care, waiver agency staff oversight includes ongoing risk assessment and harm reduction management. If there are any concerns, waiver agency staff will increase monitoring of the child or situation which could be as frequent as daily child contact.

Participant record reviews could include the child's person-centered plan and approved restrictive measures plan, as well as waiver agency tracking data concerning behavioral incidents, antecedent behavior tracking, and use of the restrictive measure(s), and related training documentation. The SMA

would also review any appeal and grievance issues related to a restrictive measure.

During the annual review process, the waiver agency's restrictive measures tracking tool is reviewed to ensure timeliness of initial approval and annual renewal. If the review discovery leads to out-of-compliance timelines for initial or annual renewal approval ,remediation of identified individual or systems issues takes place with follow-up by the SMA Oversight Team. It may or may not need a corrective action plan, but the SMA Oversight Team would follow up in their regular meetings with the waiver agency.

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 Support and Service Coordinator, under the supervision of the county waiver agency's supervisor, is responsible for assessment of each child's strengths and needs and the services and supports that are needed to assure that the supports and services on the Individual Service Plan will address these needs and assure health, safety and welfare. This includes an assessment of the child's health and healthcare needs, including medication administration. If the child or young adult is in an out-of-home setting permitted under the CLTS Waiver Program, a comprehensive plan to address these needs is developed. The administration of medication is defined under Adult Family Home and Children's Foster Care regulations found respectively in Wisconsin Administrative Code DHS ch.88 and DCF ch. 57.

ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The majority of children who are enrolled in the CLTS Waiver Program reside with their parents who are responsible for the management of their children's medication management and are not under the jurisdiction of the Department or the county waiver agency.

In circumstances where children reside in regulated settings such as Adult Family Home (youth age 18 through 21) or Foster Care settings the county waiver agency is responsible for assessing each child for his or her healthcare needs, including medication administration. If the child is in an out-of-home regulated setting, a comprehensive plan to address these needs is developed including medication administration plan. The administration of medication is regulated under Adult Family Home and Foster Settings license or certification regulations. The administration of medication is defined under Adult Family Home and Children's Foster Care regulations found respectively in Wisconsin Administrative Code DCF ch. 88 and DCF ch. 57

The CLTS Waiver Program permits two types of residential settings other than the child and family's home. These settings are Adult Family Home and Children's Foster Care. Adult Family Home settings are licensed facilities under Wisconsin Administrative Code DHS ch. 88 and Children's Foster Care is defined under Wisconsin Administrative Code DCF ch. 57. Medication Administration is regulated under these codes for

individuals within these settings. Both codes define safety standards for administration, storage and disposal of all medications within the setting. Both standards define the required training and documentation associated with medication, including medication refusal. A licensee or service provider must have a written order from a physician and a properly labeled prescription, including the dosage, prior to dispensing medication. If the medication prescribed is given on an as-needed basis, then a clear definition of the circumstances under which the medication is to be administered must be provided as well. Staff administering medications must receive training related to medication administration specific to the child or young adult. The type of services provided and the capability of the staff that will be providing the service will determine the amount of that specific training. The training must be sufficient to assure the health and safety of the child or young adult. Medication errors such as a missed dose or wrong medication must be documented and if the error resulted in an adverse event, it must be reported as an incident. Children's Services Specialists follow up on each Critical Incident Report.

The DHS Division of Quality Assurance, Wisconsin's designated State Survey Agency, and the Department of Children and Families, report any findings related to health and safety that are discovered in out-of-home settings that include a CLTS Waiver Program participant. Medication errors such as a missed dose, or wrong medication must be documented and if the error resulted in an adverse event, it must be reported as an incident on the Incident Report form. DHS Children's Services Specialists review all of the incident reports to ensure that appropriate steps are taken to prevent future errors or complications.

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).

The administration of medication is defined under Adult Family Home and is monitored by the Division of Quality Assurance (DQA), the designated State Survey Agency. The Division of Quality Assurance surveys all Adult Family Homes and as part of the survey process, verifies that medications issued by unlicensed personnel are appropriately trained. The requirements for medication administration by unlicensed assistive personnel are posted at: http://www.dhs.wisconsin.gov/rl_dsl/Publications/pdfmemos/04-004at.pdf

DQA also has a registered pharmacist on staff who delivers medication administration training to providers on a regular basis, and issues a monthly newsletter, which can be accessed at: https://www.dhs.wisconsin.gov/dqa/memos/pharm-capsule.htm

The Department of Children and Families administer the regulations for licensed foster care providers. DHS does not have specific training requirements for medication administration by these providers who are licensed foster-care providers.

A service provider must have a written order from a physician and a properly labeled prescription, including the dosage, prior to dispensing medication. If the medication prescribed is given on an as-needed basis, then a clear definition of the circumstances under which the medication is to be administered must be provided as well. Staff administering medications must receive training related to medication administration specific to the child or adult. The type of services provided and the capability of the staff that will be providing the service will determine the amount of that specific training. The training must be sufficient to assure the health

and safety of the child or adult. Medication errors such as a missed dose, or wrong medication must be documented and if the error resulted in an adverse event, it must be reported as an incident. DHS Children's Services Specialists follow up on each Critical Incident Report.

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:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the State:

◉ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

Medication errors such as a missed dose or wrong medication must be documented and if this results in an adverse event, must be reported as an incident on the Incident Report form. Agencies providing these services are reviewed by the waiver agency on at least an annual basis and more frequently if non-compliance has been identified in any area. The identification of potentially harmful practices is reviewed during this process. The State agencies provide ongoing oversight of these practices and intervene if a pattern of error is discovered.

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.

Representative samples of the CLTS Waiver Program applications are reviewed by the DHS external quality review organization, in consort with the Bureau's Children's Services Specialist staff. This includes a review of all medications taken by the child. The narrative assessment and the Individual Support Plan must address the management of medications for the individual child including the administration of medications by providers other than the child's family. The DHS Division of Quality Assurance and the Department of Children and Families report any findings related to health and safety that are found in out-of-home settings that include a CLTS Waiver Program participant. Medication errors such as a missed dose, or wrong medication must be documented and if the error resulted in an adverse event, it must be reported as an incident. Children's Services Specialist reviews all of the IR reports to ensure that appropriate steps are taken to prevent future error and complications.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent 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:
Reports of abuse, neglect and exploitation are remediated to assure the health, safety and wellbeing of the participant. Numerator = number of reports of abuse, neglect and exploitations for which remediation occurred to assure health, safety and wellbeing. Denominator = number of all incidents of abuse, neglect and/or exploitation reported.

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

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

	Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Children's Incident Tracking and Reporting system, upon implementation (targeted for 2nd quarter 2017)

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:

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:
Percent of critical incident reports that indicated that the incident was addressed in a manner that ensures the health and safety of the participant. Numerator = number of critical incidents reported in which the incident was addressed in a manner that ensures the health and safety of the participant. Denominator = total number of critical incidents reported.

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

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

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Children's Incident Tracking and Reporting system, upon implementation (targeted for 2nd quarter 2017)

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:

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 approved restrictive measures are reviewed annually and meet WI Restrictive Measures policies and protocols. Numerator = the percent of restrictive measures recertifications submitted to DHS in timely manner, according to WI Restrictive Measures protocol. Denominator = the percent of restrictive measures recertifications submitted which meet the requirements and are approved by DHS.

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

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

		☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Other
If 'Other' is selected, specify:
Children's Incident Tracking and Reporting system, upon implementation (targeted 2nd quarter 2017)

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:

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:
Parents or guardians are educated on the importance of an annual well visit with their primary care provider. Numerator = number of participant records reviewed that document parents or guardians were educated on the importance of an annual well visit with their primary care provider. Denominator = total number of participant records reviewed.

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):*
	☐ **Weekly**	☐ **100% Review**

☑ **State Medicaid Agency**		
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **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.
Strategies for discovering issues pertaining to the health, safety, and welfare of CLTS Waiver Program participants include the review of the participants' records, complaints, incident reporting, and restrictive

measures applications. Incidents, including those that involve the death of a participant, are initially reported to the county waiver agency and then submitted to DHS for review and remediation. All deaths are reported to the county waiver agency and subsequently submitted to the Department. Reports of death are also tracked via CLTS Waiver Program disenrollment data. Wisconsin has a statewide policy on restrictive measures and uses a centralized process for reviewing and approving restrictive measures applications. Any medication errors reported through the incident reporting process will be monitored and trended during review of reports and analysis of data. The BCS Children's Services Specialist review the critical incident and death reports on an on-going basis.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The county waiver agency is responsible for addressing individual issues related to the health, safety, and welfare of each CLTS Waiver participant. The support and service coordinator works with the appropriate agencies and officials, such as child protective services and law enforcement, to ensure appropriate and timely remediation occurs and to provide follow-up as needed. Incidents are currently tracked in the CLTS enrolment database for DHS to track the timeliness of the response, remediation and closure of the incident report. Dates include when the incident was discovered, when it was reported by the waiver agency to DHS, the alleged perpetrator, and when the incident was closed. As described in the associated Performance Measures, incident details are also regularly reviewed during the CLTS record review process and details regarding the waiver agency's response to the incident are tracked during that process. The State's role is to ensure that waiver agencies comply with all existing policies related to reporting incidents and that waiver agencies take all necessary steps to immediately respond to the incident prevent a reoccurrence of the incident. The BCS staff reviews the incident reporting data on a quarterly basis to monitor for any trends that might indicate a systems level issue. If a systemic issue is identified, then appropriate corrective action plan improvements are required. Issues or concerns related to restrictive measures may be discovered through various means and are documented accordingly. The BCS program integrity section compiles all data related to incidents and restrictive measures to monitor for trends.

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 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.

DHS is developing a web-based Children's Incident Tracking and Reporting (CITR) system to create a centralized process for county waiver agencies to submit reports to the Department of incidents of abuse, neglect, exploitation and unexplained death of CLTS waiver participants. This system will improve the county waiver agencies' ability to report, track, remediate and finalize incident reports for participants. DHS will use the system to monitor, track and ensure incidents reports have been remediated, to assure the health and safety and welfare of CLTS waiver participants.

The web-based CITR system will permit county waiver agencies to submit incident reports to the Department, track their timeliness, and any changes to the status of the report, The Department's development of the CITR system is to demonstrated it has designed and implemented an effective system for assuring the health and welfare of CLTS waiver participants on an ongoing basis, and that it has effectively resolved and prevented future instances of abuse, neglect, exploitation and unexplained death, to the extent possible.

County waiver agencies are responsible to report and remediate incidents of abuse, neglect, exploitation and unexplained death for CLTS waiver participants to DHS within required timeframes. The incident reports must contain the required information and demonstrate actions to both resolve the current incident and that seek to prevent further similar incidents in the future to the extent possible.

The CITR system replaces an existing manual paper incident reporting process and will improve the Department's ability to monitor and track incident reports and trends, and more easily meet state and federal reporting requirements. The CITR system will also provide DHS with to data to track that county waiver agencies have effectively resolved CLTS incidents and are taking required actions to prevent further incidents from occurring to other children, to the extent possible;

The CITR system is targeted for full implementation during the 2nd quarter 2017.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The CLTS Waiver Program's Quality Improvement System (QIS) is designed to ensure that children with long-term support needs receive the appropriate services and supports to meet their assessed needs along with the home and community needs of their family, and desired outcomes. This is achieved by developing various quality improvement strategies to ensure the CLTS Waiver Program's policies and procedures are properly administered and implemented on a statewide basis.

The scope of the QIS includes the statewide implementation of the CLTS Waiver Program through county waiver agencies that have been delegated by the Department of Health Services and mandated by Wisconsin's Legislature, under state statutes, to operate the program. The QIS includes close oversight of the Department's delegated functions to the county waiver agencies, in addition to the oversight of other program-related functions, such as the utilization of the web-based CLTS Functional Screen (CLTS FS) used by trained and certified screening staff employed by county waiver agencies to determine the child's functional eligibility and appropriate level of care. Other functions within the QIS scope include the review children's timely CLTS Waiver Program enrollment, review of Individual Service Plans, and encounter-level claims data on allowable CLTS waiver services, and assurance that the services are delivered by screened and qualified providers.

The Department uses a variety of methods and processes for trending, prioritizing and implementing system improvements. Trends will be identified over time through consistent data collection, monitoring activities and program evaluation. Priorities for systems level improvements are determined based on multiple factors, including input from various stakeholder groups, other Wisconsin policy-makers such as the Governor and the Legislature. The expectations of CMS, DHS and the Bureau ultimately determine the priorities for systems improvements. Participant health, safety and welfare is a critical area and given high priority based on the extent that significant improvement can be achieved and sustained over time. Ensuring children and families have the information for making informed choices and having access to necessary supports and services, and maintaining cost-neutrality are other priority areas for the CLTS Waiver Program.

The DHS Bureau of Children Services (BCS) provides the administrative oversight for the CLTS Waiver Program. The BCS management team, including the program integrity section is responsible for the

implementation of the QIS. This includes the development of an annual quality work plan that outlines quality improvement activities to be implemented, identifies priorities, and provides oversight to the quality assurance and improvement activities, ensures appropriate data and reporting trend and analysis, and presents recommendations for system improvement activities for management decision-making.

BCS has developed a revised CLTS Waiver Program record review process that will be utilized in 2017. The record review tool has been revised to reflect updated federal performance measures and expectations, and is being assessed during its utilization to track the results. Data collected during the 2017 record reviews will be reviewed and analyzed, and its efficacy will be known by mid-2018.

Record reviews in 2017 will be completed on a representative sample of waiver participant records, with a 95 percent level of confidence, +/- 5% margin of error and a 50/50 distribution. The results will be evaluated in subsequent waiver years and the distribution level may be adjusted in consultation with CMS if appropriate. The record reviews will be conducted using a tool that incorporates criteria related to the performance measures defined in this application and take place on-site at county waiver agencies throughout the calendar year. The onsite record review process will be complemented by producing regular program data reports available via the Department's systems.

Data collection and reporting mechanisms related to performance measures are used to monitor and ensure compliance with waiver policies, processes and requirements within the six assurance areas defined by CMS. The performance measures are defined in this renewal application and also serve to ensure the county waiver agencies' program operations meet the Department's expectations, and therefore also ensure administrative oversight. These performance measures and reporting mechanisms will be in place and operational within the first quarter of 2017. Once fully in place, BCS will create a quality dashboard report using the performance measures to provide a monitoring and trending mechanism . Additionally, other reporting strategies will be used for quality monitoring such as data to identify over- and under-utilization of waiver services, CLTS FS data, incident reporting, restrictive measures applications and fair hearing data.

The Bureau's Program Relations and Operation's Children's Services Specialist (CSS) staff are assigned to specific regions within Wisconsin and provide ongoing technical assistance, training and quality assurance activities for the county waiver agencies. The Bureau uses a SharePoint site to track any corrective action plans (CAPs) and remediation compliance with all aspects of the CLTS Waiver Program. The CSS provide technical assistance or follow-up training to the county waiver agencies and assist in documenting remediation activities. When trends or individual participant issues are discovered during this process, they are reported to the BCS program integrity section for determination of further corrective actions or sanctions.

The DHS contracts with an External Quality Review Organization (EQRO) which is responsible for carrying out the CLTS Waiver Program's record reviews process. The EQRO conducts the on-site county waiver agencies' participant record reviews and reports all findings to DHS. The Bureau of Children Services provides oversight to county waiver agencies in addressing the issues that were discovered, providing follow-up to ensure that appropriate remediation occurs, and participating in the implementation of quality improvement activities as needed.

The BCS management team meets regularly to review and update the annual QIS work plan, as necessary. The BCS management team will be meeting quarterly to review the quality dashboard report. When trends are identified that indicate a quality concern, further analysis may be conducted to more clearly define the root cause issue and identify the system improvements needed. Methods for further analysis may include conducting targeted reviews, cause and affect diagramming, process mapping or flow-charting and failure mode and effects analysis. Results of analysis and recommendations for improvement are used to establish priorities for systems improvement. The results of systemic changes will be evaluated based on the quantitative data available that can demonstrate the effectiveness of change.

BCS management team meeting occur weekly to establish priorities and monitor progress related to the CLTS Waiver Program systems and procedures. Information and reports regularly reviewed within BCS include: wait list and enrollment/disenrollment data, quality dashboard/performance measures; incident reporting and mortality review; restrictive measures applications; waiver service utilization data and trends; appeals and fair hearing decisions, record review and audit findings, results of any corrective actions in place; policies and procedures; and recommendations from stakeholders.

The CLTS Council consists of members appointed by the DHS Secretary. It meets quarterly and quality reports are routinely shared with the CLTS Council. The membership consists of representatives from DHS and other statewide departments, advocacy organizations, county waiver agencies, participants' parents/guardians, and service providers. Meetings are open to the public, and public input is one method for establishing priorities. The Council provides DHS/BCS with input, feedback and recommendations to improve the CLTS Waiver Program service delivery. Information shared with committee members include progress updates on implementation and analysis of quality improvement activities. The Council's recommendations and feedback provided during these meetings are used by the Bureau in making policy and system improvements and priority setting.

Another advisory group, the Autism Council, is comprised of Governor-appointed members and provides input and guidance to DHS/BLTS. This council is specifically focused on the issues facing families of children with a diagnosis of Autism Spectrum Disorder. Members of the group include representatives from DHS, county waiver agencies, autism advocacy groups, autism researchers and autism service providers. During the 2016 transition of the CLTS Waiver coverage of autism treatment services to a covered ForwardHealth Behavioral Treatment Benefit, the Autism Council provided DHS with valuable input and recommendations to regarding the waiver supports and services that were still needed by children diagnosed with autism spectrum disorder.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Quality Improvement Committee**	☑ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The CLTS Waiver Program accomplishes Continuous Quality Improvement (CQI) utilizing the "Design-Discovery-Remediation-Improvement" (DDRI) methodology to structure implementation (strategize), monitor progress, evaluate effectiveness of change, and determine if any additional changes or modifications are needed. The BCS quality management team manages and coordinates the implementation of systems improvement. Depending on the nature of the systems issue, improvement processes may include: process or performance improvement projects; development and implementation of training/education and technical assistance; development and implementation of additional resources for CLTS Waiver Program participants and families; corrective action plans that require larger system changes (e.g., agency infrastructure, roles/responsibilities of staff resources, significant process changes); modification of existing data collection and reporting mechanisms or development of new mechanisms; or modification of existing policies and procedures or development of new ones to address additional program needs.

As system changes are completed, the BCS management team will oversee the collection of data and reports from the new systems. The data analyst is responsible for the development, coordination, and implementation of the various reporting mechanisms to obtain data related to performance measures and other monitoring activities. The data analyst aggregates data, conducts analysis of data, and generates the quality dashboard report.

The program integrity section manager will document any system change activities in a report or summary format that can be shared and distributed as appropriate within DHS and to other stakeholders as needed or required depending on the nature of the change. This report will include a description of the issue, the desired change to be made, what steps or activities were implemented to achieve desired change, any indicators and measures related to activity, a summary of findings and conclusions drawn as a result.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The QIS is designed based upon current processes implemented during the initial waiver application and includes modifications to data collection and reporting mechanisms, incorporation of performance measures for each of the six assurance areas, and implementing strategies for more structured quality assurance and improvement activities. The QM team plans to conduct an initial evaluation after the first year of implementation, December 2017, to assess the current structure and processes in place for efficacy, and make modifications as needed.

After three years of implementation, the BCS quality management team will conduct a more thorough evaluation of its QIS and summarize achievement of quality improvement efforts to demonstrate the strengths of the current system, identify challenges and barriers, and determine what additional changes need to be made to improve its effectiveness. Program evaluation methodology will include summary of findings from performance measures and quality improvement activities that are implemented within the timeframes: January through December 2017, and January 2017-2021.

The BCS program integrity section is responsible for evaluating the impact and effectiveness of system design changes. Whenever feasible, indicators for improvement will be defined with corresponding measures and incorporated into the DDRI methodology so that the evaluation is built into the process up front. If the systems change relates to one of the six quality assurance areas and related performance measures, the performance measures will be trended over time to demonstrate if change resulted in improvement. Other methods may be used depending on the improvement activity. For example, if training and technical assistance (TA) is the improvement activity, then a process will be developed to measure the impact of training or TA, such as a pre-test/post-test.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Health Service (DHS) ensures the financial integrity of payments that have been issued for CLTS waiver services. The Division of Long Term Care's (DLTC) Bureau of Long Term Care Finance (BLTCF), the Bureau Children Services (BCS), the Office of Inspector General's (OIG) Audit Section, and the Bureau of Fiscal Services (BFS) each have responsibilities in monitoring key aspects of financial accountability. These functions are described below.

DHS currently contracts with a third-party administrator to process authorized CLTS Waiver service claims. BFM provides oversight of the service utilization data reporting to DHS by the CLTS Waiver's third-party claims administrator, Wisconsin Physicians Service (WPS). Service utilization data details are submitted to the Department through the encounter data reporting system. WPS is the exclusive submitter of data to this system related to the CLTS Waiver Program. The encounter data system collects data submitted electronically through a standard .xml file format. The data is reconciled and certified by staff at WPS before data is transmitted to DHS.

The Department's third-party administration (TPA) claims process operates as follows. Waiver agencies prepare participant Individualized Service Plans (ISPs) and authorize services for children based on their needs. This includes claims for support and service coordination from county waiver agencies. Service authorizations are transmitted to both the service provider and the TPA vendor, WPS. The provider delivers the authorized service and submits claims to

private health insurance, as appropriate, before submitting a claim to the TPA. The TPA is contractually obligated to ensure coordination of benefits (COB). After ensuring COB, the TPA processes claims with the corresponding authorizations. The TPA invoices the Department daily. The Department reviews and approves or denies the daily invoice. If approved, the provider receives payment. If denied, the TPA reviews and resubmits the corrected invoice to the Department.

Both the county waiver agency and the Department conduct CLTS Waiver Program fiscal reconciliations. County waiver agencies utilizes the Community Aids Reporting System (CARS), which contains their State contract funding data, the encounter data, and the participant ISP to ensure claims paid match the claims authorized. Any variances must be clarified between the source documents referenced above with the TPA. If a claim was paid in incorrectly, the waiver agencies must request a refund through the TPA. County waiver agency reconciliation is an ongoing protocol embedded in the reconciliation process.

Using encounter data and the daily invoices, Department Division of Enterprise Services/Bureau of Long Term Care Finance (BLTCF) staff verifies that the amount paid from the bank account match the claims submitted. BLTCF also reconciles the receivables account, including cross-referencing encounter data with reports from the TPA and bank account balances. Any variances must be clarified with the TPA and if a payment was not appropriate, the Department must request a refund from or through the TPA. BLTCF reconciliation is completed monthly when bank statements arrive. Finally, DMS/BLTCF conducts a final reconciliation process, which is used to ensure that participants were eligible for Waiver services when they received them and that the appropriate funding source is applied to the appropriate services. BFM's reconciliation process occurs annually, after the end of the calendar year. County waiver agencies are responsible for verifying that BLTCF reconciliation is correct.

The county waiver agency conducts a reconciliation of claim processing and their authorization system. Issues with individual claims submissions to the encounter system must be corrected through a reversal process or through BLTCF directly. The reversal process involves waiver agency submitting documentation to reverse the suspended claim and then process the revised claim. The second method requires documentation to the original claim. This method is used when the service was appropriate for the participant, but there was a coding error. WPS has established edits to detect prescribed coding logic. In addition, there could be instances of reversing the claim would require a provider to refund the waiver. In order to avoid that, the State has an edit file that corrects errors during the monthly reconciliation process. The second method is used when, for example, a waiver agency erroneously bills the wrong waiver.

The DLTC IT Unit administers the WPS' contract. WPS submits their contract invoices for administrative services to BCS, based on an enrollment per member per month expense. Administrative services refer to the service the TPA vendor performs on behalf of the Department (i.e. the TPA's cost for processing claims). These costs are not participant waiver service costs. These invoices are verified by BCS for accuracy and are then submitted to BLTCF for payment processing. The BCS verification process includes ensuring the number of participants with claims is not greater than the number of enrolled participants, than the total claim amount does not exceed the anticipated claim amount, and that no unauthorized provider is paid. WPS, the Department's TPA claims vendor, processes the checks or electronic funds transfers and mails them to the rendering providers or deposits them in the providers' supplied account.

The final verification is completed by submitting the approved invoice through the DES Bureau of Fiscal Services, which is the entity that issues the payment. Department staff releases funds to WPS to pay claims only after Department fiscal staff review the claims submission. Funds are released to WPS on a "just in time" basis based on the actual claims expenditures. Any discovered anomaly maybe addressed through a monthly reconciliation process.

The Department's Division of Enterprise Services (DES) ensures county waiver agencies to have a contracted independent CPA firm perform the single audits. The CPA firm conducts an audit of waiver agency operations, following the procedures provided in the State Single Audit Guidelines, which are written and approved each year by the Children's Services Section. These guidelines include requirements for ensuring participants were eligible at time of service, only qualified providers were used, and audits of waiver agency vendors.

The DHS contract with WPS requires the WPS support and maintain internal quality assurance (QA) processes to detect and correct problems in all functional areas, and support and maintain internal quality improvement (QI) processes to detect and prevent quality issues from occurring. DHS staff are assigned to oversee the quality assurance processes and review evidence from these endeavors.

The Bureau of Children Services (BCS) is responsible for contract administration and payment to the TPA for

administrative services. BCS is responsible for ensuring the TPA is in compliance with the contract. BCS is also responsible for assuring that the per member per month (PMPM) administrative charge to the Department from the TPA is appropriate.

The DMS/Bureau of Long Term Care Finance (BLTCF) has day-to-day accountability and integrity roles. BLTCF runs monthly checks of encounter data, including ensuring waiver agencies are properly billing and coding authorizations, based on their contracts, ensuring that participants are eligible for the waiver at the time that services were billed, authorizing the daily invoice from the TPA after verifying payments are correct, and working with the Bureau of Fiscal Services to ensure the bank account reconciliation process is complete. BLTCF also conducts year end waiver agency contract reconciliation, which runs a year end check to ensure that service claims were appropriate, disallowing them if they were not and ensuring the correct funding source was used for participants.

Additionally, outside of DMS, the Division of Enterprise Services (DES) Bureau of Information Technology Services (BITS) ensures the accuracy and integrity of the data submitted by the TPA, including checking for appropriate coding.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: Financial Accountability**
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(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:
Encounter claims are coded and paid in accordance with the state reimbursement methodology by the Third Party Administrator. Numerator = number of waiver encounter claims coded and paid for in accordance with reimbursement methodology. Denominator = all claims reviewed in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLTS Data Warehouse – encounter paid claims

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

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☑ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = +/- 5%
☐ **Other** Specify:	☐ **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:
Claims are paid in accordance with the state rate methodology. Numerator = Claims reviewed that were paid in accordance with the state rate methodology. Denominator = Paid claims in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
CLTS encounter claim 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 = +/- 5%
☐ **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**

Responsible Party for data aggregation and analysis *(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:

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

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The Division of Long Term Care is responsible for ensuring CLTS Waiver Program services claims are pre-authorized, billed and paid appropriately. All claims are reviewed on a monthly basis and inappropriate claims are reversed or adjusted. The Division of Enterprise Services is responsible for the annual financial audit of waiver agencies. DMS oversees the audit process and tracks financial findings in the audits. The county waiver agencies are required to reimburse the State and Federal government for errors found during the financial audit. DMS monitors the errors monthly and continues to follow up on errors using MMIS data until they are resolved. All adjustments are tracked through business intelligence reports.

Each week, the BCS sends Wisconsin Physicians Service (WPS), the TPA vendor and fiscal agent, a listing of participants enrolled in the CLTS Waiver Program, which includes the participant's enrollment start date (and end date when applicable) their target group and the applicable responsible county waiver agency. WPS will reject service authorizations and claims for any person not included on the enrollment list. DHS staff runs quality encounter data checks to ensure claims are only paid for authorized children and the payment is associated with the correct county waiver agency.

WPS rejects claims for any service that is not prior authorized by the county waiver agency. The Department uses the initial plan review process, the on-site record review process, and the annual Single State Audit process as means of discovery to ensure that the services provided were included on the individualized service plan.

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**

Responsible Party*(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:

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.
In 2011, the Department began implementation of a third-party administration claims process through a contracted vendor, Wisconsin Physicians Service (WPS) to replace the prior Human Services Reporting System (HSRS) for tracking county waiver agencies' CLTS waiver expenditures and claims. The change to the TPA process, which utilizes HIPAA codes and encounter level reporting requirements, was phased in on a statewide basis. The TPA claims process was fully implemented as of January 1, 2012. In addition, WPS has converted to a new system as of February 1, 2015. This conversion has processes for coding and capturing accurate claims data in the Department's Medicaid Management Information System.

The Division of Long Term Care, in conjunction with the Bureau of Technology Services, has developed a quality assurance process to review the accuracy of the claim data prior to uploading the CLTS encounter data reports into the Department's data warehouse.

The Bureau's program integrity section is working with the Department's fiscal and IT staff to develop a comprehensive and regularly scheduled quality assurance claim monitoring process.

In addition, the Bureau also revised the Single State Audit Guidelines to reflect the CLTS Waiver Program's TPA claims process, and independent auditors review a selected sample of the county waiver agency's authorizations and paid claims.

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 Wisconsin Department of Health Services (DHS) will plan and implement a three-year, comprehensive strategy to set consistent rates for all Children's Long-Term Support Waiver (CLTS) Program covered services. This strategy includes not only creating a rate-setting methodology, but also updating the existing CLTS third party administrator claims processing system to ensure proper rate payments, an external communications plan, and a planned website to

post rate information. The rate-setting methodology devised through this project will apply to all waiver allowable services, including those provided to individuals self-directing their individual service plans within an individually assigned budget. DHS will exercise direct financial oversight by ensuring that key fiscal staff works closely with the rate-setting vendor to establish a sound methodology. In addition, DHS describes under Requirement 2 of this document plans to implement a claims processing and payment system that will allow DHS to validate payments against the Community Integration Program (CIP) fee schedule. DHS anticipates leveraging a third party administrator (TPA) to manage the claims processing functions. DHS already contracts with a TPA to process claims for the CLTS waiver service claims, which will facilitate the transition for the CIP Waiver to a TPA. The Requirement 2 narrative provides more detail about how DHS will exercise financial oversight of claims processing.

As the Rate Structure Project moves forward, DHS will communicate progress to CMS on a quarterly basis. In addition, DHS will likely be seeking CMS guidance throughout the process.

Requirement 1
During the first half of 2015, DHS will need to complete a variety of planning activities to meet CMS requirements and ensure a successful outcome. This includes outreach to other states and stakeholders to understand system's needs, member and provider impacts; methodology and administrative issues; an in-depth review of current DHS systems capabilities; an analysis of needed statutory changes (if applicable); budget development; and, a funding strategy. These efforts will lead to procurement of a rate-setting vendor. The complexity of the project, lack of existing staff resources, and the need to identify the most qualified vendor requires DHS to use the procurement processes governed by Wis. Stat. Chapter 16. From development to vendor selection and contracting, the RFP process takes a minimum of 9 months and can take as long as a year.
Once the rate-setting vendor is in place in 2016, DHS and the vendor will begin working to develop rates, including an outlier methodology. At the same time, DHS will develop state-county contracts that will require compliance with the new rate-setting methodology.
In 2017, DHS will work with the rate-setting vendor to conduct detailed financial impact modeling. The main purpose of the financial impact modeling is to understand how rates will change throughout the state and the potential redistributional impacts of the rate-setting methodology on providers, counties and participants. Secondly, the financial impact modeling will help DHS assess the need for a phased-in approach of the new rates, beginning January 1, 2018.
Once the rate-setting methodology is established, DHS will work with the rate-setting vendor to create an ongoing process to update rates as necessary.

Currently, DHS reviews and approves county waiver agency's rates for support and service coordination. Rates for other services are currently established by counties and providers in accordance with the requirements detailed in the DHS Allowable Cost Policy Manual. Rates for services that are self-directed are determined in the same manner as other service rates. County waiver agencies work with participants and their legal representative at the time of plan development on the allowable cost requirements and the waiver agency rate setting methodologies which establish appropriate rate structures based on the state's Allowable Cost Policy Manual.

The Allowable Cost Policy Manual contains service specific cost policies, and requires all costs meet the following general criteria:

- Be necessary and reasonable for proper and efficient program administration and allocable thereto under these guidelines. A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost. In determining the reasonability of a given cost, consideration shall be given to:
- whether the cost is ordinary and necessary to the operation of the agency or to the performance of the award;
- the restraints or requirements imposed by such factors as sound business practices, arms-length bargaining, laws and regulations, and terms and conditions of the program;
- the market prices for comparable goods and services;
- whether the individuals involved acted with prudence considering their responsibilities to the agency, the public at large, and the granting agency; and
- whether the costs were incurred in accordance with the agency's established procurement policy.

Support and service coordination rates are set using a weighted average hourly rate for all support and service coordinators in an agency. The rate includes allowable administration costs, if they are supported through the use of the Department's established methods: the percent total agency costs attributed to support and service coordination staff, in relation to all agency staff or itemized expenses. The agencies must submit the Department's approved,

statewide form, which requires documentation of all listed amounts for Division of Long Term Care's approval. Approved rates must follow the criteria above, must not increase more than the rate of inflation over the prior year approved rate, and must be reasonable in relation to the statewide average. Variance from the statewide average is acceptable with justification. For example, the Milwaukee Metropolitan Area would likely have a higher rate due to the higher cost of living in a large, urban area.

Except in rare instances, DHS currently does not set rates for services covered under the CLTS Waiver Program and thus, does not solicit public comments regarding rates. Information about the rates is shared with participants by the waiver agency.

DHS will devise a strategy to communicate with all stakeholders, including county waiver agencies, providers, advocates, program participants and interested parties

DHS will initially focus on communicating to interested parties the rate-setting initiative, the time line of events and the requirements established by CMS. DHS will conduct a needs assessment to determine methods to receive feedback from interested parties. As the rate setting project progresses DHS will, as necessary, seek information from interested parties on the impact of the project. DHS will, as necessary, engage interested parties as it explores options for a rate setting methodology. Interested parties may be utilized to obtain a wide range of feedback throughout the process. Once the rate methodology has been developed and approved, DHS will comply with all CMS public notice requirements.

During 2016, the focus of communication with the county waiver agencies will be regarding the Information Technology (IT) system requirements, so the county waiver agencies can begin to plan for the transition. DHS plans to announce the 2018 rates during the second half of 2017 and publish them on the DHS website for public access. Also during 2017, DHS will finalize the CLTS Waiver amendment by issuing proper public notice and subsequently submitting to CMS for approval. The waiver amendment will be effective January 1, 2018, as the rate-setting methodology goes live.

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:

The Department of Health Services, Division of Long Term Care contracts with Wisconsin Physicians Service (WPS) as the intermediary entity for routing billings from providers.

County waiver agencies authorize services and provider payments based on the participant's individualized service plan (ISP). The county waiver agencies issue a prior authorization to both the service provider and to WPS. The Bureau provides WPS with a list of CLTS waiver enrollees, as well as a monthly file of Medicaid eligible participants with private health insurance. Waiver providers submit their service claims to WPS. WPS is responsible for ensuring coordination of benefits, and then pays claims that conform to the waiver agency's authorization. WPS pays providers by check or EFT from a bank account held by the Wisconsin Department of Administration. The Division of Long Term Care reviews a daily invoice and, once approved, submits it for processing through the Department's Bureau of Financial Services and the Wisconsin Department of Administration. The State pays all expenses billed by the third-party administrator. If the waiver agency is responsible for the non-federal share of the expense, the State makes cash-back adjustments to the waiver agency's annual contract. The federal portion of the claims is reported quarterly.

The flow of billing for self-directed services is the same as other services, with the exception that some of these services are paid for through a fiscal agent. The fiscal agent submits claims to the Department's TPA vendor on the providers' behalf as the billing provider, and receives payment for those claims, then issues payment to the rendering providers.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

○ **No. State or local government agencies do not certify expenditures for waiver services.**

◉ **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☑ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

Using encounter data and the daily invoices, Department staff verifies that the amount paid from the bank account match the claims submitted. Bureau of Long Term Care Finance (BLTCF) also reconciles the receivables account, including cross-referencing encounter data with reports from the TPA and bank account balances. Any variances must be clarified with the TPA and if a payment was not appropriate, the Department must request a refund from or through the TPA. BLTCF reconciliation is completed monthly when bank statements arrive. Finally, BLTCF conducts a final reconciliation process, which is used to ensure that participants were eligible for CLTS Waiver Program services when they received them and that the appropriate funding source is applied to the appropriate services. BLTCFs reconciliation process occurs annually, after the end of the calendar year. Waiver agencies are responsible for verifying that BLTCF reconciliation is correct.

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

The county waiver agency conducts internal reviews to verify that each claim is reimbursable under the CLTS Waiver Program by determining that: the participant was eligible for services, the authorized services only include those listed on the child's approved individualized service plan (ISP), and the provider actually delivered the service to the participant.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

◉ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

○ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

○ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The State's Medicaid Waiver Provider Agreement includes a provision detailing the possible payment sources, including the third-party claims administrator (a fiscal agent) or the waiver agency. If a provider bills the waiver agency directly, they are, in effect, billing the State directly. The fiscal agent for the CLTS Waiver Program service claims is Wisconsin Physicians Service. The State-held bank account and the payment file from the fiscal agent, based upon encounter entry of approved claims, avoids a conflict of interest as it is independent of the entities/persons delivering services or goods. Based on the participant's authorized ISP, which was developed jointly by the parent/guardian and the county waiver agency, the fiscal agent processes claims for expenditures that meet all required authorizations, answers inquiries from waiver agencies and providers, solves related problems, and provides the Department with a weekly certification of expenditures through the State's encounter reporting system.

DHS contracts with a fiscal agent to perform all of the functions identified above. When deficiencies are identified, DHS works with the contractor to achieve remediation. If necessary, a corrective action plan is

implemented followed by a re-review.

The fiscal agent submits paid claims through the DHS encounter reporting system and certifies that the submitted claims are true and accurate. To ensure financial integrity and accountability, DHS performs audits and other quality checks related to the fiscal agent encounter reporting and certified paid claims against participants' authorized individualized budgets, and to determine if there is documentation that the services for paid claims were included in the ISP and were rendered. Where deficiencies are identified, remediation is required, according to the terms of the contract.

In addition, the fiscal agent conducts its own internal quality check to ensure that payments were made correctly. These include:
- Assuring prior authorization for every claim paid under the CLTS Waiver Program. This assurance is met by WPS requiring that claims data submitted from the provider is exact and within the code parameters on the authorization in order for a payment to be made (service code/modifiers, provider #, dates of service, participant ID, units of service allowed). Any data element that does not match will cause the claim to be denied.
- Assuring that high dollar claims get additional review. This assurance is met by an edit that will force a claim to pend when billed charges are over $15,000 for professional services and $30,000 for institutional services. WPS staff will review the claim to ensure the billed charges were submitted as intended. This edit prevents inappropriate escalated charges and/or entry errors.
- Assuring that the correct rate is applied. This assurance is met by using pricing logic to pay the authorized rate regardless of charge amount or pay the lower of rate or billed charges.
- Assuring there are not duplicate payments. This assurance is met using duplicate logic editing that compares new claims against pended and previous paid claims. Any new claim that matches a pended or paid claim will either auto reject or pend for desk level review.
- Assuring that retroactive changes are enforced. This assurance is met through retro code change protocols. If a retro change to a record causes a previous processed claim to overpay, WPS reviews claim history and request refunds. These retro changes can include enrollment, COB indicator, rate changes, provider ID change, or participant ID number change.
- Assure basic claim validation. This assurance is met by using a variety of other claim validation edits to ensure claims are processed accurately. These include assuring participant eligibility, COB, provider eligibility, proper HIPAA coding, disallowing claims for future dates, etc.

Provider Payment – Banking Process:
WPS makes payments for provider claims directly from a State-controlled bank account. WPS transmits a daily invoice to DMS for approval to fund the State-controlled bank account for the daily invoice dollar amount. The approved invoices are submitting through the Bureau of Fiscal Services to the Department of Administration, who administers the account. The payment account is a zero-balance account funded by the State and cannot receive external deposits. A separate receivables account was established for deposits and this account cannot be drawn upon.

Money Refunds:
The receivables account cannot be used to make payments. When WPS makes a payment or collects a receivable, WPS records the process in their system, which is certified and reported monthly to the State encounter-data system. The monies are put back into the bank account are transitions processed through MMIS.
Payments:
In general, providers should not receive payments from the State Agency. However, providers are able to receive payments from the State Agency. In some instances, such as when a provider fails to cash a check, WPS returns the funds to the State after 180 days and the State is responsible for maintaining those funds. A provider has six years under State law to claim the payment and would claim the payment from the State Agency directly.
Billing Process:
Providers are informed about the billing process through TPA training materials and forms from DHS and WPS, as well as the waiver agency.

☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

The Department has submitted a Section 1915(b)4 Waiver Fee-for Service Selective Contracting program application to the Centers for Medicare and Medicaid Services, designating county social/human/community services as the sole provider for the delivery of their Support and Service Coordination and foster care services, as well as reimbursement for covered goods and equipment costs for CLTS Waiver participants. County waiver agencies receive payment for delivered waiver services through the TPA claims process.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

○ **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**

◉ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

○ **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

◉ **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**

○ **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

○ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

○ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

◉ **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

○ **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

☑ **Appropriation of State Tax Revenues to the State Medicaid agency**

☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an

Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- ○ **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ◉ **Applicable**

Check each that applies:

- ☑ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

The CLTS Waiver Program is operated by local government agencies. The county government agency has the ability to levy taxes through both property and local sales tax processes. These funds, if utilized through the waivers, are transferred through intergovernmental transfer and tracked through the Data Warehouse and CARS (State of Wisconsin – Department of Health Services reporting system) and a county waiver agency must show adequate non-federal match in order to claim the FFP. Wis. Stat. 46.22 gives counties authority to levy taxes for social service expenditures.

- ☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- ◉ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ○ **The following source(s) are used**

Check each that applies:

- ☐ **Health care-related taxes or fees**
- ☐ **Provider-related donations**
- ☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- ○ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- ◉ **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

County waiver agencies must show that the CLTS waiver costs incurred for those participants residing in substitute care do not include room or board expenses. Because the use of Medicaid waiver funds is prohibited, the waiver participant pays some or all of the room and board costs. When the room and board costs exceed the participant's available resources, another source of funding, other than Medicaid waiver dollars, must be used.

The substitute care provider is responsible for the determination of the rate for their facility and for providing a breakdown to the waiver agency that identifies facility-specific costs attributed to room and board. The county waiver agency is responsible for assuring that such methodology is in place when contracting with a substitute care provider. Documentation identifying the facility costs for room and board must be kept on file at the waiver agency and should be updated at least annually to assure the facility costs are accurate and allowable.

Items and cost specifically related to room and board costs include the following: rent, or depreciation and mortgage interest; insurance such as title, mortgage, property and casualty; building or grounds maintenance costs; resident food; household supplies necessary for the resident room; furnishings used by the resident; utilities such as electricity, water and sewer, heating fuel, resident telephone, and resident cable television.

Facility specific documentation is maintained at the waiver agency and must be updated at least annually. Participant-specific documentation of substitute care room and board costs should be maintained in the participant record.

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: Hospital, Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8969.67	12701.10	21670.77	213133.06	17450.18	230583.24	208912.47
2	9308.39	13125.46	22433.85	220591.82	18210.36	238802.18	216368.33
3	10021.05	14246.43	24267.48	237445.37	19767.64	257213.01	232945.53
4	10205.24	14713.49	24918.73	242615.94	20384.40	263000.34	238081.61
5	10384.23	15192.61	25576.84	246510.09	20898.88	267408.97	241832.13

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: Hospital	Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	8479	1615	587	6277
Year 2	9787	1915	673	7199
Year 3	9886	1905	687	7294
Year 4	9885	1868	694	7323
Year 5	9886	1830	703	7353

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 three current waivers (WI.0413, WI.0414, and WI.0415).

The waitlist for children's waiver services, totaling 2,300 people, is assumed to be eliminated by December 2018. Children on a waitlist are assumed to be enrolled evenly over a period of 24 months from January 2017 through December 2018.

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 for these estimates is as follows:

The Factor D estimate is generally based on actual CY2014 waiver service costs in the CMS 372 reports. This is the most recent reporting year available. Alternate data sources were used for the following services:

Transition of Early Intensive Behavior Intervention and Consultative Behavior Intervention to benefits under Wisconsin's Medicaid State Plan is assumed to be completed by December 31, 2016. Much of the cost of these services is transitioned to State plan service costs; however, some existing waiver services are increased anticipating increased demand due to the transition.

Services in the current waivers transitioning to EPSDT services in the State plan were reviewed. Nursing Services are transitioned entirely to the State plan. A portion of Adaptive Aids and Specialized Medical and Therapeutic Services are assumed to be covered by the State plan services and are transitioned accordingly. Encounter data indicates no EPSDT services are reported for Community Integration Services, Counseling and Therapeutic Services, and Supportive Home Care-Personal Care; therefore no adjustments

were necessary for these services.

Child Care Services, Relocation Services, and Training for Parents/Guardians & Families of Children with Disabilities were added as new services. Cost and utilization are based on similar services in the existing children's waivers. Adjustments were made assuming Child Care will reduce Respite utilization and Relocation will replace Housing Start-up.

Supported Employment is split between Individuals and Small Groups based on membership in in each employment situation assumed in other waivers. This change was made based on the September 16, 2011 CMS Informational Bulletin updating the 1915(c) Waiver Instructions and Technical Guide regarding employment and employment related services. In this guidance, supported employment was changed into two separate 1915(c) waiver services, Supported Employment-Individual and Supported Employment-Small Group.

Consumer and Family Directed Supports has been eliminated as a separately reported service. Members are still self-directing services, but the services are being reported in the category of the service received.

Costs are trended forward using the Consumer Price Index for All Items. A trend of 0.1% is applied in CY2015 and a trend 2.0% is applied in all other years.

The unduplicated participant count in the derivation is projected using the same method to derive Average Length of Stay as described above.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D′ is based on actual CY 2014 service costs paid by the State Medicaid plan for waiver members and estimated EPSDT services provided as waiver services under the current approved waivers. The portion of Factor D′ related to self-directed personal care services is from certified encounter data. All other State plan service costs in Factor D′ are pulled from the same Medicaid fee-for-service paid claims data in the State's MMIS used as for CY2014 CMS 372 reporting.

Costs are trended forward using the Consumer Price Index for Medical Care. A trend of 2.6% is applied in CY2015 and a trend of 2.8% is applied in all other years.

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 CY2014 Medicaid institutional costs for children residing in State Centers, IMDs, and Nursing Facilities as well as inpatient hospital stays to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. Costs are trended forward using the Consumer Price Index for All Items. A trend of 0.1% is applied in CY2015 and a trend 2.0% is applied in all other years.

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay (ALOS) between the institutional populations and the waiver population. With the institutional population having a lower ALOS than the waiver participants, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional populations are adjusted by the ratio of the institutional ALOS to the wavier ALOS, which increases Factors G and G′ for the waiver population relative to the institutional population.

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 CY2014 Medicaid non-institutional costs for children residing in State Centers, IMDs, and Nursing Facilities as well as inpatient hospital stays to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. Costs are trended forward using the Consumer Price Index for Medical Care. A trend of 2.6%

is applied in CY2015 and a trend of 2.8% is applied in all other years.

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay (ALOS) between the institutional populations and the waiver population. With the institutional population having a lower ALOS than the waiver participants, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional populations are adjusted by the ratio of the institutional ALOS to the wavier ALOS, which increases Factors G and G′ for the waiver population relative to the institutional population.

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	
Consumer Education and Training	
Day Services	
Respite	
Support and Service Coordination	
Supported Employment – Individual	
Supportive Home Care	
Financial Management Services	
Adaptive Aids	
Adult Family Home	
Child Care Services	
Children's Foster Care	
Communication Aids/Assistive Tehcnology/Interpreter Services	
Community Integration Services	
Counseling and Therapeutic Services	
Daily Living Skills Training	
Home Modification	
Housing Counseling	
Mentoring	
Personal Emergency Response System (PERS)	
Relocation Services	
Specialized Medical and Therapeutic Supplies	
Supported Employment - Small Group	
Training for Parents/Guardians & Families of Children with Disabilities	
Transportation	

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
Consumer Education and Training Total:							**225236.31**
Consumer Education and Training	☐	Hours	347	18.76	34.60	**225236.31**	
Day Services Total:							**305607.69**
Day Services	☐	Hours	108	212.44	13.32	**305607.69**	
Respite Total:							**15837488.17**
Respite	☐	Hours	3842	228.63	18.03	**15837488.17**	
Support and Service Coordination Total:							**17973474.48**
Support and Service Coordination	☐	Hours	8361	106.00	20.28	**17973474.48**	
Supported Employment – Individual Total:							**33862.42**
Supported Employment – Individual	☐	Hours	7	295.69	16.36	**33862.42**	
Supportive Home Care Total:							**6049174.39**
Supportive Home Care - Days	☐	Days	29	157.20	141.59	**645480.49**	
Supportive Home Care - Hours	☐	Hours	860	310.75	20.22	**5403693.90**	
Financial Management Services Total:							**900990.22**
Financial Management Services	☐	Hours	2858	7.56	41.70	**900990.22**	
Adaptive Aids Total:							**1554096.89**
Other	☐	Items	544	10.77	75.23	**440763.54**	
Vehicle Modifications	☐	Items	113	2.75	3582.73	**1113333.35**	
Adult Family Home Total:							**1674911.74**
Adult Family Home	☐	Days	46	247.56	147.08	**1674911.74**	
Child Care Services Total:							**3726467.81**

GRAND TOTAL:	**76053844.43**
Total: Services included in capitation:	
Total: Services not included in capitation:	76053844.43
Total Estimated Unduplicated Participants:	**8479**
Factor D (Divide total by number of participants):	**8969.67**
Services included in capitation:	
Services not included in capitation:	8969.67
Average Length of Stay on the Waiver:	290

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Child Care Services		Hours	904	228.63	18.03	3726467.81	
Children's Foster Care Total:							5961322.23
Children's Foster Care		Days	238	201.72	124.17	5961322.23	
Communication Aids/Assistive Tehcnology/Interpreter Services Total:							82085.27
Communication Aids/Assistive Tehcnology/Interpreter Services		Items	138	11.24	52.92	82085.27	
Community Integration Services Total:							600348.12
Community Integration Services		Days	33	164.28	110.74	600348.12	
Counseling and Therapeutic Services Total:							6925402.86
Counseling and Therapeutic Services - Hours		Hours	1506	83.13	54.59	6834328.45	
Counseling and Therapeutic Services - Items		Items	103	2.04	433.44	91074.41	
Daily Living Skills Training Total:							9715632.33
Daily Living Skills Training		Hours	2024	225.68	21.27	9715632.33	
Home Modification Total:							1700518.22
Home Modification		Projects	312	2.57	2120.77	1700518.22	
Housing Counseling Total:							2369.86
Housing Counseling		Hours	4	19.33	30.65	2369.86	
Mentoring Total:							1634523.67
Mentoring		Hours	454	106.58	33.78	1634523.67	
Personal Emergency Response System (PERS) Total:							29687.22
Personal Emergency Response System (PERS)		Each	138	7.19	29.92	29687.22	
Relocation Services Total:							51795.87
Relocation Services						51795.87	

GRAND TOTAL:	**76053844.43**
Total: Services included in capitation:	
Total: Services not included in capitation:	76053844.43
Total Estimated Unduplicated Participants:	**8479**
Factor D (Divide total by number of participants):	**8969.67**
Services included in capitation:	
Services not included in capitation:	8969.67
Average Length of Stay on the Waiver:	290

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	☐	Projects	7	1.00	7399.41		
Specialized Medical and Therapeutic Supplies Total:							**642912.37**
Specialized Medical and Therapeutic Supplies	☐	Items	917	30.22	23.20	**642912.37**	
Supported Employment - Small Group Total:							**6830.44**
Supported Employment - Small Group	☐	Hours	2	295.69	11.55	**6830.44**	
Training for Parents/Guardians & Families of Children with Disabilities Total:							**75770.92**
Training for Parents/Guardians & Families of Children with Disabilities	☐	Hours	347	4.00	54.59	**75770.92**	
Transportation Total:							**343334.94**
Specialized Transportation - Miles	☐	Miles	330	802.78	0.52	**137757.05**	
Specialized Transportation - Trips	☐	Trips	186	65.75	16.81	**205577.90**	

GRAND TOTAL:	**76053844.43**
Total: Services included in capitation:	
Total: Services not included in capitation:	76053844.43
Total Estimated Unduplicated Participants:	**8479**
Factor D (Divide total by number of participants):	**8969.67**
Services included in capitation:	
Services not included in capitation:	8969.67
Average Length of Stay on the Waiver:	290

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 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 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Education and Training Total:							**267877.20**
Consumer Education and Training		Hours	400	18.95	35.34	**267877.20**	
Day Services Total:							**363870.58**
Day Services		Hours	125	214.99	13.54	**363870.58**	
Respite Total:							**18910416.20**
Respite		Hours	4431	231.44	18.44	**18910416.20**	
Support and Service Coordination Total:							**21505160.45**
Support and Service Coordination		Hours	9648	107.68	20.70	**21505160.45**	
Supported Employment – Individual Total:							**40426.46**
Supported Employment – Individual		Hours	8	301.51	16.76	**40426.46**	
Supportive Home Care Total:							**7266556.14**
Supportive Home Care - Days		Days	34	160.00	147.56	**802726.40**	
Supportive Home Care - Hours		Hours	992	315.39	20.66	**6463829.74**	
Financial Management Services Total:							**1070342.56**
Financial Management Services		Hours	3289	7.65	42.54	**1070342.56**	
Adaptive Aids Total:							**1843039.00**
Other		Items	626	10.87	76.79	**522526.77**	
Vehicle Modifications		Items	130	2.78	3653.88	**1320512.23**	
Adult Family Home Total:							**2040119.48**
Adult Family Home		Days	53	252.23	152.61	**2040119.48**	
Child Care Services Total:							**4446999.25**
Child Care Services		Hours	1042	231.44	18.44	**4446999.25**	
Children's Foster Care Total:							**7187386.54**
						7187386.54	

GRAND TOTAL:	**91101186.59**
Total: Services included in capitation:	
Total: Services not included in capitation:	91101186.59
Total Estimated Unduplicated Participants:	**9787**
Factor D (Divide total by number of participants):	**9308.39**
Services included in capitation:	
Services not included in capitation:	9308.39
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Children's Foster Care		Days	278	204.04	126.71		
Communication Aids/Assistive Tehcnology/Interpreter Services Total:							**98236.97**
Communication Aids/Assistive Tehcnology/Interpreter Services		Items	158	11.35	54.78	**98236.97**	
Community Integration Services Total:							**749193.90**
Community Integration Services		Days	39	168.88	113.75	**749193.90**	
Counseling and Therapeutic Services Total:							**8338240.94**
Counseling and Therapeutic Services - Hours		Hours	1741	84.62	55.86	**8229486.24**	
Counseling and Therapeutic Services - Items		Items	119	2.07	441.50	**108754.70**	
Daily Living Skills Training Total:							**11604431.93**
Daily Living Skills Training		Hours	2337	228.30	21.75	**11604431.92**	
Home Modification Total:							**2012063.82**
Home Modification		Projects	358	2.60	2161.65	**2012063.82**	
Housing Counseling Total:							**2445.78**
Housing Counseling		Hours	4	19.56	31.26	**2445.78**	
Mentoring Total:							**1986707.39**
Mentoring		Hours	530	108.81	34.45	**1986707.38**	
Personal Emergency Response System (PERS) Total:							**35318.08**
Personal Emergency Response System (PERS)		Each	159	7.29	30.47	**35318.08**	
Relocation Services Total:							**62752.88**
Relocation Services		Projects	8	1.00	7844.11	**62752.88**	
Specialized Medical and Therapeutic Supplies Total:							**762480.88**

GRAND TOTAL:	**91101186.59**
Total: Services included in capitation:	
Total: Services not included in capitation:	91101186.59
Total Estimated Unduplicated Participants:	**9787**
Factor D (Divide total by number of participants):	**9308.39**
Services included in capitation:	
Services not included in capitation:	9308.39
Average Length of Stay on the Waiver:	295

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical and Therapeutic Supplies	☐	Items	1053	30.54	23.71	762480.88	
Supported Employment - Small Group Total:							7133.73
Supported Employment - Small Group	☐	Hours	2	301.51	11.83	7133.73	
Training for Parents/Guardians & Families of Children with Disabilities Total:							90634.10
Training for Parents/Guardians & Families of Children with Disabilities	☐	Hours	401	4.06	55.67	90634.10	
Transportation Total:							409352.35
Specialized Transportation - Miles	☐	Miles	382	813.60	0.53	164721.46	
Specialized Transportation - Trips	☐	Trips	214	66.50	17.19	244630.89	
					GRAND TOTAL:		91101186.59
					Total: Services included in capitation:		
					Total: Services not included in capitation:		91101186.59
					Total Estimated Unduplicated Participants:		9787
					Factor D (Divide total by number of participants):		9308.39
					Services included in capitation:		
					Services not included in capitation:		9308.39
					Average Length of Stay on the Waiver:	295	

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 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 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Education and Training Total:							291203.20
Consumer Education and Training	☐	Hours				291203.20	
					GRAND TOTAL:		99068122.35
					Total: Services included in capitation:		
					Total: Services not included in capitation:		99068122.35
					Total Estimated Unduplicated Participants:		9886
					Factor D (Divide total by number of participants):		10021.05
					Services included in capitation:		
					Services not included in capitation:		10021.05
					Average Length of Stay on the Waiver:	311	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			404	20.00	36.04		
Day Services Total:							**395246.63**
Day Services		Hours	126	227.31	13.80	**395246.63**	
Respite Total:							**20570488.31**
Respite		Hours	4479	244.29	18.80	**20570488.31**	
Support and Service Coordination Total:							**23403841.40**
Support and Service Coordination		Hours	9747	113.69	21.12	**23403841.40**	
Supported Employment – Individual Total:							**43962.05**
Supported Employment – Individual		Hours	8	321.36	17.10	**43962.05**	
Supportive Home Care Total:							**7895846.54**
Supportive Home Care - Days		Days	34	168.92	150.36	**863559.58**	
Supportive Home Care - Hours		Hours	1003	332.76	21.07	**7032286.96**	
Financial Management Services Total:							**1165323.49**
Financial Management Services		Hours	3328	8.07	43.39	**1165323.49**	
Adaptive Aids Total:							**2005002.57**
Other		Items	633	11.46	78.37	**568510.09**	
Vehicle Modifications		Items	132	2.92	3726.89	**1436492.48**	
Adult Family Home Total:							**2199739.58**
Adult Family Home		Days	53	266.79	155.57	**2199739.58**	
Child Care Services Total:							**4836062.56**
Child Care Services		Hours	1053	244.29	18.80	**4836062.56**	
Children's Foster Care Total:							**7815679.20**
Children's Foster Care		Days	279	216.77	129.23	**7815679.20**	

GRAND TOTAL:	**99068122.35**
Total: Services included in capitation:	
Total: Services not included in capitation:	99068122.35
Total Estimated Unduplicated Participants:	**9886**
Factor D (Divide total by number of participants):	**10021.05**
Services included in capitation:	
Services not included in capitation:	10021.05
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Communication Aids/Assistive Tehcnology/Interpreter Services Total:							**106823.44**
Communication Aids/Assistive Tehcnology/Interpreter Services	☐	Items	160	11.95	55.87	**106823.44**	
Community Integration Services Total:							**813480.79**
Community Integration Services	☐	Days	39	179.83	115.99	**813480.79**	
Counseling and Therapeutic Services Total:							**9071435.16**
Counseling and Therapeutic Services - Hours	☐	Hours	1757	89.45	56.97	**8953613.14**	
Counseling and Therapeutic Services - Items	☐	Items	120	2.18	450.39	**117822.02**	
Daily Living Skills Training Total:							**12617823.83**
Daily Living Skills Training	☐	Hours	2361	240.95	22.18	**12617823.83**	
Home Modification Total:							**2186044.66**
Home Modification	☐	Projects	363	2.73	2205.92	**2186044.66**	
Housing Counseling Total:							**2620.54**
Housing Counseling	☐	Hours	4	20.55	31.88	**2620.54**	
Mentoring Total:							**2159906.22**
Mentoring	☐	Hours	532	115.57	35.13	**2159906.22**	
Personal Emergency Response System (PERS) Total:							**38240.83**
Personal Emergency Response System (PERS)	☐	Each	160	7.69	31.08	**38240.83**	
Relocation Services Total:							**68102.32**
Relocation Services	☐	Projects	8	1.00	8512.79	**68102.32**	
Specialized Medical and Therapeutic Supplies Total:							**830851.03**
	☐	Items	1068	32.16	24.19	**830851.03**	

GRAND TOTAL:	**99068122.35**
Total: Services included in capitation:	
Total: Services not included in capitation:	99068122.35
Total Estimated Unduplicated Participants:	**9886**
Factor D (Divide total by number of participants):	**10021.05**
Services included in capitation:	
Services not included in capitation:	10021.05
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical and Therapeutic Supplies							
Supported Employment - Small Group Total:							**7757.63**
Supported Employment - Small Group	☐	Hours	2	321.36	12.07	**7757.63**	
Training for Parents/Guardians & Families of Children with Disabilities Total:							**98422.45**
Training for Parents/Guardians & Families of Children with Disabilities	☐	Hours	405	4.28	56.78	**98422.45**	
Transportation Total:							**444217.93**
Specialized Transportation - Miles	☐	Miles	385	859.96	0.54	**178785.68**	
Specialized Transportation - Trips	☐	Trips	216	70.10	17.53	**265432.25**	
					GRAND TOTAL:		**99068122.35**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		99068122.35
					Total Estimated Unduplicated Participants:		**9886**
					Factor D (Divide total by number of participants):		**10021.05**
					Services included in capitation:		
					Services not included in capitation:		10021.05
					Average Length of Stay on the Waiver:		311

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 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 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Education and Training Total:							**298175.58**
Consumer Education and Training	☐	Hours				**298175.58**	
					GRAND TOTAL:		**100878846.20**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		100878846.20
					Total Estimated Unduplicated Participants:		**9885**
					Factor D (Divide total by number of participants):		**10205.24**
					Services included in capitation:		
					Services not included in capitation:		10205.24
					Average Length of Stay on the Waiver:		312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			405	20.05	36.72		
Day Services Total:							**404759.77**
Day Services		Hours	126	227.99	14.09	**404759.77**	
Respite Total:							**20985116.73**
Respite		Hours	4481	244.55	19.15	**20985116.73**	
Support and Service Coordination Total:							**23835440.15**
Support and Service Coordination		Hours	9748	113.57	21.53	**23835440.15**	
Supported Employment – Individual Total:							**44660.30**
Supported Employment – Individual		Hours	8	321.02	17.39	**44660.30**	
Supportive Home Care Total:							**8033157.76**
Supportive Home Care - Days		Days	34	168.55	151.33	**867226.83**	
Supportive Home Care - Hours		Hours	1004	332.59	21.46	**7165930.93**	
Financial Management Services Total:							**1190920.16**
Financial Management Services		Hours	3335	8.07	44.25	**1190920.16**	
Adaptive Aids Total:							**2064641.19**
Other		Items	635	11.48	80.00	**583184.00**	
Vehicle Modifications		Items	133	2.93	3801.63	**1481457.19**	
Adult Family Home Total:							**2215422.68**
Adult Family Home		Days	53	266.16	157.05	**2215422.68**	
Child Care Services Total:							**4936021.66**
Child Care Services		Hours	1054	244.55	19.15	**4936021.66**	
Children's Foster Care Total:							**7935528.05**
Children's Foster Care		Days	277	217.41	131.77	**7935528.05**	

GRAND TOTAL:	**100878846.20**
Total: Services included in capitation:	
Total: Services not included in capitation:	100878846.20
Total Estimated Unduplicated Participants:	**9885**
Factor D (Divide total by number of participants):	**10205.24**
Services included in capitation:	
Services not included in capitation:	10205.24
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Communication Aids/Assistive Tehcnology/Interpreter Services Total:							**109033.93**
Communication Aids/Assistive Tehcnology/Interpreter Services	☐	Items	161	11.98	56.53	**109033.93**	
Community Integration Services Total:							**821282.96**
Community Integration Services	☐	Days	39	178.75	117.81	**821282.96**	
Counseling and Therapeutic Services Total:							**9191577.39**
Counseling and Therapeutic Services - Hours	☐	Hours	1753	89.25	57.98	**9071275.40**	
Counseling and Therapeutic Services - Items	☐	Items	120	2.18	459.87	**120301.99**	
Daily Living Skills Training Total:							**12859484.00**
Daily Living Skills Training	☐	Hours	2360	241.21	22.59	**12859484.00**	
Home Modification Total:							**2252875.27**
Home Modification	☐	Projects	365	2.74	2252.65	**2252875.26**	
Housing Counseling Total:							**2679.65**
Housing Counseling	☐	Hours	4	20.60	32.52	**2679.65**	
Mentoring Total:							**2176197.75**
Mentoring	☐	Hours	527	115.25	35.83	**2176197.75**	
Personal Emergency Response System (PERS) Total:							**39028.29**
Personal Emergency Response System (PERS)	☐	Each	160	7.69	31.72	**39028.29**	
Relocation Services Total:							**68590.24**
Relocation Services	☐	Projects	8	1.00	8573.78	**68590.24**	
Specialized Medical and Therapeutic Supplies Total:							**852016.81**
	☐	Items	1072	32.23	24.66	**852016.81**	

GRAND TOTAL:	**100878846.20**
Total: Services included in capitation:	
Total: Services not included in capitation:	100878846.20
Total Estimated Unduplicated Participants:	**9885**
Factor D (Divide total by number of participants):	**10205.24**
Services included in capitation:	
Services not included in capitation:	10205.24
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical and Therapeutic Supplies							
Supported Employment - Small Group Total:							**7877.83**
Supported Employment - Small Group	☐	Hours	2	321.02	12.27	**7877.83**	
Training for Parents/Guardians & Families of Children with Disabilities Total:							**100381.19**
Training for Parents/Guardians & Families of Children with Disabilities	☐	Hours	405	4.28	57.91	**100381.19**	
Transportation Total:							**453976.85**
Specialized Transportation - Miles	☐	Miles	385	860.51	0.55	**182212.99**	
Specialized Transportation - Trips	☐	Trips	217	70.20	17.84	**271763.86**	
					GRAND TOTAL:		**100878846.20**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		100878846.20
					Total Estimated Unduplicated Participants:		**9885**
					Factor D (Divide total by number of participants):		**10205.24**
					Services included in capitation:		
					Services not included in capitation:		10205.24
					Average Length of Stay on the Waiver:		312

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other 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 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consumer Education and Training Total:							**304384.59**
Consumer Education and Training	☐	Hours				**304384.59**	
					GRAND TOTAL:		**102658545.87**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		102658545.87
					Total Estimated Unduplicated Participants:		**9886**
					Factor D (Divide total by number of participants):		**10384.23**
					Services included in capitation:		
					Services not included in capitation:		10384.23
					Average Length of Stay on the Waiver:		311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			405	20.09	37.41		
Day Services Total:							**414501.94**
Day Services		Hours	126	228.61	14.39	**414501.94**	
Respite Total:							**21390349.84**
Respite		Hours	4484	244.76	19.49	**21390349.84**	
Support and Service Coordination Total:							**24264727.73**
Support and Service Coordination		Hours	9751	113.42	21.94	**24264727.73**	
Supported Employment – Individual Total:							**45352.74**
Supported Employment – Individual		Hours	8	320.65	17.68	**45352.74**	
Supportive Home Care Total:							**8171439.58**
Supportive Home Care - Days		Days	34	168.13	152.26	**870382.11**	
Supportive Home Care - Hours		Hours	1005	332.33	21.86	**7301057.47**	
Financial Management Services Total:							**1217517.59**
Financial Management Services		Hours	3343	8.07	45.13	**1217517.59**	
Adaptive Aids Total:							**2119782.71**
Other		Items	636	11.50	81.66	**597261.24**	
Vehicle Modifications		Items	134	2.93	3877.85	**1522521.47**	
Adult Family Home Total:							**2230221.43**
Adult Family Home		Days	53	265.47	158.51	**2230221.43**	
Child Care Services Total:							**5032742.88**
Child Care Services		Hours	1055	244.76	19.49	**5032742.88**	
Children's Foster Care Total:							**8055620.98**
Children's Foster Care		Days	275	218.02	134.36	**8055620.98**	

GRAND TOTAL:	**102658545.87**
Total: Services included in capitation:	
Total: Services not included in capitation:	102658545.87
Total Estimated Unduplicated Participants:	**9886**
Factor D (Divide total by number of participants):	**10384.23**
Services included in capitation:	
Services not included in capitation:	10384.23
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Communication Aids/Assistive Tehcnology/Interpreter Services Total:							**110399.00**
Communication Aids/Assistive Tehcnology/Interpreter Services	☐	Items	161	11.99	57.19	**110399.00**	
Community Integration Services Total:							**807586.24**
Community Integration Services	☐	Days	38	177.65	119.63	**807586.24**	
Counseling and Therapeutic Services Total:							**9325616.65**
Counseling and Therapeutic Services - Hours	☐	Hours	1751	89.05	59.02	**9202784.98**	
Counseling and Therapeutic Services - Items	☐	Items	120	2.18	469.54	**122831.66**	
Daily Living Skills Training Total:							**13105363.20**
Daily Living Skills Training	☐	Hours	2360	241.44	23.00	**13105363.20**	
Home Modification Total:							**2306872.97**
Home Modification	☐	Projects	366	2.74	2300.34	**2306872.97**	
Housing Counseling Total:							**3420.45**
Housing Counseling	☐	Hours	5	20.63	33.16	**3420.45**	
Mentoring Total:							**2196770.50**
Mentoring	☐	Hours	523	114.92	36.55	**2196770.50**	
Personal Emergency Response System (PERS) Total:							**40089.35**
Personal Emergency Response System (PERS)	☐	Each	161	7.69	32.38	**40089.35**	
Relocation Services Total:							**69046.64**
Relocation Services	☐	Projects	8	1.00	8630.83	**69046.64**	
Specialized Medical and Therapeutic Supplies Total:							**874276.94**
	☐	Items	1077	32.29	25.14	**874276.94**	

GRAND TOTAL:	**102658545.87**
Total: Services included in capitation:	
Total: Services not included in capitation:	102658545.87
Total Estimated Unduplicated Participants:	**9886**
Factor D (Divide total by number of participants):	**10384.23**
Services included in capitation:	
Services not included in capitation:	10384.23
Average Length of Stay on the Waiver:	311

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical and Therapeutic Supplies							
Supported Employment - Small Group Total:							**8003.42**
Supported Employment - Small Group	☐	Hours	2	320.65	12.48	**8003.42**	
Training for Parents/Guardians & Families of Children with Disabilities Total:							**102374.60**
Training for Parents/Guardians & Families of Children with Disabilities	☐	Hours	405	4.28	59.06	**102374.60**	
Transportation Total:							**462083.89**
Specialized Transportation - Miles	☐	Miles	384	860.91	0.56	**185130.09**	
Specialized Transportation - Trips	☐	Trips	217	70.28	18.16	**276953.80**	

GRAND TOTAL:	**102658545.87**
Total: Services included in capitation:	
Total: Services not included in capitation:	102658545.87
Total Estimated Unduplicated Participants:	**9886**
Factor D (Divide total by number of participants):	**10384.23**
Services included in capitation:	
Services not included in capitation:	10384.23
Average Length of Stay on the Waiver:	311