

## Chapter VII – Recertification, Plan Review and ISP Update

### 7.01 Introduction

The county waiver agency must ensure that an annual recertification for every Medicaid waiver participant occurs no less than every twelve months. Failure of the waiver program agency to meet the annual recertification requirements may result in a loss of waiver funds. Recertification determinations may be conducted prior to the anniversary date of program eligibility but must occur within the twelve-month period to maintain program eligibility.

The annual recertification process includes a re-determination of level of care and financial eligibility as well as reviewing and updating or creating a new Individual Service Plan (ISP). The completion of the re-determination of level of care and financial eligibility need not occur in the same month, but each must be completed annually, no later than the end of the program eligibility anniversary month. The recertification process will differ, depending on the individual Medicaid Waiver Program that serves the participant.

The Individual Service Plan (ISP) represents an agreement between the waiver program agency and the participant as to how the program will meet the identified needs of the person and in so doing, help the participant reach his/her individual outcomes. The ISP is not a static document. Rather, it should be seen as an evolving instrument that adapts to meet changes in the participant's individual outcomes, needs and preferences.

The ISP should be updated when new individual outcomes are identified or when a change in status of an existing outcome occurs. An update is also necessary when a change among either formal or informal waiver program service providers occurs. The individual service plan must reflect a **current, accurate** description of the waiver program interaction with the participant. The Individual Outcomes form (DDE-445A) should change correspondingly to remain consistent with the Individual Service Plan form (DDE 445). These forms are two parts that when combined make up the Individual Service Plan. See Section 7.05 for more details about service plan update requirements.

### 7.02 Annual Recertification

#### A. Brain Injury Waiver (BIW)

The BIW program rules require that each waiver participant has his/her BIW program eligibility reviewed on an at least annual basis. Annual recertification includes a face to face meeting with the participant and the completion of required recertification documentation. This process herein after referred to as the annual “recertification” verifies that the conditions necessary to meet the established

standards for BIW participation are present. The month in which recertification occurs may not exceed 12 months from the previous recertification or original BIW start date.

The county waiver agency has the responsibility to assure that the appropriate tasks occur and also that they are documented. Annual BIW recertification packets are sent to the Bureau of Long Term Support -Developmental Disabilities Services Section. In the case of the BIW, the DDSS assigns level of care. The packet should include a cover letter outlining the request so that BLTS is better able to complete the process. The BIW review packet sent to BLTS– Developmental Disabilities Section office must include:

1. New Level of Care Assignment Forms OQA 2256 and OQA 2256a

The support and service coordinator arranges for forms OQA 2256 and OQA-2256a to be completed, and that the forms are signed by a physician or by a registered nurse. Additional information that documents the functional and health status of the participant is helpful when included. The BLTS reviews the forms along with other appropriate documentation and assigns the BIW Level of Care rating.

Work is underway at BLTS to create an electronic tool to assign BIW eligible level of care but it is not yet available. The BLTS paper based care level rating process will continue until a new electronic process is operational.

For the BLTS to assign a level of care compatible with the BIW, the waiver participant's condition must meet the definition of "Brain Injury" (as described in Wisconsin Statute) and the participant must also be eligible for treatment of his/her brain injury in a Brain Injury Rehabilitation Facility. When in doubt as to whether or not to include clinical information and supporting documentation along with the request for BIW level of care, waiver agency staff are asked to err on the side of inclusion. Please refer to Appendix A-7 of this manual for helpful information concerning the Brain Injury definition, and also Brain Injury Level of Care.

2. New Individual Service Plan Form (DDE-445) and (DDE-445A)

The new updated Individual Service Plan form (DDE-445) and also the accompanying Individual Outcomes form (DDE-445A) must be completed as a part of the recertification process. The ISP may call for changes to the type and amount of services or may call for providing the same services and supports. New completed forms must also include a new current, completed signature page. Copies of the forms DDE-445 and the DDE-445A may be accessed through Appendix I of this manual.

3. New Eligibility Cost Sharing Worksheet (DDE-919) or the Income Maintenance provided CARES screen printouts.

The new Financial Eligibility form (DDE-919) is completed by following the instructions on the form. All current financial eligibility information must be documented on this form.

For those BIW participants whose Medicaid financial eligibility occurs through financial eligibility groups B or C, the recertification documents also include a copy of the CARES form which is obtained from the county Income Maintenance Specialist.

All forms submitted to BLTS must be complete and include dates verifying that they were completed no later than the same month the annual recertification is due. After the recertification documents are received and approved by BLTS, the Bureau sends a letter to the county waiver agency with information indicating the assigned level of care. The BLTS letter also acknowledges the person's continued participation in the BIW program and shows the calendar month in which any subsequent annual recertification must occur.

#### **B. Community Integration Program (CIP 1A and CIP- 1B)**

The CIP-1A and CIP 1B program rules require that each waiver participant has his/her CIP Waiver eligibility reviewed on at least an annual basis. Annual recertification includes a face to face meeting with the participant and the completion of all required recertification documentation. This process herein after referred to as the annual "recertification" verifies that the conditions necessary to meet the established standards for CIP 1 Waiver participation are present. The month in which recertification occurs may not exceed 12 months from the previous review.

The BLTS sends a County Monthly Recertification Assurance Report to the waiver agency on a monthly basis. One form is sent for each of the waiver participants from that local waiver agency that is due to have his/her CIP 1 Waiver participation recertification occur in that calendar month. This form is completed, signed by the support and service coordinator and is returned to the BLTS Developmental Disabilities Section. The completed form serves as documentation that the support and service coordinator has completed all steps involved in the waiver recertification process.

The recertification process completed by the support and service coordinator includes the following steps:

1. New Level of Care (LOC) Determination and Verification

The disability level of care of persons using the CIP 1 Waivers must be reviewed and verified each year. The rules of this waiver require that this

review and verification be done by an individual who meets the definition of Qualified Mental Retardation Professional (QMRP). Appendix A of this manual includes the definition of QMRP. The QMRP qualified support and service coordinator completes the DHFS electronic Long Term Care Functional Screen for each waiver participant not less than annually. This tool assures that the waiver participant's level of care remains appropriate to meet the CIP 1 Waiver requirements.

The LTC-FS generates an output report that evidences both that the screen review occurred and also that the appropriate waiver LOC for the CIP-1 Waiver is present. Best practice includes entering edits to the screen as changes in level of functioning and/or medical condition occur. The LTC-FS Screen output page must be made available for inspection during audits or monitoring reviews if requested.

## 2. Individual Service Plan

A new or updated Individual Service Plan form (DDE-445) and also the accompanying Individual Outcomes form (DDE-445A) must also be completed as a part of the CIP-1 annual recertification process. The participant/guardian should be active participants in this process. The plan may call for changes to the type or amount of services, or it may call for providing the same services and supports but must be submitted as a new document with a new signature page. Copies of forms DDE-445 and the DDE-445A may be accessed through Appendix I of this manual. Each year following the initial eligibility certification, the support and service coordinator completes a new Individual Service Plan by using forms (DDE-445) and (DDE-445A). Substitution of this form with a BLTS approved substitute is allowable. The individualized service plan forms need not be sent to the BLTS as a part of the annual recertification process.

## 3. Medicaid Waiver Eligibility and Cost-Sharing Worksheet/ CARES Screen

Each year following the initial certification of eligibility, the waiver agency must complete a new Medicaid Waiver Eligibility and Cost-Sharing Worksheet (DDE-919) or CARES Screens. This form must be maintained by the waiver agency in an easily accessed location and be made available for inspection during individual monitoring reviews or program or provider audits. This form serves as documentation that the waiver participant continues to meet the financial eligibility rules of the CIP -1 Waiver. This form need not be sent to the BLTS.

### C. Community Integration Program II (CIP- II) and Community Options Program Waiver (COP-W)

Annual recertification requirements must be met in order to assure the participant's continuous eligibility for CIP II/COP-W program participation. Annual recertification includes a face to face review of the service plan with the participant and the completion of required recertification documentation. The annual review may involve meeting with the participant's guardian or other legal representative (e.g., activated POA-HC). However, even in circumstances where someone other than the participant signs the service plan, the annual review must always include a face to face meeting with the participant.

Beginning in 2003 all county waiver agencies were required to develop a local process to complete internally monitored recertification (self-recertification) of all Group A participants (DDES Memo 2003-04). County agencies also have the option to complete internally monitored recertification of Group B and C participants.

#### 1. Externally Monitored Annual Recertification

Externally monitored recertification of program eligibility for COP-W and CIP II includes the preparation of the following documentation:

- a. A **current** Medicaid Waiver Program Health Report (DDE-810)<sup>1</sup> completed by the care manager and by the physician, or by a physician's assistant, or a registered nurse.
- b. A **current** Long Term Care Functional Screen (LTC-FS) Eligibility Report, indicating an eligible level of care (See footnote <sup>1</sup> below).
- c. A **current** Medicaid Waiver Eligibility and Cost Sharing Worksheet (DDE-919) or current CARES screen printouts, as applicable and, if required, the current Income Allocation worksheet.
- d. A new, complete and updated individual service plan (DDE 445 and 445A) signed by the CM/SSC and by the participant or by his/her guardian or legal/authorized representative.

---

<sup>1</sup> The documentation of health status, the Medicaid Waiver Program Health Report (DDE-810) must be **current**, completed no more than 90 days before or after the recertification month. The Long Term Care Functional Screen completed for recertification must contain **current**, complete and accurate information and should be completed **not later than** twelve months from the previous screen completion date.

When completed, the COP-W and CIP II recertification documentation is sent, with a cover letter, to the Bureau of Long Term Support – Community Options Section or its quality assurance designee for review. Upon approval of the recertification, a letter certifying the participant’s continued eligibility will be sent to the county agency including, if needed, a No Active Treatment re-determination.

## 2. Internally Monitored Annual Recertification

Internally monitored annual recertification of program eligibility for COP-W and CIP II participants includes the preparation of the following documentation:

- a. A current Medicaid Waiver Program Health Report (DDE-810) completed by the care manager and by the physician or the physician assistant or registered nurse (See footnote<sup>1</sup> on page VII-5.)
- b. A current and complete Long Term Care Functional Screen – Eligibility Report indicating an eligible level of care (See footnote<sup>1</sup> on page VII-5).
- c. A current Medicaid Waiver Eligibility and Cost Sharing Worksheet (DDE-919) or current CARES screen printouts as applicable and, if required for Group C, the current Income Allocation worksheet.
- d. A new, complete and updated individual service plan (DDE 445 and 445A) signed by the CM/SSC and by the participant or by his/her guardian or legal/authorized representative.

When completed, the internally monitored recertification documentation is forwarded to the locally designated recertification reviewer (unit supervisor, lead worker, etc.) In those circumstances where a No Active Treatment determination is required, the NAT may be completed by a QMRP at the county agency or requested from the BLTS Community Option Section quality assurance designee. At the agency’s option, after the local internal review is done a recertification assurance form may be completed and filed with the required recertification documentation in the participant record.

### **D. Children’s Long Term Support Waivers (CLTS)**

Annual recertification is required to assure the participant’s continued eligibility for the waiver program. All waiver agencies are required to complete and submit the Children’s Long-Term Support (CLTS) Waivers Recertification Checklist. The annual recertification process includes completion of the following:

1. An updated CLTS Functional Screen with eligibility results.

2. An updated assessment, reflecting the child and family's current abilities, preferences, and needs, either as a component of the notes section of the CLTS Functional Screen or another assessment tool.
3. A new, updated individual service plan signed by the participant, by his/her guardian or by his/her legal representative.
4. A current Medicaid Waiver Eligibility and Cost Sharing Worksheet (DDE-919) or current CARES screen printouts as applicable.
5. A new, updated copy of the Participants Rights and Responsibilities document, signed by the participant and guardian, as well as information about client rights as outlined under HFS94, Wis. Admin. Code.
6. If applicable, written notification to the family if the child is receiving Intensive In-Home Autism Treatment Services and due to transition to on going services during the next year.

When completed, a copy of the signed CLTS Waivers Recertification Checklist, the current CLTS Functional Screen eligibility page, and a copy of the current signed ISP is sent to the Bureau of Long Term Support's Children's Services Section. Upon receipt and approval of the recertification, a letter certifying the participant's continued eligibility will be sent by e-mail to the waiver agency CLTS contact.

### **7.03 Timeliness of Recertification and Documentation**

Federal standards and state program requirements require that eligibility for all Medicaid waiver program participation be re-established annually. The process assures that the participant continues to be both financially and functionally eligible for the Waiver program at the time of recertification. Therefore, the documentation completed to certify continued eligibility must be **current**. This means that the individual service plan must be **complete** and up to date and include **accurate** individual outcomes. It must contain a complete list of waiver funded and non-waiver funded services/supports, specify both the daily, ongoing costs as well as any one-time expenses and include funding source information for each provided service or support. (Please refer to the information in Chapter VI of this manual for additional information on ISP content requirements.)

The **financial** eligibility documentation must accurately reflect the participant's **current** financial situation and must be completed within twelve months of the initial financial eligibility, and then documented annually within twelve months of the previous recertification. Completion of financial eligibility documentation later than the annual anniversary month of eligibility may result in the waiver agency experiencing a loss of waiver funds.

The **functional** eligibility documentation must accurately reflect the participant's **current** functional status. Functional eligibility must be re-determined and documented annually and must occur within twelve months of the initial (or recertification) eligibility screen. The waiver agency that completes functionality eligibility re-determinations later than every twelve months may experience a loss of waiver funds.

While annual recertification is required, the waiver agency may determine that the recertification month should be changed. Changing the recertification month is permissible but the agency must maintain no more than a twelve-month interval between recertifications to maintain participant eligibility. To change a recertification month the review must be conducted **prior** to the month it is due (e.g., the recertification that is due in July is conducted in the month of March or May, or another month, as long as it occurs **before** the recertification is due).

Changing the recertification month in this manner moves the annual recertification month to March or May or another earlier month in the following year. County waiver agencies are encouraged to manage their system of annual recertification requirements in a manner so as to have the Medicaid financial review occur in the same month as does the waiver program review.

#### **7.04 Individual Service Plan Review**

At a minimum, the individual service plan (DDE 445 and 445A) must be reviewed **every six months during a face to face meeting** with the participant. Please refer to the Care Management/Support and Service Coordination service (Chapter IV, page IV-22). This review is documented by having the participant re-sign the individual service plan or sign a new updated ISP **and** by a case note in the participant record.

The case note documenting the service plan review should indicate at a minimum, that the identified individual outcomes and the services/supports put in place to address those outcomes were discussed with the participant and, when applicable, the guardian/legal representative. The case note should describe any changes that will be made. The changes may have been made as a result of newly identified individual outcomes or by a decision to increase/decrease current services in place or by an agreement to add new supports/services.

When the plan review is completed by telephone, the case note should indicate that a reasonable effort was made to meet face to face with the guardian/legal representative and explain why such a meeting was not feasible. For persons with a guardian, the care manager/support and service coordinator, the participant and the guardian or other legal representative participate in the plan development and plan review.

However, in these cases the guardian/legal representative signs the updated ISP. The contact with the guardian/legal representative should be face to face as well, but if this is not feasible the guardian contact may be done by telephone and the updated plan mailed to the guardian/legal representative for his/her signature.

**Important:** For participants who have a guardian, activated power of attorney for health care, or another legal representative: Even though the guardian or another representative actually signs the ISP, **the six month face to face plan review meeting with the participant remains mandatory.** All other care management/support and service coordinator contact requirements remain in force.

### 7.05 Individual Service Plan Updates

There are certain circumstances where the individual service plan must be updated (other than at review or recertification) and a new participant or guardian/legal representative signature obtained. Additionally, some changes made to the individual service plan require that the updated plan receive prior Department approval before the service can be provided. Some examples of service plan changes requiring an update or a prior approval request include (but are not limited to) the addition of a new service, a home modification or a CBRF or the use of institutional respite.

Because the plan serves as an agreement between the agency and the participant it should be kept up to date and list all services and supports that are **currently** in place. To ensure the service plan is current, **within six months of any change** to the individual service plan, a completed and signed ISP update (DDE 445 and 445A) should be placed in the participant record. A copy of the updated ISP must be provided to the participant and his/her legal representative. The ISP is a record of Medicaid waiver services which may be subject to estate recovery, so completeness and accuracy are essential.

The table on the following page provides a quick reference guide that care manager/support and service coordinator may refer to when deciding if an ISP update (DDE 445 and 445A) should be completed or if a variance approval or a service prior approval requested.

**Quick reference guide: Updating the ISP<sup>2</sup>**

CM/SSC ACTIVITY→	CASE NOTE	COMPLETE AN ISP UPDATE	SEND NEW ISP TO BLTS/ QA DESIGNEE	BLTS PRIOR APPROVAL/ VARIANCE?	WRITTEN NOTICE TO PARTICIPANT
<b>Event ↓</b>					
<b>Outcomes: Add new or Modify Existing</b>	YES	YES	NO	NO	NO
<b>Service Ends</b>	YES	YES	NO	NO	YES
<b>Service Is Significantly Increased/ Decreased</b>	YES	YES	NO	NO	YES (For service reduction)
<b>Start New Service</b>	YES	YES	NO	NO Except Home Modification or Institutional Respite or ADC provided in a nursing home.	NO
<b>CBRF Placement</b>	YES	YES	YES In CIP 1A/B — In CIP II, COP-W → YES <i>Only if a variance is required.</i>	YES (CIP II/COP-W ONLY) CBRF larger than 20 beds and all CBRFs connected to a Nursing Home.	YES
<b>Institutional Respite</b>	YES	YES	NO	YES	NO
<b>Home Modification</b>	YES	YES	YES Required for all ramps & fences, or home modification over \$2,000	YES Required for all ramps & fences and home modifications exceeding \$2,000	

<sup>2</sup> **Reminder:** Any time an ISP is updated the completed service plan document must include an updated Outcomes page and a newly signed signature page.