CHAPTER V — USE OF FUNDING IN SUBSTITUTE CARE

5.01 Introduction

Medicaid waiver funds may be used to provide services to eligible persons residing in waiver allowable substitute care settings, including Adult Family Homes, CBRFs, RCACs and Children’s Foster Care/Treatment Foster Care Homes. Some types of settings or settings above a certain size are not covered or permitted as a living arrangement by specific waivers. See Chapter II, Section 2.07 for additional details as to which settings are permitted by the different waivers. The use of Medicaid waiver funds in substitute care settings is regulated by federal law, Wisconsin Statutes, DHS Administrative Rules, the CMS-approved waivers and waiver program policy. Specific service definitions, requirements and provider standards for each setting are described in Chapter IV, Section 4.10 of this manual.

5.02 Determining Waiver Allowable Costs

Federal law prohibits the use of Medicaid waiver funds for room and board costs. Waiver agencies must be able to show that the 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, often some or all of the room and board costs are paid by the waiver participant. When the room and board costs in the facility exceed the participant’s available resources, another source of funding, other than Medicaid waiver dollars, must be used. Below is an overview of substitute care costs that are allowed or are not allowed to be paid by the waivers. Forms and instructions used to determine substitute care costs are located in Appendix J of this manual.

A. Waiver Allowable Costs – Care and Supervision

Medicaid waiver funds may be used to pay costs for care and supervision services provided to participants residing in the facility. Some examples of costs related to care and supervision include staff salaries and health insurance costs/benefits, travel, administrative overhead, staff/agency liability insurance as well as staff development and education materials. For a more detailed breakdown of allowable care and supervision costs, see Appendix J. (See also the Allowable Cost Policy Manual at Grants/Administration/AllowableCost/ACPM.htm.)

Important: Documentation clearly describing the individual care and supervision costs in the facility must be maintained in the participant record located at the waiver agency.

B. Non-Waiver Allowable Costs – Room and Board

The waiver agency is responsible for assuring that documentation identifying the room and
board cost methodology is in place for all substitute care providers. This methodology may consist of a county developed rate system or a facility provided rate structure. Either framework is allowable as long as it is clear that these costs are separate and distinguishable from care and supervision costs and they are not paid for with waiver funds.

**Important:** Documentation identifying the 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 current, accurate and allowable.

Certain facility expenses or a portion of such expenses may be included as room and board costs. Facility costs that are determined to be room and board expenses cannot be paid for with Medicaid Waiver funds. Examples of room and board expenses include all or a portion of certain insurance premiums, maintenance costs, food, furnishings, and utilities (This is a partial list of examples only. Please see Appendix J.) Waiver agencies may use the model forms provided in Appendix J or another methodology to determine room and board costs. No specific form is required. However, the methodology used must fairly allocate room and board costs to each resident.

C. The Special Housing Amount

Participants who reside in substitute care settings may be eligible for the special housing amount deduction in the calculation of the personal maintenance allowance. The CM/SSC determines the rent portion of the room and board costs in the facility. To calculate rent, subtract the facility-reported costs for the resident’s food, telephone and cable television from the resident’s room and board total. The remainder is the rent amount. The CM/SSC provides the calculated rent amount to the income maintenance worker who calculates the Special Housing Amount deduction using CARES (See Appendix J.)

5.03 Ability to Pay - Room and Board

The participant’s contribution toward the cost of room and board in substitute care arrangements is closely linked with financial eligibility for waiver programs. The Financial Eligibility and Cost Sharing Worksheet (F-20919) or the CARES Community Waivers Budget eligibility determination should be completed prior to determining a waiver participant’s ability to contribute toward room and board.

A. Required Formula to Determine Amount of Income Available to Pay for Room and Board (F-20920 – formerly titled the DDE-920)

For waiver eligible persons who reside in a substitute care living arrangement – except

---

1 Furnishings may be waiver allowable when the participant is starting on the waiver (CIP 1A/1B and BIW only.) They may also be allowable for persons relocating from an institution. See Chapter IV, Housing Start Up or Relocation-Related Housing Start Up.
children residing in Children’s Foster Care settings – the F-20920 must be used to determine the amount of income available to pay room and board. Using financial information from the F-20919 or CARES Community Waivers Budget screens, the CM/SSC completes the F-20920 \(^2\) (See form and instructions in Appendix J or go to F-20920.)

The form must be completed at the point the participant enters a substitute care living arrangement. It must be reviewed at each annual recertification and updated whenever the participant’s financial situation changes. Completed F-20920 forms shall be maintained in the participant record together with other application/recertification documents.

When completing the F-20920, the total income entered on line 1 includes income that may have been disregarded in the Medicaid eligibility determination (e.g., VA Aid and Attendance benefits, etc.) The monthly amount of discretionary income (line 2) may not be less than $65. This amount represents the discretionary income retained by the participant. Discretionary income remains the property of the participant and may not be designated or directed toward any planned services. The amount on line 6 of the form represents the applicant/participant’s out of pocket medical remedial expenses (See Chapter III.) CM/SSCs must remember that this deduction is available to all Medicaid waiver eligibility groups residing in a substitute care setting, including Group A. (See the F-20920 Instructions.)

**Important:** Local agencies do not have the option of permitting, limiting or excluding allowable deductions from income when calculating the person’s ability to contribute to room and board. The amounts entered on the F-20920 should correspond to the figures used in the eligibility calculations on the F-20919 or CARES.

The amount on line 15 of the form is the maximum amount the participant may be charged for room and board in the living arrangement. If the participant’s remaining income amount on line 15 is less than the actual room and board rate (line 16), the balance of the facility room and board costs may be paid with COP\(^3\), Community Aids or in some cases, funds granted by other housing assistance programs. If the participant’s remaining income is greater than the actual room and board rate, that is, if there is an excess of participant income (regardless of source) after the room and board costs are calculated, the excess represents additional discretionary income that is retained by the participant. Participants residing in substitute care who have a cost share obligation must continue to pay that cost share amount toward a waiver allowable service.

**Note:** The participant may not be charged for or required to contribute to waiver allowable care and supervision or other waiver services beyond his/her cost share obligation (see Chapter IV, Section 4.07.)

---

\(^2\) The formula outlined on the F-20920 form is not applicable to Children’s Foster Care settings.

\(^3\) COP funds may not be used to pay for RCAC services.
B. Supplemental Security Income Exceptional Expense (SSI-E)

If a waiver participant receives SSI-E and lives in substitute care, the room and board, personal needs and community services not covered by a funding source must equal or exceed the SSI-E service/need standard amount in order to qualify for the E Supplement.

Please note that CBRFs with Independent Apartments and facilities with more than 20 beds (unless grandfathered) are not an SSI-E allowable living arrangement. Allowable living arrangements for SSI-E recipients must be in an integrated setting, accessible to community services and resources. Any facility that is adjacent to, a part of or on the grounds of an institution may not be an SSI-E-allowable setting. For more information consult the state SSI-E Handbook at [http://www.emhandbooks.wi.gov/ssi-e/](http://www.emhandbooks.wi.gov/ssi-e/).

5.04 Waiver Specific Requirements: CIP 1A/1B, BIW

CIP 1A, CIP 1B and BIW waiver funds may be used for services provided in five to eight bed CBRFs and in licensed or certified Adult Family Homes. CIP 1A, and CIP 1B and BIW funds may not be used for services provided in a CBRF larger than eight beds or in facilities that are located within or structurally connected to an ICF-MR, a nursing home or other institution or to provide RCAC services. The use of funds for CBRF services is subject to approval as part of the person’s individual service plan.

5.05 Waiver Specific Requirements: CLTS

CLTS waiver funds may be used to provide services in licensed or certified Adult Family Homes. However, Department policy and the CMS approved CLTS Waivers prohibit the use of a Children’s Group Home as a residence for any child. Children participating in these waivers may not reside in a Group Home of any size. There is no process to make an exception to this regulation. Residential Respite care may be provided in a Group Home to any child served by any of the waivers covered in this manual.

5.06 Waiver Specific Requirements: CIP II and COP-W and COR

A. Maximum Amount of Funds Used for CBRF Care

COP lead agencies must establish a limit to the amount of the annual allocation for COP or COP-W (including federal COP-W matching funds) that will be spent for community based services to participants who reside in CBRFs (s.46.27 (3) (f) Wis. Statutes.) The lead agency shall establish a separate such limit for participants in CIP II. (Community based services include all services funded by COP, COP-W or CIP II). The county determined maximum
amount includes all expenses in all types of CBRFs, including those comprised of independent apartments and those with a dementia care program.

The limits may be expressed either as a specific dollar amount or as a percentage of the allocations, and shall be incorporated into the county COP Plan, subject to approval. Whenever COP is used as match for any other Medicaid waiver program for a person residing in a CBRF, only the COP funds are counted in the expenditure total.

According to DHS 73.10 (3), if an agency is at or above the applicable limit, reimbursement for CBRF services may not be provided to any additional applicant unless an exception has been granted by the Department. To request an exception, the agency must file an application approved by its Long-Term Support Planning Committee in which the agency documents that:

- The applicant has been diagnosed as terminally ill by a physician and hospice services can be provided in the CBRF, and
- The CBRF meets appropriate licensing and size criteria, and
- The CBRF is the person’s preference.

Note: All exceptions under DHS 73.10 are person specific.

Exceptions end under any of the following circumstances:

- The participant no longer resides in the facility where the exception was granted.
- The facility can no longer meet the participant’s needs.
- The lead agency can accommodate the cost of services to the participant within its limit on funding for services for residents of CBRFs.

B. Conditions for the Use of CIP II/COP-W and COR in CBRFs

CIP II and COP-W and COR waiver funds may be used in a facility of 20 beds or less, provided the placement criteria in number 3 below have been met. Effective in March, 2008, policy changes outlined in DLTC Memo Series 2008-04 established new variance requirements for the use of CIP II/COP-W in CBRFs based on facility size and location. (See the memo at DLTC_NMemo2008-04.) In addition, the new policy requirements change the content of the variance required in certain circumstances and limit availability of some types of CBRFs to certain target groups.

1. Facility Size
   A waiver agency may use CIP II or COP-W or COR funds to provide services to a person residing in a CBRF with up to 20 beds. Facilities larger than 20 beds may be used if a variance is granted by the Department. However, the variance process and requirements will differ depending on the target group of the person to be served. (See Sections 5.06 (F) and 5.06 (G) below.)

2. CBRFs Connected to a Nursing Home
The use of CIP II/COP-W or COR funds for services provided in CBRFs connected to a nursing home may be allowed, depending on the target group of the person served. (See DLTC Memo 2008 – 04.)

- A waiver agency may use CIP II or COP-W or COR funds to provide services to a frail elderly participant (must be age 65 or older) residing in a CBRF structurally connected to a nursing home if a variance has been approved by the Department (See Section 5.06 (G) below for a description of the variance requirements.)

- A waiver agency may not use CIP II or COP-W or COR funds to pay for CBRF services for applicants/participants under age 65 who are disabled (See Chapter II) to reside in a CBRF that is structurally connected to a nursing home.

3. Placement Criteria
Subject to size and variance requirements, CIP II and COP-W and COR funds may be used to provide services to a person residing in a CBRF if certain criteria are met. The list below is a summary of the criteria. The policy/process was originally described in DLTC N Memo 2002-25. That memo has been partially superseded by new variance requirements outlined in DLTC N Memo 2008-04 and by changes to pre-admission requirements described in DLTC N Memo 2009-07. (See also Appendix J.)

**Important:** In all circumstances, whether the applicant/participant is seeking CBRF placement independently, or is referred to the agency by a facility (see number 4 below); in order to use COP, CIP II or COP-W or COR funds for CBRF services, the waiver agency must document in the applicant/participant record that all criteria below have been met. The criteria include:

4. The 2007 – 2009 state budget bill (2007 Wisconsin Act 20) contained a provision that repealed the preadmission assessment/consultation requirement. The remaining four criteria are still required prior to a CBRF admission. (See DSL Memo 2002 – 25 for a detailed description of these criteria.)
The CBRF admission is for Residential Respite. Reminder: The respite stay may not exceed 28 days without prior approval by the Bureau.

An optional model form has been developed as a guide to meeting the four conditions. The form is available at formsF-00113.doc.

4. Preadmission Requirements
State law has been changed relative to required CBRF preadmission activities (See DLTC Numbered Memo 2009-07). With the passage of 2007 Wisconsin Act 20, the requirement for preadmission assessment or consultation (commonly known as the ‘PAC’) has been repealed. The statutes now require CBRF operators to refer prospective residents to the local ADRC or county waiver agency, as appropriate and set new requirements as to the manner and content of the waiver agency/ADRC response.

   a. Referral Requirements for CBRFs:
   By law (s. 50.035 (4n)), when the CBRF first provides written information\(^5\) to a prospective resident the facility must make a written referral (See DQA form F-62493.doc) to the local ADRC or county waiver agency, as applicable. (See DLTC Memo 2009 - 07.)

   **Exemptions:** Persons seeking a CBRF admission for short term respite and those who are enrolled in a managed care organization at the time written information is provided are exempt and need not be referred. All other persons seeking a CBRF admission who meet the criteria outlined in s. 50.035 (4n) should be referred to the local waiver agency/ADRC.

   The F-62493 referral form allows the prospective resident to “opt out” and decline any follow-up contact from the agency/ADRC. However, regardless of whether the person has chosen to decline the contact or not, facilities must send the referral.

   **Note:** The referral requirements apply to all CBRFs of any size. The requirements do not apply to Adult Family Homes. RCACs are not required to refer unless the facility is located in a county or region covered by managed care.

   **Reminder:** The CBRF referral requirements apply to the CIP II and COP-W and COR waiver programs. They do not apply to CIP 1A/1B, BIW or CLTS waivers.

   b. The Waiver Agency/ADRC Response to Referrals

---

\(^5\) The requirement for the CBRF to make a referral applies to face to face meetings between the facility operator and the prospective resident. When the facility sends information after a written, telephone or e-mail request, the operator is not required to make a referral.
If the prospective resident has **not** “opted out” of the follow up contact the receiving agency must follow up (“Opting out” is indicated by answering “no” to question 4 in Section II of the referral.) In these instances, **upon receipt of the referral** from the CBRF and within **five business days**, the local waiver agency/ADRC must contact the prospective resident to offer options counseling.

The counseling provided must be “face to face” with the prospective resident or his/her legal representative. It must include information and advice to the person concerning all of the following:

i. The availability of long-term care options open to the individual: including home care, community services, case management services, residential care and nursing home options.

ii. Sources and methods of both public and private payment for long-term care services: including, CIP II, COP-W, COR, the fee-for-service system and, where available, Family Care, Pace/Partnership and IRIS.

iii. Factors to consider when choosing among the available programs, services and benefits: including cost, quality, outcomes, estate recovery and compatibility with the person’s preferred lifestyle and residential setting.

iv. Advantages and disadvantages of the various options in light of the individual’s situation, values, capacities, knowledge and resources and the urgency of the individual’s situation.

v. Opportunities and methods for maximizing independence and self-reliance: including the utilization of supports from family and community.

c. **Agency Responsibility:**

   In counties where an ADRC is operational and CIP II/COP-W waiver programs continue to be administered by a separate local agency, these local agencies must **designate** which entity will receive and respond to the required CBRF referrals. (See **DLTC Numbered Memo 2009-007** for information.) The agency designated must inform the facilities in its service area that it will receive these referrals.

   When contacted by the designated agency, the prospective CBRF resident may choose to accept or decline the options counseling offered. Declining the offer will not disqualify the person from receiving CIP II/COP-W funds if/when s/he is determined to be eligible.

---

6 “Contact” means a direct face to face or telephone contact with the prospective resident or the contact person named on the F-62493.
If the offer of options counseling is **accepted**, the agency should then meet with the person within **ten business days**. The ten day time line may be extended at the request of the prospective resident.

- If the agency is unable to make contact within the five working day time frame, the agency must send a written offer to provide counseling to the person.

- If there is no response to the written offer after 20 calendar days, the agency/ADRC should document the post-referral contact attempt(s). No additional follow up is required.

- All follow up contacts with prospective residents made or attempted as a result of these CBRF referrals (including those that are accepted, declined or unsuccessful) must be documented and a record of the contact(s) maintained at the agency.

If the referral form received indicates the prospective resident has chosen to “opt out” of a follow up contact and the person is not a current program participant, the waiver agency/ADRC need not contact the person but should maintain a record of the referral. There is no required format or manner to maintain documentation of the agency response to these referrals. The format chosen should give the agency ready access to documentation of their follow up activities and the ability to track the persons contacted. Paper documents or an electronic data base may be used.

d. **Current Program Participants and Repeat Referrals**

If, in meeting the referral requirement, the CBRF refers a current CIP II/COP-W or COR waiver program participant to the waiver agency/ADRC, the requirement to follow up and offer options counseling **does not apply**. However, the agency should contact the participant to explore the reasons behind his/her apparent interest in CBRF admission.

There may be persons who contact more than one facility over a period of time which may trigger multiple referrals to the waiver agency/ADRC. If the prospective resident referred by a CBRF has been referred to the designated agency at any time in the previous six months **and** the appropriate required follow up has occurred, the agency is not required to make another follow up contact unless the prospective resident requests it.

### C. Independent Apartment CBRFs

Independent Apartment CBRFs entirely consist of apartments with separate lockable access and egress, and with kitchen, bathroom, sleeping, and living areas. Independent apartment CBRFs are waiver allowable settings, regardless of size, under SPC 506.63. Funding may be used in facilities designated by the Department of Health Services, Division of Quality Assurance as consisting entirely of independent apartments (s. 46.27 (7)(cj)(1).)
Admissions to a CBRF with Independent Apartments are not subject to the placement criteria that must be met prior to use of COP or waiver funding (See 5.06 B (3) above.) However, these facilities may be subject to other placement and variance requirements.

**Important:** Independent Apartment CBRFs shall not be located within the same building as a facility providing skilled or intermediate nursing care. Nor shall such a CBRF be physically connected to a nursing facility except by common service units for laundry, kitchen or utility purposes. Such CBRFs may only offer temporary shelter or respite care for less than 30 days in a number of apartments not exceeding one per 50 apartments of licensed capacity.

**D. Use of Funding for a CBRF for Persons with Dementia**

1. In order to use waiver funding for a person with dementia and be exempt from the criteria (see Section 5.06 B (3) above) the person must have a diagnosis of Alzheimer’s disease or a related dementia and reside in a facility which has dementia programming. To determine if the facility has dementia programming, the following criteria must be used:
   
   a. The facility is licensed as a Community Based Residential Facility by the Department of Health Services, Division of Quality Assurance under Wisconsin Administrative Code, DHS 83; and
   
   b. The CBRF client group is designated as irreversible dementia by licensure and program statement (DHS 83.06(1)(e); and
   
   c. Staff members receive resident group specific training in dementia care (in accordance with DHS 83.21(2); and
   
   d. Staff members provide appropriate programming and services consistent with this client group (DHS 83.38(c).

**Important:** A variance may still be required if the dementia facility is larger than 20 beds or connected to an institution.

**E. Use of Funding in CBRFs with More Than 20 Beds: General Requirements**

Medicaid home and community-based waivers are in-home care programs, created to provide an alternative to institutional care. As these facilities get larger, they may operate like or feel like an institution. The Department recognizes that some large CBRFs have been designed to make the facilities and programming consumer focused, respectful of the individual, offer privacy and autonomy, and meet resident needs individually or in small, familiar groups. If the county waiver agency can document that the facility design and programming compensates for the effects of large scale congregate living, the Department may grant a variance to size limitations.

---

7 A reminder: CIP 1A/1B or HIW participants may not reside in CBRFs larger than eight beds. There is no variance to this size limitation.

January 2010
1. COP, COP-W and CIP II and COR waiver funds cannot be used in CBRFs with more than 20 beds unless one of the following applies:

   a. The facility consists entirely of independent apartments. Meeting the criteria for independent apartments constitutes Department approval of the facility and a size variance is not required (See Section 5.06 (C) above or Appendix J for a description of CBRFs with Independent Apartments); or

   b. The Department has approved a variance, requested by the local waiver agency, to provide waiver funding for an applicant/participant to reside in a specific facility. (See Sections 5.06 (F) and 5.06 (G) below.)

   **Important:** CM/SSCs should keep in mind that Medicaid does not cover personal care in CBRFs with more than 20 beds (DHS 107.112 (4)) - even if a COP, COP-W, or CIP II or COR funding variance is granted for the facility.

F. Variance Requirements: CBRFs With More Than 20 Beds

Local waiver agencies must receive variance approval to use CIP II or COP-W or COR funds, for services provided in a CBRF larger than twenty beds. A variance must be obtained for regular CBRF admissions or to use the facility for Residential Respite.

**Important:** The variance process will differ by waiver target group.

1. **Frail Elderly Persons**
   Waiver agencies must submit a new service plan for a new applicant or complete an ISP Update for an ongoing participant. The service plan must contain a completed and signed copy of page 3B of the F-20445 (See F-20445.3B) See also DLTC Numbered Memo 2008-04. The completed page 3B will indicate the type of variance sought and attest to the two requirements:

   a. That the facility is non-institutional and the facility operates in a manner that enhances resident dignity and independence, and
   b. It is the preferred residence of the applicant/participant or his/her legal representative.

   The new plan or ISP Update containing the variance request must be submitted to the appropriate Bureau or its quality assurance designee. Plan approval constitutes variance approval. **This type of variance is person-specific.** This means that every proposed admission of a frail elder applicant/participant to a facility larger than 20 beds must receive a separate, approved variance.

2. **Persons Under Age 65 with A Disability**
   For applicants/participants with a disability who are under age 65, agencies seeking a variance to the twenty bed size limitation for particular facilities shall submit a request to
the appropriate Bureau. This variance is facility-specific and must include all of the following elements:

a. A narrative of how the facility design and programming are such that the facility is non-institutional that includes the facility floor plan and photographs.

b. A description of the CBRF efforts to provide services in a manner that enhances resident dignity, independence, privacy and choice, and that mitigates the effects of large, congregate living buildings.

c. If the variance is requested for a facility that provides services to persons with an irreversible dementia, the request shall contain documentation provided by the CBRF that it is able to accommodate the special needs of these persons. This documentation may include the facility program statement, descriptions of the activity program and a description of staff training.

d. Variance requests shall be reviewed and approved by the county’s Long Term Support Planning Committee prior to submission to the Department. Ideally, members of the committee will visit the facility before approving the request. Documentation of committee approval must be sent with the variance request. This may be included in the cover letter or in actual copies of committee meeting minutes.

If an agency intends to utilize a facility for which another waiver agency has previously received a variance, the agency must seek approval of the local Long Term Support Planning Committee as prescribed above and submit a request to the appropriate Bureau as described below.

For CIP II/COP-W, agencies are to submit requests for a variance to use funding in CBRFs with more than 20 beds to the Bureau of Long-Term Support, Community Options Section (BLTS-COS). In considering the variance request, the Bureau will consult with the Regional Human Service Area Coordinator, the Ombudsman, or the DHS Division of Quality Assurance as needed.

For COR waiver participants, the variance request must be sent to the Bureau of Prevention, Treatment and Recovery (BPTR) in the Division of Mental Health and Substance Abuse Services for consideration.

G. Variance Requirements: Use of Funds in CBRFs Connected to a Nursing Home

CIP II and COP-W and COR waiver funds may be used to provide services in a CBRF structurally connected to a nursing home under specific conditions. CBRFs that are structurally connected to a nursing home are an allowable living arrangement for frail elderly persons only (participants age 65 or older) and they are only allowable if a
variance is approved by the Department prior to admission. This variance is person-specific and must meet two conditions described in 1 a. and b. below.

1. Variance Requirements - CBRF Connected to a Nursing Home
For frail elderly applicants/participants, the agency must submit a completed and signed ISP form F-20445, with a signed page 3B (F-20445.3B) to the appropriate DHS Bureau or its quality assurance designee. The new plan (for a new applicant) or ISP Update (for a current participant) containing the variance request must be submitted to the Bureau or its designee. For these requests, plan approval constitutes variance approval. The variance attests to the following:

a. The environment is non-institutional and the facility operates in a manner that enhances resident dignity and independence, and

b. The facility is the preferred residence of the applicant/participant or his/her, legal representative.

2. For CIP II and COP-W and COR applicants/participants with a disability who are under age 65, CBRFs that are structurally connected to a nursing home are not an allowable living arrangement. There is no variance to this placement restriction.

5.07 Purchasing Substitute Care Services

A. Provider Agreements and Service Contracts

1) Medicaid Waiver Provider Agreements
In order to receive COP or Medicaid waiver funds, the substitute care provider must have a Medicaid Waiver provider agreement with the State Medicaid Agency (DHS.) See Chapter IV, Section 4.02 B of this manual for more information.

2) Substitute Care Contracts
Purchase of service contracts between the waiver agency and the AFH, CBRF or RCAC may not impose unique local waiver policies or requirements on the provider. These contracts may only address basic facility rates, individual participant-specific care and supervision requirements and the local billing and payment processes. These contracts are subject to all applicable audit requirements, found in s.46.036 Wis. Statutes and in the Allowable Cost Policy Manual (See Grants/Administration/AllowableCost/ACPM.htm.) For additional guidance on the updated requirements for Purchase of Service Contracts see the DLTC Numbered Memo at NMemo2009_10.pdf.

B. Funding Costs During Resident Absence

January 2010
Medicaid waiver funds should not be paid to a facility for periods when the participant is not residing there and not receiving waiver services. Federal regulations prohibit the use of Medicaid waiver dollars for substitute care costs while the participant resides in a hospital, a nursing home or an ICF-MR. Below are three examples of methods agencies may consider to address resident absences.

1. Build these costs into the rate. For example, if facility residents spend an estimated average of 20 days a year in hospitals or nursing homes, the annual waiver allowable support and supervision expenses may be averaged over 345 instead of 365 days per year. Note: End of year adjustments may be needed to assure payments reflect actual costs.

2. Build the costs into the rate at any time during the year, adjusting monthly, or make adjustments at the end of the year to reflect actual costs.

3. Agencies may use non-Medicaid funds such as COP to cover the costs of services that would have been paid with waiver funds.

There is no required methodology for utilizing any of the above options other than conforming to acceptable accounting practice and assuring that waiver billing conforms to the requirement to address actual units of service provided monthly per participant.