

CHAPTER II – WAIVER ELIGIBILITY

2.01 Waiver Eligibility

Waiver program eligibility is established when the applicant meets **all** of the following criteria:

1. Meets the definition of an appropriate target group;
2. Meets a waiver-eligible level of care;
3. Resides in an eligible setting;
4. Meets the non-financial and financial eligibility criteria for Medicaid;
5. Meets any applicable requirements for Wisconsin residency, and
6. Is determined to need Medicaid waiver services

Important: Information provided in the application for the Home and Community Based Waivers is used to determine a person's eligibility for Medicaid. The waiver agency is responsible to inform persons, parents, and guardians applying for the Medicaid Waiver that any person who makes a false statement or fails to disclose relevant events in order to obtain or retain Medicaid, including Waiver benefits may be subject to prosecution under Wis. Stat. s. 49.49 (1).

2.02 Waiver Target Groups

In order to be served by one of the Medicaid waiver long term support programs, applicants must meet the eligibility criteria for the appropriate target group. This section contains descriptions of the waiver target groups, alphabetically listed by waiver program. The chart below identifies the waiver(s) that serve persons in a particular target group. For detailed descriptions of the waiver target groups, see sections A – E below.

Waiver Program	BIW	CIP 1A/ CIP 1B	CIP II/ COP-W	CLTS- DD	CLTS- PD	CLTS- SED	COR
Target Group Description	Persons of any age with a brain injury regardless of age of onset	Persons of any age with a developmental disability (Federal definition)	Persons who are frail elders, or persons with physical disabilities; Persons with developmental disabilities who do not need active treatment	Persons under age 22 with a developmental disability (Federal definition)	Persons under age 22 with a physical disability	Persons under age 22 with a severe emotional disturbance	Persons over age 18 living with serious mental illness and a co-occurring physical disability

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

~~Children and adults with brain injury may be served by the Brain Injury Waiver (BIW). Brain injury is defined in s. 51.01 (2g) (a) of Wisconsin Statutes as any injury to the brain, regardless of age of onset, whether mechanical or infectious in origin including brain trauma, brain damage and traumatic brain injury, the result of which constitutes a substantial impairment to the individual and is expected to continue indefinitely. Brain injury includes any injury to the brain that is vascular in origin that is sustained by the person prior to attaining age twenty-two. Brain injury does not include alcoholism, Alzheimer's disease or a like irreversible dementia. Please refer to the information that follows under BIW LOC for more detailed information on Brain Injury eligibility requirements. Children up to 22 years old with a brain injury may apply for the CLTS DD Waiver because a childhood acquired brain injury is considered a developmental disability. For additional technical assistance see the brain injury decision tree at [BIWtree.pdf](#) or [Appendix A](#).~~

B. Community Integration Program 1A/1B (CIP 1A, CIP 1B)

The CIP 1A or CIP 1B may serve persons over the age of 18 who have a developmental disability. The term “developmental disability” is defined in s. 51.01 (5) (a) Wisconsin Statutes and also in Federal Rule P.L. 95-602. Eligibility criteria for the CIP 1A/1B waivers require that the person meet the **federal definition** of developmental disability. According to the federal definition:

A developmental disability means a severe, chronic disability of a person which:

1. Is attributable to a mental or physical impairment, or a combination of mental or physical impairments;
2. Is manifested before the person attains the age twenty-two;
3. Is likely to continue indefinitely;
4. Results in a substantial functional limitation in three or more of the following seven areas:
 - a. Self care
 - b. Receptive or expressive language
 - c. Learning
 - d. Mobility
 - e. Self direction
 - f. Capacity for independent living

g. Economic self-sufficiency, **and**

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.

For additional technical assistance, see [Developmental Disability decisiontree.pdf](#) and the companion instructions at [DDdecision tree_instrux.pdf](#) or [Appendix A](#) .

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

The CIP II and COP-W programs may serve *frail elderly* persons age 65 and over who have a long term or irreversible illness or disability that impairs daily functioning. *Long term* means an illness, condition or disability that is expected to impair functional ability indefinitely or for the foreseeable future (i.e., one year or longer).

The CIP-II and the COP-W programs also serve adults age 18 and over with physical disabilities who have received a disability determination (See section 2.05 (B) below). Physical disability means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly impairs at least one major life activity of a person (See s.15.197 (4) 2. Wis. Stats.) For additional technical assistance see the guidelines at [FunctionalScreen/PDdefinition.pdf](#) or [Appendix A](#).

According to the statute, “major life activity” means any of the following:

1. Self care
2. Performance of manual tasks unrelated to gainful employment
3. Walking
4. Receptive and expressive language
5. Breathing
6. Working
7. Participating in educational programs
8. Mobility, other than walking
9. Capacity for independent living

While the CIP II and COP-W programs primarily serve frail elderly persons over age 65 and persons over age 18 with a physical disability, there are additional populations that may be served by CIP II/COP-W under certain conditions. CIP II/COP-W may also serve persons who have a brain injury as defined in s. 51.01 (2g) (a) of Wisconsin statutes when the brain injury occurred before age 22 **and** the person has received a No Active Treatment (NAT)

determination (See Section 2.04 below). CIP II and COP-W programs may also serve persons who have a developmental disability when the disability is primarily physical in nature, such as epilepsy or cerebral palsy, where there is no mental retardation **and** the person has received a No Active Treatment (NAT) determination.

Note: Persons who are mentally retarded and younger than age 65 may not be served by CIP II/COP-W.

In general, developmentally disabled participants aged 65 and older continue to be served by CIP1A/1B/~~BIW~~. However, if the person's condition has changed **and** the participant no longer requires active treatment **and** receives an NAT determination, the person may be served by the CIP II/COP-W. Agencies are encouraged to proceed with caution when making such changes. It must be clear that the NAT is appropriate and that there are other appropriate program services available (See Section 2.04 below.)

1. Required Documentation of Health Status in CIP II/COP-W

COP-W and CIP II participants must have documentation of their health status verified at the initial application and at annual recertification. At application, a completed Medicaid Waiver Program Health Report form (F-20810) or a completed LTC-FS Assessment/Supplement signed by a registered nurse meets the verification requirement (See [Appendix A](#)). The completed Assessment/Supplement or the F-20810 ensures that medical status has been reviewed and medical information has been provided in writing, to the care manager or support and service coordinator, by a physician, nurse or physicians assistant, at least annually. At recertification the annual documentation of health status is verified with the completion of a new F-20810. (The Medicaid Waiver Program Health Report form is available at [F-20810](#).)

D. Children's Long Term Support Waivers (CLTS)

The CLTS waivers serve children and persons under the age of 22 who have a developmental disability, physical disability and those who have a severe emotional disturbance.

1. Developmental Disability

Children with a developmental disability may be served by the CLTS – Developmental Disabilities waiver, provided his/her condition meets the federal definition of a developmental disability and s/he receives an ICF/MR Level of Care on the Children's Long Term Support Functional Screen, referred to hereafter as the Developmental

Disability LOC (DD LOC). The federal definition is described in section 2.02 B above (See also DD LOC in [Appendix A.](#))

2. Physical Disability

Children with physical disabilities may be served by the CLTS – Physical Disabilities waiver. Physical disability is defined as a long term medical or physical condition that significantly diminishes the child’s functional capacity and interferes with his/her ability to perform age appropriate activities of daily living at home and in the community. The child must also meet an eligible hospital or nursing home level of care on the Children’s Long Term Care Functional Screen (See s.15.197 (4) 2, Wisconsin Statutes and Section 2.02 C above. See also [Appendix A.](#))

3. Severe Emotional Disturbance

Children with severe emotional disturbance may be served by the CLTS - Mental Health Waiver. A child must meet multiple criteria including: be under the age of 22, have a diagnosis of a long term emotional and/or behavioral condition, have significant psychiatric symptoms or functional impairments, and currently receiving services. The child must also meet an eligible Severe Emotional Disturbance LOC on the Children’s Long Term Care Functional Screen (CLTS-FS). Also see Appendix A-10.

For additional technical assistance, see the clinical instructions for the children’s screen available at cltsfs/instructions.htm or [Appendix E.](#)

E. ~~Community Opportunities and Recovery (COR) Waiver~~

~~COR is a nursing home relocation Medicaid Waiver that serves adults living with a serious mental illness and a co-occurring physical disability. People served by COR are expected to continue to meet the nursing home level of care but, with appropriate supports, can be successful in the community.~~

~~Physical disability means a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly impairs at least one major life activity of a person (See s.15.197 (4) 2. Wis. Stats.) According to the statute, “major life activity” means any of the following:~~

- ~~1. Self care~~
- ~~2. Performance of manual tasks unrelated to gainful employment~~
- ~~3. Walking~~

- ~~4. Receptive and expressive language~~
- ~~5. Breathing~~
- ~~6. Working~~
- ~~7. Participating in educational programs~~
- ~~8. Mobility, other than walking~~
- ~~9. Capacity for independent living~~

~~The COR program is specifically designed to meet the needs of a sub-population within the nursing home eligible population. COR was also designed to work within current systems of care within a community for mental health services. Both Community Support Programs (CSP) and Comprehensive Community Services (CCS) are current programs utilized within communities in order to support persons who live with mental illness, where available. These programs will partner with COR in order to best serve the individual while not duplicating services. Appropriate persons for COR will meet all functional and financial requirements for the COP-W as well as the additional requirement for a diagnosed serious mental illness.~~

2.03 Waiver Services for Persons with Severe and Persistent Mental Illness

Except for eligible children as described in 2.02 D (3) above, persons with severe and persistent mental illness must meet the same functional eligibility requirements of the applicable waiver program **and** be determined to be eligible for admission to a nursing home or an ICF-MR at a level of care reimbursable by Medicaid. These persons must also meet all other waiver eligibility criteria.

2.04 Active Treatment/ No Active Treatment (NAT) Determination

A. Active Treatment

To be eligible for Medicaid Waivers ~~BIW~~, CIP 1A, CIP 1B and CLTS, the individual with the disability must meet the same level of care as required for admission to an ICF-MR and need a system of support and/or service in the community that is generally equivalent to the active treatment provided in an ICF-MR. Federal rule defines active treatment as: “A continuous treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services.

Active treatment services are directed toward the acquisition of behaviors necessary for the participant to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain generally independent persons who function with little support, or in the absence of a continuous active treatment program.”

Note: Children up to the age of 21 years are expected to be able to benefit from education and /or related service. It should never be assumed that a child cannot benefit from education and training.

B. No Active Treatment (NAT)

The Department recognizes that there are certain persons with a developmental disability who may not, or may no longer benefit from active treatment in an ICF-MR or from a comparable system of supports and services focused on habilitation in the community. Such individuals may qualify for a No Active Treatment (NAT) rating. Federal rule provides for exceptions to the requirement that persons with a developmental disability receive active treatment in a nursing home or in an ICF-MR or comparable services in the community are as follows:

1. The person’s medical needs are of such a severe and chronic nature as to require skilled nursing facility (SNF) care or,
2. The person’s physical or mental incapacitation is due to advanced age, and the person’s needs are similar to those of geriatric nursing home residents.

The following criteria may be used to help to identify when the NAT determination may be appropriate:

1. The person is 65 years of age or older, and there are factors that indicate that the individual has reached his/her maximum potential and will not benefit from active treatment.¹ Such factors may include:
 - a. The person has lived more than ten (10) years in a nursing facility;
 - b. The person has a degenerative health status;
 - c. The person was discharged or transferred from an ICF/MR after age 55;
 - d. The person was discontinued from habilitation services due to a determination that he/she has reached a maximum benefit from those services;

1. Note: Attaining age 65 is not a requirement for a No Active Treatment designation. Persons under 65 who meet the criteria may also qualify.

- e. Assessment by a Qualified Mental Retardation Professional (QMRP) (see Appendix A for definition), psychologist, or other appropriate staff indicates that the individual has reached his/her maximum potential and the objectives of the care plan are to maintain present skills;
 - f. The person has a terminal illness, as documented by his/her physician and the medical needs of the person outweigh his/her need and receipt of a system of support or service that is generally equivalent to the nursing home or ICF-MR resident's need for active treatment.
2. The person has a related disability, such as epilepsy, brain injury, autism or cerebral palsy, but does not have mental retardation and the person is competent.

Important note: The NAT determination may make the person with a developmental disability **ineligible** for the ~~BIW~~, CIP 1A, 1B and CLTS Medicaid waiver programs. These persons may become eligible for the CIP II or COP-W Medicaid waivers with the NAT determination. However, NAT ratings should not be pursued for the purpose of changing funding source, nor should the NAT determination be sought in order to avoid facility size restrictions.

Any effort to assign an NAT to a person with a developmental disability must be undertaken with caution. Consideration must be given regarding the availability of other programs and/or services. The participant must be given information; the opportunity to choose and have his/her informed choice considered in the decision to seek an NAT.

C. Procedure to Request an NAT Determination

The waiver agency submits a written request for the NAT determination to the BLTS COP Section or its designee. The request must include the applicant's proposed service packet. Additionally, when the applicant is ending their participation in waiver programs ~~BIW~~, CIP 1A, CIP 1B or CLTS, the NAT request must also include a copy of the most recent individual service plan in force from the previous waiver program **and** must provide evidence that the transition from one waiver to another waiver or termination of waiver participation has been carefully considered.

All requests for NAT that involve a participant who is proposed to transition from Waivers ~~BIW~~, CIP 1A, CIP1B and CLTS to CIP II or COP-W must include documentation that the transition consideration process included:

1. The active involvement of the participant (and guardian as appropriate), and that informed choice supports the NAT request;

2. A reassessment of the person's needs and individual outcomes that supports the request for the NAT rating;
3. A review of funding and service availability should the NAT be denied;
4. A review of each service the person was receiving relative to the service(s) he/she may or may not have access to should the NAT be approved;
5. A determination that any other applicable CIP II/COP-W eligibility criteria will be met (e.g., NH LOC, allowable living arrangement, etc.)

Staff at the Bureau are available to offer technical assistance in the NAT determination process. Once received, the Bureau reviews each request individually and makes the decision to approve or deny. The Bureau decision to approve or deny the request for an NAT is noted in the application approval letter sent to the applicant county agency.

2.05 Medicaid Non-Financial Eligibility Requirements

Certain Medicaid non-financial eligibility determinations are made by the county Income Maintenance Agency (IMA). These include the determination of residency and/or citizenship and in some circumstances disability (see section B below). The determination of need for Medicaid waiver program services is made by the waiver agency.

A. Residency/Citizenship

With one exception, the Wisconsin Medicaid waiver programs follow the federal Medicaid residency/citizenship requirements. (See Medicaid Handbook at handbooks.wi.gov/meh-ebd/ for definitions.) The exception is the CLTS waivers where a six-month state residency requirement exists for children specifically seeking in-home treatment services when a waiting list exists for funding for that treatment.

B. Disability Determination

With one exception, Medicaid waiver participants who are children and persons aged 18 to 64 must have a disability determination. The exception applies to the CLTS waivers and is described below.

1. Disability Determination – CLTS Waivers
A child applying for the CLTS waivers in a state-matched slot is required to have a disability determination completed. The SSC provides written notification to the county Income Maintenance Unit indicating that the child is applying for a **state-matched** CLTS waiver slot which requires a disability determination by the Disability Determination

Bureau (DDB). The income maintenance worker then follows established procedures to submit an electronic Medicaid Disability Application (MADA). A child applying for a **locally-matched** CLTS waiver slot is not required to have a disability determination however, the child must still meet an appropriate Level of Care. Children who currently receive Medical Assistance through SSI or the Katie Beckett Program have already had a disability determination completed.

The DDB adjudicators follow federal disability rules which are highly regulated and very precise. Medical evidence is the cornerstone for the determination of disability and must be provided by medical professionals defined by the Social Security Administration (SSA) regulations as “acceptable medical resources.” In general under title XVI, a child under age 18 is considered disabled if he or she has a medically determined physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that has lasted or can be expected to last for a continuous period not less than 12 months or that can be expected to cause death.

Medically determined physical or mental impairment is defined as an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by the individual’s or parent’s statement of symptoms.

The Disability Determination Bureau issues approval and denial letters regarding disability determinations or related appeals directly to applicants. A disability determination is also not a permanent decision. If approved, a child is given a medical review “**diary date**” which is the month and year when the child’s disability will again be officially reviewed.

Additional information can be obtained regarding the SSA disability criteria for children are located at: <http://www.ssa.gov/pubs/10026.html>.

2. Presumptive Disability – All Waivers

In certain circumstances the county Income Maintenance Agency or DDB may make a **presumptive disability** determination at the time of application. An applicant with a presumptive disability may be considered to have met this eligibility standard until a final disability determination is made. If the presumptive disability determination is later reversed by DDB and the disability is denied, the person becomes ineligible for the Medicaid waiver program and participation must end after appropriate notice is given.

The applicant may appeal the denial of disability or the termination of waiver services or

both. Medicaid covered services received during the period of presumptive disability may not be recovered.

Important: For CLTS waivers, if the disability is denied, the county is liable for all services billed to the CLTS waiver.

Reminder: A disability determination is **not the same** as a level of care determination and one cannot be substituted for the other. Persons who have received a disability determination must also meet the appropriate level of care. The Disability Determination Bureau (DDB) within the Division of Health Care Access and Accountability (DHCAA) or the Social Security Administration makes the disability determination.

C. Need for Medicaid Waiver Program Services

Persons who have been determined to meet the non-financial and functional eligibility criteria for waiver participation but who **do not have an assessed need** for waiver services are not eligible for Medicaid using the special waiver program eligibility criteria (42CFR, 435.217(c)).

The federal Centers for Medicare and Medicaid Services (CMS) defines “reasonable need” as follows: “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.”

1. Applies to ~~BIW~~, CIP 1A/1B, CIP II , and COP-W ~~and COR~~

In those instances where care management/support and service coordination is the only service funded by the waiver program, there must be evidence that the participant is receiving other long-term support services. Those services may be funded by another payment source, or may be provided by family members or another informal support provider. In such circumstances the waiver agency must provide assurance that all of the assessed needs of the participant are met and that care management/support and service coordination services are justified.

2. Applies to CLTS Waivers

A child who participates in the CLTS Waiver must have at least one CLTS Waiver service in addition to Support and Service Coordination identified as **an assessed need** on the child’s Individual Service Plan (ISP) each service year,

AND

- a) The child must **need and receive** at least one CLTS Waiver service in addition to Support and Service Coordination at least monthly and this must be included in the documentation on the child's individual service plan,
- OR**
- b) The child must require monthly monitoring and the Support and Service Coordinator documents this need on the child's individual service plan.

If a child does not meet the criteria as described above, the waiver agency must terminate that child's participation in the CLTS Waiver once 90 days have elapsed since the above described criteria were not met.

2.06 The Parental Payment Limit

After program eligibility is established a parental payment may be required. The waiver agency must obtain required information and complete documents related to the parental payment limit for all children under the age of 18 applying for **any** Home and Community-Based Waiver program. Additional information regarding the Parental Payment Limit may be found at <http://dhfs.wisconsin.gov/bdds/clts/ppl/index.htm>.

2.07 Level of Care (LOC)

~~A. BIW Level of Care~~

~~In order to receive the proper level of care (LOC), the applicant's medical status/condition must meet the definition of "Brain Injury" found in Wisconsin Statute 51.01 (2g) (a), and the applicant must qualify for a level of care reimbursable by Medicaid in a nursing home or be eligible for post-acute rehabilitation institutional care, as indicated on the Title XIX Care Level Determination form. The BLTS paper based care level rating process will continue until a new electronic process is operational.~~

~~The waiver agency support and service coordinator submits needs specific information on each applicant in order to establish LOC. The completed, [F-62256](#) and [F-62256A](#) forms, Parts A and B, the Individual Service Plan, together with appropriate documentation from the original hospitalization are all considered in this process (See [Appendix A](#)). Information that states the date of onset, etiology of the brain injury, and how the person's functional status is impaired due to the brain injury must also be reviewed. 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. Appendix A 7 of~~

~~this manual includes helpful information concerning the Brain Injury definition, and also Brain Injury Level of Care. (See also the BIW decision tree at [BIWtgtree.pdf](#).)~~

~~All applications for BIW LOC must include the following written documentation:~~

- ~~1. Level of Care Assignment forms F-62256 and F-62256a~~

~~The support and service coordinator arranges for forms [F-62256](#) and [F-62256A](#) to be completed, and for the forms to be 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.~~

- ~~2. Individual Service Plan Form (F-20445) and (F-20445A)~~

~~The Individual Service Plan form ([F-20445](#)) with the accompanying Individual Outcomes form ([F-20445a](#)) must be completed as a part of the application process. The ISP will list the type and amount of services and supports to be provided to meet assessed needs and address identified individual outcomes. The completed forms must also include a current, completed signature page. Copies of the forms F-20445 and the F-20445A may be accessed through [Appendix I](#) of this manual.~~

- ~~3. Eligibility Cost Sharing Worksheet (F-20919) or the CARES Community Waivers Budget screen printouts.~~

~~The financial eligibility worksheet ([F-20919](#)) is completed by the CM/SSC or the IM staff. All current financial eligibility information must be documented on this form. For those BIW applicants whose Medicaid financial eligibility is met under the waiver financial eligibility groups B or C, the certification documents also include a copy of the CARES Community Waivers Budget form which is obtained from the county Income Maintenance staff.~~

B. CIP 1A and CIP 1B Level of Care

In order to be eligible, applicants to the waivers CIP IA and CIP IB must qualify for a DD level of care (LOC) reimbursable by Medicaid in an ICF-MR at a level of DD-1a, DD-1b, DD-2 or DD-3 as determined by the Wisconsin Adult Long Term Care Functional Screen (LTC-FS). LOC must be determined not less than annually. (Please see [Appendix A](#) or the clinical instructions at [Adult FunctionalScreen/instructions.htm](#).)

C. CIP II and COP-W and Level of Care

Level of care eligibility for CIP II/COP-W is established when the applicant meets a level of care reimbursable by Medicaid in a skilled nursing facility (SNF) or an intermediate care

facility (ICF). Beginning January 1, 2005 all initial level of care determinations and annual re-determinations of level of care are made using the Wisconsin Adult Long Term Care Functional Screen (For more information, see Appendix A or the LTC-FS clinical instructions at [Adult FunctionalScreen/instructions.htm](#).) Waiver eligibility is established with a determination of a qualifying Nursing Home LOC, as indicated on the LTC-FS Eligibility Results page. A screen result of Intensive Skilled Nursing (ISN) or Skilled Nursing Facility (SNF) is equivalent to HSRS Level 1. A screen result of Intermediate Care Facility (ICF-1 or ICF-2) is equivalent to HSRS Level II.

The qualifying screen result means the person has a need for services and supports that is equivalent to the threshold level of care for nursing home admission. These needs may include assistance with activities of daily living (e.g., bathing, dressing, eating, mobility, etc.) and/or instrumental activities of daily living (meal preparation, medication management and/or administration, money management, etc.) Identified needs may also include assistance with health related services including nursing assessment, skilled therapies and the like. Level of care eligibility rests then on the level of assistance/need identified on the functional screen, the frequency of assistance needed and the risk that without the provision of such assistance the person would face institutionalization.

D. CLTS Level of Care

In order to be eligible, applicants to the CLTS Waivers must qualify for a DD, PD, or SED level of care (LOC) reimbursable by Medicaid in a comparable institutional setting, as determined by the Children's Long Term Care Functional Screen (see [Appendix A](#).) See also [Appendix E](#) for additional CLTS waivers policy information.

~~E. COR Waiver Level of Care~~

~~Level of care eligibility for COR is established when the applicant meets a level of care reimbursable by Medicaid in a nursing facility (NF) as determined by the Wisconsin Adult Long Term Care Functional Screen (LTS-FS).~~

2.08 Eligible Living Situations

To be eligible for waiver participation the applicant must reside in an eligible living arrangement. As used in this section, references to a person's living arrangement, where the person may "reside" or to his/her "residence" refers to the participant's permanent residence or living arrangement. This does not include places where the waiver participant may stay on a temporary basis or a place where they may receive services such as respite care. For example, a waiver

participant's permanent living arrangement does not change while they are staying in a dormitory or residence hall while attending school. Similarly, the residence of a person receiving respite services is not the location of the facility providing the respite care.

The following lists indicate, by waiver program, which permanent living arrangements are permitted or prohibited.

A. BIW, CIP1A/1B

1. Permitted living arrangements:

- A house, apartment, condominium or other private residence
- A rooming/boarding house
- An adult family home certified for 1 or 2 beds
- An adult family home licensed for 3 or 4 beds
- A CBRF licensed for 5-8 beds

2. Prohibited living arrangements:

- A hospital
- An institution for mental disease (IMD)
- A licensed nursing facility (SNF, ICF)
- A Residential Care Apartment Complex (RCAC)
- An intermediate care facility-mental retardation (ICF-MR) including any of the Wisconsin Centers for the Developmentally Disabled
- A jail, prison or other correctional facility

B. COP-W and CIP II and ~~COR~~

1. Permitted living arrangements:

- A house, apartment, condominium or other private residence
- A rooming/boarding house
- A certified adult family home (1-2 beds)
- A licensed adult family home (3-4 beds)
- A certified RCAC
- A licensed CBRF (5-20 beds);

Living arrangements permitted with an approved variance:

- A CBRF licensed for more than 20 beds (applies to eligible persons with disability and frail elders)

- A CBRF of any size that is structurally connected to a nursing home (Applies to frail elder target group only - refer to [Chapter V](#) for variance information.)

2. Prohibited living arrangements:

- A hospital
- A nursing home
- An ICF-MR including any of the state centers
- An institution for mental disease (IMD)
- A jail or prison or other correctional facility

C. CLTS

1. Permitted living arrangements:

- A house, apartment, condominium, rooming/boarding house or other private residence with the participant's natural or adoptive family or a non-legally responsible adult relative (i.e. aunt/uncle, grandparent)
- A house, apartment, condominium, rooming/boarding house or other private residence, for a participant age 18-22 living independently
- A licensed child foster home
- A licensed child treatment foster home
- A certified Adult Family Home (1-2 beds) - participants age 18-22
- A licensed Adult Family Home (3-4 beds) - participants age 18-22

2. Prohibited living arrangements:

- A hospital
- A licensed group home for children
- A licensed nursing facility (SNF, ICF)
- An ICF-MR including any of the Wisconsin Centers for the Developmentally Disabled
- Residential Care Center for Children
- A juvenile detention facility

2.09 Waiver Participant Moves

This section addresses responsibility for funding waiver services when a participant voluntarily moves from one county to a different county. It also describes the processes used to accomplish the transition of funding between the two counties. In this chapter, the two counties are referred

to as the “**sending county**,” which is the original county **from which** the participant moved and the “**receiving county**,” which is the county **to which** the participant moved.

State policies concerning funding responsibility support the ability of the waiver participant to freely move across county lines without consequence to the person’s waiver funding or waiver services. The state Medicaid waiver policy does not extend to other funding sources which are governed by other statutes, policies and rules (e.g., COP, Community Aids, etc.) An eligible waiver participant who has begun receiving services has a right to continuity of services and freedom of movement while residing in Wisconsin. This means that an eligible waiver participant should be able to move anywhere in Wisconsin without losing eligibility to receive funding for waiver-covered services. Medicaid waiver services may not be reduced or terminated solely because the participant has moved to a different county.

~~The COR Waiver may have a different set of policies governing a participant’s voluntary move from one county to another county. Unlike some other waiver programs in Wisconsin, COR is directly administrated by the Division of Mental Health and Substance Abuse Services (DMHSAS.) Counties/tribes are required to submit a written description addressing implementation issues in order to participate in COR. The COR waiver is not available within counties operating the Family Care program and may not necessarily be portable across county lines within Wisconsin.~~

Note: Portability of funding as discussed in Section 2.09 below refers to Medicaid Waiver dollars. Services and supports funded solely by COP, Community Aids or by local funding sources are subject to state statutes, guidelines and local county policy governing such funding and are not similarly transferable (see COP Guidelines, Chapter IV, Section 4.01.)

Reminder: Any discussion of potential moves from one county or another must at a timely point involve the Income Maintenance agency. It is the responsibility of the waiver CM/SSC to ensure that IM staff is informed so that necessary transfers can occur and Medicaid eligibility is not interrupted.

A. CIP 1A/1B and BIW

1. Program Responsibility

When a CIP IA or; CIP IB ~~or BIW~~ participant moves to a different county, the sending county is required to continue to fund a level of services and supports sufficient to address the person's needs and assure individual’s health and safety until the receiving county is able to assume responsibility. The sending county must revise the participant’s

individual service plan to reflect changes in residence and service provider(s); coordinate and monitor services and ensure that providers meet waiver requirements and standards.

Waiver participants and the sending county have the responsibility to notify the receiving county, with as much advance notice as possible, of the participant's plans to move. If the receiving county lacks the resources to finance the plan, it must place the person on the wait list by registering the person on HSRS as waiting for funds to become available. (See [Chapter I](#), Section 1.06.)

In circumstances where there is other service funding in place (state GPR, COP, local levy, etc.) agencies must notify participants that those funds will not necessarily follow the person as they move. Agencies must also make a reasonable effort to inform the participant as to the availability of services and funding in their new county of residence.

When funding issues arise, county waiver staff should contact their assigned Area Quality Specialist (AQS) and/or the BLTS DDSS central office for guidance as they support participants in the moves process.

B. CLTS

1. Waiver Agency Responsibility

When a CLTS participant voluntarily moves to a new county and establishes legal residence there (physical presence and intent to remain), the participant or the sending county have the responsibility to notify the receiving county with as much advance notice as possible, of their plans to move. After notification, which agency has fiscal and program responsibility for addressing the person's needs and assuring the individual's health and safety depends upon the type of funding attached to the child's waiver slot.

- a. **Locally-Matched Slot or State-Matched Slot** (not including Crisis or Autism slots – see Section B below): The receiving county must respond to the move and fund the plan thirty days after receiving notice of the move from either the participant or the sending county (whichever was first). If the receiving county lacks the resources to finance the plan, it must place the person on the wait list by registering the person on HSRS with the appropriate SPC Code. The effective date that the county registers the child on HSRS should be the date they received notice of the move. State policies outlined in Chapter I govern the person's placement, priority movement and ultimately the acceptance for services from the wait list.

The sending county is required to continue to fund the service plan until the receiving county has sufficient resources to do so. For the entire period the sending county is funding services, this waiver participant is considered to be the responsibility of the sending county for all purposes associated with the waiver program, including HSRS reporting. If the move is of significant distance (either more than two hours drive or further than 100 miles from the location of the service coordinator), the ISP must also address how participant health and safety will be monitored and assured by the sending county. All SSC contact requirements continue to apply and cannot be waived because of travel time, distance or cost. The sending county may arrange for the transfer of Support and Service Coordination responsibilities to the receiving county while maintaining the funding responsibility.

When the waiver participant who moved is next on the receiving county's waiting list and the resources needed to fund the plan become available, the receiving county shall use those resources to finance the plan. Once the receiving county has begun to fund the waiver participant's service plan, the receiving county is then obligated to take primary program responsibility for the waiver participant. After the transfer of program responsibility, the receiving county is obligated to maintain ongoing services and address any new or increased needs.

If the waiver participant is also receiving Family Support Program funds when he/she moves to another county within the state, the family must apply for the Family Support Program in the new county of residence. At their discretion, the sending agency may continue to use Family Support Program funds to fund services during the transition. Following the transition, the sending county must allocate other local resources to continue services, until the receiving county assumes responsibility.

- b. **State-Matched Crisis Slot or State-Matched Autism Slot** (intensive or ongoing):
The receiving county is required to assume full responsibility. The slot remains with the child as long as the child maintains waiver eligibility, and when the child discontinues waiver participation in the future, the funding returns to DHS. Sending and receiving county follow these steps in HSRS:
- (1.) Sending county closes all SPC's, the slot and episode as of the date of the move (the sending county can still enter costs for the period of time they served the child, but they cannot open new services).
 - (2.) Sending county shares with the receiving county the child's HSRS ID number so that the receiving agency can register the child using the same ID.
 - (3.) Receiving county registers the child in HSRS and e-mails DHS central office to request that the slot be activated using the date of the move.

C. CIP II/COP-W ~~and COR~~

A person who has been determined eligible for participation in a Medicaid waiver program and who has begun receiving services has a right to continuity of waiver services and freedom of choice while residing in Wisconsin. This means that a waiver program participant may not have his/her waiver eligibility terminated solely because s/he has moved to a different county in the state. Generally, CIP II/ COP-W funds will move with the person, subject to the provisions described below. However, services funded solely by non Medicaid Waiver sources including COP, Community Aids and other local/county dollars are subject to state guidelines, local county policy and funding availability, and are not similarly transferable.

Waiver participants must be informed at the outset of program participation that it is their responsibility to inform the waiver program agency, with as much advance notice as possible, of plans to move to another county.

1. CIP II

If a CIP II waiver program participant moves out of the county, the CIP II slot and funding follow the participant to the new county of residence. The funding stays with the receiving county until that county is able to fund the participant or the participant is no longer eligible for program participation. At that time the CIP II slot reverts back to the sending county.

2. COP-W

If a COP-W program participant chooses to move out of the county the receiving county is responsible for funding the participant. However, if the receiving county is unable to provide funds to serve the participant, the sending county retains funding responsibility until the receiving county is able to fund the waiver participant. This may be accomplished using any one of the following options:

a. The sending county continues to report expenses on HSRS and receive reimbursement for the participant.

(1) The sending county may continue to provide care management, if the frequency of contact requirements can be met, and to pay the providers directly.

(2) A subcontract may be arranged with the receiving county for some or all of the waiver services including care management.

- OR -

b. The sending county may move the participant's funding to an available CIP II slot and instruct the Department to move the slot to the receiving county. The receiving county would report the expenses on HSRS and provide care management services. In this

situation the CIP II slot would be returned to the sending county when the receiving county was able to provide funding for the waiver program services.

- OR -

- c. If there are compelling reasons why options a or b above are not feasible, the Department may adjust the COP-W contracts. This would entail the reduction in the COP-W allocation by a minimum of one slot for the sending county and an increase in the allocation by one slot for the receiving county. This change in slot allocation will be permanent and future contracts will reflect this change. The receiving county would be required to serve the participant using the increased allocation.

When a COP-W participant decides to move, the two counties involved should discuss each situation individually and determine which solution will work best for them while ensuring that the participant's waiver program services continue uninterrupted. When unusually complex situations arise, the Bureau will facilitate problem solving.

~~3. COR~~

~~If a COR participant voluntarily moves out of their county of COR Waiver origin, COR may not necessarily be available within their new county system. Counties must be approved by DMHSAS for the operation of the COR waiver. If both the sending and the receiving counties are COR approved, DMHSAS must be contacted for approval of the transfer. Both counties must agree to the transfer as well. If a COR participant relocates to a non-COR county, they may contact the DHS to apply for another Wisconsin waiver program.~~

D. Family Care/Managed Care Waivers

The term "COP/Waiver Counties" means those Wisconsin counties where the COP-W, CIP 1, and CIP II, ~~and COR and Brain Injury~~ Waivers are available, and where the Family Care benefit is not available. Additional information concerning the Family Care moves policies may be found on the Department's web location at [FamilyCareMovesProtocol.pdf](#).

E. Moves During Transition from the Waivers to Managed Care

As local programs transition from the Medicaid Waivers to Managed Care there are certain protocols that may fall outside the Waiver moves processes described in Sections A through C above. There will be participants who move to established Managed Care counties or counties that are in transition. Or, members of established MCOs may seek to move to counties where the Medicaid Waivers continue to operate. Agencies may seek guidance from Managed Long-Term Care Expansion Planning Information Memos addressing such moves at the following link: [info_6_residency.pdf](#). Agencies may also consult the LTC Fiscal

Update Memo Series available on the DLTC Information Memo site at:

InfoMemos/DLTC/CY2008/index.htm. For individual situations that do not fall within the prescribed policies, agencies should contact the Bureau for guidance.

Important: In all 'moves' situations county waiver agencies, MCOs and ADRCs must assure that the consumer is fully informed of **any** program and service differences that may impact the choice of service provider and availability of funds to support that choice. For example, COP funds may not follow the person from one county to another; or COP funds that were used to pay for a non-waiver allowable service in one county may not be available in the next. The Department expects all agencies involved to provide timely notice to the receiving county program and IM staff to assure service and eligibility transitions are as smooth as possible.

2.10 Denial of Participation or Termination of Program Participation

A. Denial and Termination

Conditions under which an otherwise Medicaid-eligible applicant/participant may be denied participation in the Waiver and/or have their participation terminated include:

1. The individualized assessment and service plan indicates that health and safety cannot be assured in the community setting.
2. The participant fails to meet non-financial eligibility criteria (see Section 2.05).
3. The participant fails to meet functional eligibility criteria at initial application, annual recertification or at any time while participating in the Medicaid waiver program.
4. The participant fails to meet Medicaid financial eligibility criteria at initial application, annual recertification or at any time while participating in the Medicaid waiver programs.
5. The participant fails to meet post-eligibility program requirements. These requirements include meeting the monthly spenddown obligation or making the monthly cost share payment(s).
6. The cost of planned service(s) exceeds the specific waiver program cost average requirements as described below:
 - a. ~~CIP 1A/1B and BIW~~
Denial of participation or plan termination must occur when an individual's cost of Medicaid card services plus Medicaid waiver planned services cause the average cost

of the entire waiver caseload to exceed the average cost of serving the institutional population (institutional costs plus his/her card costs).

b. CIP II/COP-W ~~and COP~~

(1) Denial of participation or termination may occur if the estimated cost to Medicaid of CIP II/COP-W ~~or COP~~ services exceeds the allowable Medicaid community waiver program average daily rate on a per person basis and the inclusion of the applicant/participant in the Medicaid community waiver would cause average program expenditures for the county to exceed the average allowed in the state-county contract. (In these circumstances the county should contact the Bureau COP Section to discuss alternative arrangements.)

(2) Denial of participation or termination for CIP II/COP-W ~~or COP~~ participants may also occur when the total projected cost to Medicaid of the waiver services plus the Medicaid card services for the person exceed the average per person amount specified in the Medicaid waiver application approved by the Center for Medicare and Medicaid Services (CMS).

c. CLTS

For CLTS programs, the policies and procedures describing the termination process are located in [Appendix E](#) or at [CLTSWaiverTermination.pdf](#).

d. COP

Community Options funded services may be terminated only in the following situations:

- (1) The participant is no longer eligible for Community Options services or,
- (2) The participant no longer needs Community Options Services or,
- (3) The health, welfare and safety of the participant or others can no longer be reasonably assured or,
- (4) The participant has fraudulently obtained or misused Community Options funds or Community Options services or,
- (5) A participant who initially received services on or after January 1, 1990 has become waiver eligible but has refused Medicaid community waiver services or,
- (6) The lead agency allocation is insufficient to meet the service commitment to current participants, and the lead agency has:

- a) Made all reasonable efforts to secure resources to avoid service reductions;
- b) Closed admission to new participants;
- c) Assured the reduction in services does not endanger the health and safety of the participant and/or caregivers and has referred the participant to other available programs and services needed to protect the health and safety of the participant and,
- d) Adopted a fair and equitable policy for distributing service reductions among participants.

Prior to any action by a county/waiver agency to terminate or reduce COP funded services participants must be properly notified. The notification and applicant/participant rights obligations described in Chapter 5, Section 5.10 (G) of the COP Guidelines apply.

B. Notification and Rights (Applies to all waivers)

The notification and applicant/participant rights procedures **apply to all waivers**. If a determination is made to deny or terminate waiver participation or if waiver services are reduced or terminated, the agency shall give the applicant/participant appropriate written notice of the decision.

Appropriate notice shall clearly state:

- What action the agency intends to take,
- The effective date of the agency action, and
- The specific regulation supporting the action.

1. Denial of Participation

If upon completion of the assessment the application for waiver participation is denied, the waiver agency must notify the applicant **within thirty calendar days** of the decision. The notice must contain information describing the applicant's state appeal and county grievance rights, a clear statement of the timelines that apply and a listing of whom to contact to initiate the appeal (or grievance) and whom they may contact for assistance to prepare or present the appeal.

2. Reduction or Termination of Services

The waiver agency may not reduce or terminate services to a Medicaid waiver participant without providing the participant with appropriate written notice. The notification shall cite Chapter 227 of Wisconsin Statutes and shall be given **at least ten (10) calendar days in advance** of the effective date of any reduction or termination of services.

The notice shall:

- Inform the participant that s/he has the right to request a hearing from the state Division of Hearings and Appeals (Chapter 227).
- Inform the person that if s/he requests a hearing prior to the effective date of the agency action the services will continue.
- Inform the participant that if s/he requests a hearing regarding a reduction or termination of services action, and the affected services continue pending the hearing decision, and a hearing decision upholds the action to reduce or terminate services, s/he may be required to reimburse the Department for the cost of any affected services s/he received during the time period beginning on the original effective date of the notice up to and including the date of the hearing decision.
- Inform the participant that s/he has forty-five (45) days to appeal the agency decision and that a hearing requested after 45 days may not be heard.
- Inform the participant of the county grievance process and any appeal rights under HFS 94 (Patient Rights).
- Inform the participant that pursuing a county grievance or requesting an appeal under HFS 94 may not affect the date of termination or reduction of services.

3. Termination of Waiver Program Participation

The waiver agency may not terminate participation in the waiver program without providing the participant with appropriate **written notice**. The notice shall cite Chapter 227 of Wisconsin Statutes and shall be given at least **ten** calendar days in advance of the effective date of the agency action.

- If termination of participation is occurring due to a loss of Medicaid eligibility, the effective date of the waiver program termination **may not** occur earlier than the effective date of Medicaid termination.
- If termination of participation is occurring due to a loss of waiver functional or non-financial eligibility and the participant retains their Medicaid eligibility, the waiver termination date **may not** occur earlier than ten calendar days from the date of the notification.
- If termination of participation is occurring due to a loss of waiver functional or non-financial eligibility and the participant also loses their Medicaid eligibility, the waiver termination date **may not** occur earlier than the effective date of Medicaid termination.

The written notice shall:

- Inform the participant that s/he has the right to request a hearing from the state Division of Hearings and Appeals.

- Inform the participant that if s/he requests a hearing prior to the effective date of the agency action program participation will continue.
- Inform the participant that if s/he requests a hearing regarding a termination of participation action, and the affected services continue pending the hearing decision, and the hearing decision upholds the action to terminate participation, s/he may be required to reimburse the Department for the cost of any affected services s/he received during the time period beginning on the original effective date of the notice up to and including the date of the hearing decision.
- Inform the participant that s/he has forty-five (45) days to appeal the agency decision and that a hearing requested after 45 days may not be heard.
- Inform the participant of the county grievance process and any appeal rights under HFS 94.
- Inform the participant that pursuing a county grievance or requesting an appeal under HFS 94 may not affect the date of termination or reduction of waiver services.

Important: The waiver agency care manager/support and service coordinator must promptly notify the county income maintenance staff of any change in the participant's waiver program eligibility status. The care manager/support and service coordinator and economic support staff must then work together to ensure proper notification requirements are met.

2.11 COP Eligibility after Waiver Program Termination

When a Medicaid waiver participant's program participation has been terminated because of an ineligible level of care the person may be eligible for COP. In this circumstance, the person's eligibility for COP is to be considered the same as that of a person who is referred for community placement through I. A. 1.67 under s.46.27 (6r) (b) (3).

County agencies should set local policies for serving such persons with COP. The policy should address the process the county will follow if decision is made to place these persons on a waiting list for COP services. The policy should also address, if COP funds are available, whether the county will serve the person with COP funds and the duration of service to be provided.