

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

## Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

### 1. Request Information

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**A.** The **State of Wisconsin** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

**B. Program Title:**

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

**C. Waiver Number: WI.0414**

**Original Base Waiver Number: WI.0414.**

**D. Amendment Number: WI.0414.R03.02**

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

07/01/19

**Approved Effective Date: 07/01/19**

**Approved Effective Date of Waiver being Amended: 04/01/17**

### 2. Purpose(s) of Amendment

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**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:

The federal Centers for Medicare & Medicaid Services (CMS) determined that Wisconsin's current county-based Home and Community Based Services (HCBS) rate structure for the Children's Long-Term Support (CLTS) Waiver Program does not meet federal requirements that § 1915(c) waivers service rates are established through a state based methodology. Service rates for waiver services are currently established via purchase of service agreements between county waiver agencies (CWAs) that locally operate the CLTS Waiver Program and the providers that deliver supports and services to the program participants based on allowable cost policy rules. CMS communicated the requirement that Wisconsin must develop and implement a uniform rate-setting methodology.

Per the terms of a corrective action plan (CAP) required by CMS, Wisconsin has developed a uniform statewide rate-setting methodology for most CLTS waiver services. The following waiver services are subject to a statewide rate schedule:

- Adult family home
- Child care
- Community integration services
- Counseling and therapeutic services
- Daily living skills training
- Day services
- Financial management services
- Mentoring
- Nursing services
- Respite
- Support and service coordination
- Supported employment
- Supportive home care
- Transportation

The complete rate schedule for included services is published on the DHS website, and is available at <https://www.dhs.wisconsin.gov/hcbs/ratestructure.htm>.

Market rates will be used for service categories not included in the statewide rate-setting methodology. Service categories purchased at the price typically determined by the market are as follows:

- Adaptive aids
- Children's foster care
- Communication aids
- Consumer education and training
- Home modifications
- Housing counseling
- Personal emergency response systems
- Relocation services
- Specialized medical and therapeutic supplies
- Training for unpaid caregivers

Implementing a state based rate methodology for the CLTS waiver services included in the CAP will result in consistency for providers in delivering services in Wisconsin. Once the amendment is effective, rates for services will either be using the statewide rate schedule or the market rate depending on the service category.

In January 2019, the WI Department of Health Services (DHS) will direct CWAs to begin planning to transition to state-established rates with full implementation expected by July 1, 2019, and systems validation by 2020. To minimize negative impact in the transition, counties will establish transition plans that best meet the needs of their participants and the timeline allows for ISPs to be updated during each participant's regularly scheduled 6 month plan review over the course of the transition period.

In addition to amending the waiver to reflect the state established rate methodology, Appendix I is also amended to reflect the recent DHS reorganization and the automated enrollment system currently being used for the CLTS Waiver Program called the Eligibility and Enrollment Streamlining system. This amendment also aligns the waiver period with the calendar year (from the 4/1 to 1/1 date), and updates the unduplicated counts to align with the wait list elimination efforts. The amendment also updates waiver language to reflect CMS approved corrective action plans for person centered planning and provider directory. This amendment also updated the unduplicated count for anticipated increased enrollment in years 2019-2021.

The amended language related to the state based rate methodology is the result of a two-year, extensive public outreach strategy,

culminating in the formal waiver amendment public comment period in November 2018. Public outreach included CWAs, tribes, providers, advocates, and participants. DHS began communicating the initiative to CWAs and tribes in 2016. DHS also initiated outreach through surveys to providers and CWAs in 2017 to gather input on the initiative.

During the spring of 2018, DMS presented draft rates and methodologies for in-scope services. An online survey was also available for comment. DMS considered all feedback and made edits accordingly. DHS held five regional county meetings in the spring of 2018 to share more detail about the methodology and obtain feedback. The Wisconsin Autism Council and Wisconsin Children’s Long Term Supports Council were briefed on the initiative and asked for input during the development phase. DHS posted the draft rate schedule in July 2018 for CWA, provider, advocate, and participant comment. DHS held nine public forums throughout the state during July and August to provide more information about the initiative to providers and participants and to obtain feedback. All interested parties were invited to submit written comments through an online survey and a dedicated email address. Changes were made to the rate schedule for several services based on the public feedback received during this period.

DHS conducted a formal thirty day waiver amendment public notice and comment period in November 2018, including a formal tribal consultation on November 8, 2018. Following the consultation, the tribes did not provide any comments or questions related to the initiative and waiver amendment.

The public notice and comment period included publishing notice in several Wisconsin-based newspapers directing the public to the public posting of the material on the DHS website. The posting included the waiver amendment, rate schedule, and related documents in electronic format or printed upon request. The DHS website also included an email address and online survey for the public to submit comments. Of the public comment received, a substantial number were comments and questions related to implementation. DHS intends to provide clarification through a variety of methods. However, this did not result in any modifications to the waiver amendment. Clarification methods will include updates to existing guidance, training, and technical assistance.

DMS then released the amended waiver, methodology, and guidance documents for formal 30 day public comment period. DMS will monitor how the implemented fee schedule impacts utilization and access through CWA contacts, claims data analysis, application of care levels and outlier rates, and public feedback. DMS will adjust rates as needed to address adequacy and access issues, subject to budget availability.

Based on the public comments, DHS intends to make a clarification to the waiver amendment. The clarification allows services to be paid at rates lower than the state based rate, in circumstances where a service provider’s usual and customary service rate is lower than the state based rate for a particular service.

### 3. Nature of the Amendment

**A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	<input type="text"/>
Appendix A Waiver Administration and Operation	<input type="text"/>
Appendix B Participant Access and Eligibility	B-3-a <input type="text"/>
Appendix C Participant Services	<input type="text"/>
Appendix D Participant Centered Service	D-1-d, D-1-f <input type="text"/>

Component of the Approved Waiver	Subsection(s)
Planning and Delivery	
Appendix E Participant Direction of Services	E-1-n
Appendix F Participant Rights	
Appendix G Participant Safeguards	
Appendix H	H-2, H-2-b
Appendix I Financial Accountability	I-1, I-1-b, I-2-a, I-2-b, I-2-c, I-2-d, I-3-b
Appendix J Cost-Neutrality Demonstration	J-1, J-2-a, J-2-b, J-2-c-iv, J-2-d

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

**Modify target group(s)**

**Modify Medicaid eligibility**

**Add/delete services**

**Revise service specifications**

**Revise provider qualifications**

**Increase/decrease number of participants**

**Revise cost neutrality demonstration**

**Add participant-direction of services**

**Other**

Specify:

Implement a statewide uniform rate methodology. In addition to amending the waiver to reflect the state established rate methodology, Appendix I is also amended to reflect the recent DHS reorganization and the automated enrollment system currently being used for the CLTS Waiver Program called the Eligibility and Enrollment Streamlining system. This amendment also aligns the waiver period with the calendar year (from the 4/1 to 1/1 date), and updates the unduplicated counts to align with the wait list elimination efforts. The amendment also updates waiver language to reflect CMS approved corrective action plans for person centered planning and provider directory.

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

### 1. Request Information (1 of 3)

**A.** The State of Wisconsin requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

**B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Children's Long-Term Support Waiver Program

**C. Type of Request:** amendment

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

3 years    5 years

**Original Base Waiver Number: WI.0414**

**Waiver Number:WI.0414.R03.02**

**Draft ID:               WI.036.03.12**

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

Regular Waiver

**E. Proposed Effective Date of Waiver being Amended: 04/01/17**

**Approved Effective Date of Waiver being Amended: 04/01/17**

## 1. Request Information (2 of 3)

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

### Hospital

Select applicable level of care

#### **Hospital as defined in 42 CFR §440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Children from birth through age 21 years.

#### **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160**

### Nursing Facility

Select applicable level of care

#### **Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Children from birth through age 21 years.

#### **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**

#### **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

Children from birth through age 21 years.

## 1. Request Information (3 of 3)

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**G. Concurrent Operation with Other Programs.** This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

**Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**

**Waiver(s) authorized under §1915(b) of the Act.**

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

A § 1915(b)(4) Fee-for-Service Selective Contracting Program application has been submitted concurrent with the CLTS Waiver Program § 1915(c) renewal application for the purpose of obtaining approval for county waiver agencies to be the sole provider delivering Support and Service Coordination (case management) services to participants.

**Specify the §1915(b) authorities under which this program operates** (*check each that applies*):

**§1915(b)(1) (mandated enrollment to managed care)**

**§1915(b)(2) (central broker)**

**§1915(b)(3) (employ cost savings to furnish additional services)**

**§1915(b)(4) (selective contracting/limit number of providers)**

**A program operated under §1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

**A program authorized under §1915(i) of the Act.**

**A program authorized under §1915(j) of the Act.**

**A program authorized under §1115 of the Act.**

*Specify the program:*

**H. Dual Eligibility for Medicaid and Medicare.**

Check if applicable:

**This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

## **2. Brief Waiver Description**

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**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The overall purpose of Wisconsin's Children's Long-Term Support (CLTS) Waiver Program is to provide necessary supports and services to children from birth through age 21 in Wisconsin with significant disabilities who meet functional, Medicaid financial and non-financial requirements, and reside in allowable living situations within the community to prevent placement in an institutional setting. The CLTS Waiver Program is a component of Wisconsin's support system for children with disabilities. The goal of the CLTS Waiver Program is to support children with substantial needs, as well as their parents/guardians, by delivering services to assure the child's health, safety and welfare needs in an inclusive home and community setting. A key tenet of the CLTS Waiver Program is that children are best served within the context of their family and community.

Wisconsin's CLTS system is guided by the following vision and principles which were developed in collaboration with families, advocates, providers and waiver agencies:

- The focus is on the child and his/her strengths and needs.
- Children remain in the home with their families whenever possible.
- Parents have a great capacity to care for their child with a disability if provided the supports they need.
- The service system enhances the natural supports received from family, friends, neighbors and volunteers.
- Quality service coordination supports culturally competent practices and innovative approaches to engaging children and families in their community
- Collaboration amongst interconnected support systems enhances the provision of quality care.

Wisconsin's CLTS organizational structure supports families to meet these objectives by working collaboratively at all levels of the service system. The Secretary appoints members to the CLTS Council to provide guidance to the Department of Health Services (DHS), the State Medicaid Agency, regarding waiver program policy and procedure decisions. The DHS has established statewide CLTS Waiver Program policies and procedures which are disseminated to county waiver agencies and providers through manuals, numbered memos, websites and webinars. In addition, ongoing technical assistance, monitoring and oversight activities for county waiver agencies are completed by DHS assigned Children's Services Specialists and other State Medicaid Agency staff.

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

As CLTS waiver services are coordinated as the payer of last resort with services that are covered under the IDEA Part B Special Education Program through Wisconsin's Department of Public Instruction, and services covered under the Rehabilitation Act of 1973 through Wisconsin's Department of Workforce Development's Division of Rehabilitation (DVR), as well as coordination with the child's private health insurance, and economic support programs, as applicable. DHS monitors the county waiver agencies' compliance with the CLTS Waiver Program's payer of last resort and coordination of benefit requirements through a comprehensive quality management and review system.

### 3. Components of the Waiver Request

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

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

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

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

**Yes. This waiver provides participant direction opportunities.** Appendix E is required.

**No. This waiver does not provide participant direction opportunities.** Appendix E is not required.

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

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

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

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

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

#### 4. Waiver(s) Requested

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**A. Comparability.** The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

**B. Income and Resources for the Medically Needy.** Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

**Not Applicable**

**No**

**Yes**

**C. Statewide.** Indicate whether the state requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

**No**

**Yes**

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

**Geographic Limitation.** A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

**Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make participant-direction of services as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:



## 5. Assurances

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In accordance with 42 CFR §441.302, the state provides the following assurances to CMS:

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

**J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

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*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the state secures public input into the development of the waiver:



§ 1915(c) Children's Long-Term Support Waiver Program Application Public Comments Summary:

Wisconsin Department of Health Services (DHS) posted the draft CMS § 1915(c) Home and Community-Based Services (HCBS) and draft § 1915(b)(4) Children's Long-Term Support Waiver Program applications on the Department's website on July 8, 2016 through August 18, 2016. The draft waiver renewal application was available on the DHS website at <https://www.dhs.wisconsin.gov/hcbs/index.htm>.

The posting to the website was accompanied by outreach communications to various stakeholder groups, including: each of the eleven federally recognized tribes, all 72 counties, two state contracted agencies, Wisconsin's Long Term Care Council. In addition, public notice was issued in newspapers in 16 major cities across the state, including: 1) Appleton (the Post Crescent), 2) Eau Claire (Eau Claire Leader); 3) Fond du lac (the Reporter); 4) Green Bay (Green Bay Gazette); 5) Janesville (Janesville Gazette); 6) Kenosha (Kenosha News); 7) La Crosse (La Crosse Tribune, River Valley) 8) Madison (Wisconsin State Journal); 9) Manitowoc (Manitowoc Herald Times); 10) Milwaukee (Milwaukee Journal Sentinel); 11) Oshkosh (Oshkosh Northwestern); 12) Racine (The Journal Times); 13) Sheboygan (Sheboygan Press); 14) Stevens Point (Stevens Point Journal); 15) Waukesha (Waukesha Freeman); 16) Wausau (Wausau Daily Herald).

DHS posted a Public Comment reminder on August 4, 2016, with the deadline for public comment being August 18, 2016. Public comments were able to be submitted either electronically or in writing to DHS. This document encompasses the comments and recommendations that have the potential to impact the CLTS Waiver Program application; other comments submitted for DHS consideration appear to be operations, policy and procedure related that DHS will address outside the CLTS Waiver Program application.

Individuals were informed on the Department's public notice website and in each of the local newspaper posting that they could receive a hard copy of the applications and/or provide comment via email request or by writing to the Department at the address provided. See the following notification:

Public comment or requests for paper copies of the draft CLTS Waiver Program Renewal Application can be sent to: [DHSCLTSRenewal@wisconsin.gov](mailto:DHSCLTSRenewal@wisconsin.gov) or write:

Department of Health Services, Attn: CLTS Waiver Renewal,  
1 W. Wilson St, Rm 418  
PO Box 7851  
Madison WI 53707-7851

Below is a summary of submitters, key points from the comments that impact the CLTS Waiver Program application and the resulting changes to the DHS final CLTS Waiver Application submitted to CMS on September 1, 2016.

Six entities submitted comments. Copies of each submission are available upon request. Many submissions acknowledged the removal of supports and services that are encompassed in the Early and Periodic Screening, Testing and Diagnostic (EPSDT) benefit and acknowledged full support of the additional three proposed CLTS Waiver Program services that were added, Child Care, Training for Parents/guardians and families of children with disabilities and Relocation Services.

The scope of the Early and Periodic Screening and Diagnostic and Treatment (EPSDT) benefit was of considerable discussion during stakeholder meetings and the issue was elevated again in the public comments. The crux of the issue is how to better serve and support children and families in accessing the EPSDT benefit throughout Wisconsin. The public comments submitted voiced strong encouragement for a coordinated and collaborative effort between stakeholder groups on how to transition services that historically were covered under the CLTS Waiver Program once a Medicaid denial was obtained. These issues are incorporated into the EPSDT transition plan as outlined in Attachment 1.

Two public comments noted an error in the detail description of Appendix B. The public posting of the application omitted detailed description of children with Physical Disabilities and children with Severe and Emotional Disturbance in the narrative which was an oversight when combining the current three waivers. The application did accurately reflect the inclusion of all three target groups in the level of care section of the application, the inadvertent omission of the detailed description of all three target groups was limited by the character space in section B-6. The final application was corrected by reiterating a brief description of all three target groups and adding a link to the full screen tool application.

Other changes of wording and verbiage proposed by submitters were included in the final application. Some suggestions and points of an operational nature are planned for incorporation in the Waiver Manual and related policy and procedures.

§ 1915(c) Children's Long-Term Support Waiver Program Rate WI.0414.R03.02 Amendment Public Comments

Summary:

DHS conducted a formal thirty day waiver amendment public notice and comment period in Oct 31, 2018-Nov 30, 2018, including a formal tribal consultation on November 8, 2018. The tribes did not provide any comments about the waiver amendment.

The public notice and comment period followed the process outlined above and included publishing notice in several Wisconsin-based newspapers directing the public to the public posting of the material on the DHS website. The posting included the waiver amendment, rate schedule, and related documents in electronic format or printed upon request. The DHS website also included an email address and online survey for the public to submit comments. Of the public comment received, a substantial number were comments and questions related to implementation. DHS intends to provide clarification through a variety of methods. However, this did not result in any modifications to the waiver amendment. Clarification methods include updates to existing guidance, training, and technical assistance.

**J. Notice to Tribal Governments.** The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

## 7. Contact Person(s)

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A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Cunningham

First Name:

Curtis

Title:

Assistant Administrator

Agency:

Department of Health Services, Division of Medicaid Services

Address:

1 West Wilson St. Room 350

Address 2:

PO Box 7851

City:

Madison

State:

Wisconsin

Zip:

53701-7851

Phone:

(608) 261-7810

Ext:

TTY

**Fax:** (608) 266-2713

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

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

**Last Name:** Rathermel

**First Name:** Deborah

**Title:** Director

**Agency:** Department of Health Services, Division of Medicaid Services, Bureau of Children's Long Term

**Address:** 1 West Wilson St. Room 418

**Address 2:** PO Box 7851

**City:** Madison

**State:** Wisconsin

**Zip:** 53701-7851

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

**Fax:** (608) 267-2713

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

## 8. Authorizing Signature

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This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under §1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

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**Signature:** Deborah Rathermel

State Medicaid Director or Designee

**Submission Date:** Mar 1, 2019

**Note: The Signature and Submission Date fields will be automatically completed when the State**

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**Medicaid Director submits the application.**

Last Name:

rathermel

First Name:

deborah

Title:

Director

Agency:

Division of Medicaid Services

Address:

1 W Wilson

Address 2:

Room 418

City:

Madison

State:

Wisconsin

Zip:

53707

Phone:

(608) 266-9366

Ext:

TTY

Fax:

(608) 852-0599

E-mail:

**Attachments**

deborah.rathermel@wi.gov

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**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

**Replacing an approved waiver with this waiver.**

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

**Adding or decreasing an individual cost limit pertaining to eligibility.**

**Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**

**Reducing the unduplicated count of participants (Factor C).**

**Adding new, or decreasing, a limitation on the number of participants served at any point in time.**

**Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**

**Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

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

#### COMBINING WAIVERS:

The Department currently administers HCBS waivers #0413, #0414 and #0415 via the same service delivery model and comparable service packages. The only difference among the three waivers is the target population(s) served. The county waiver agencies currently serve all CLTS Waiver participants enrolled in each of the three waivers and will continue to do so after the waivers are combined. This assures there is sufficient capacity under HCBS waiver #0414 to absorb the participants of HCBS waiver #0413 and #0415. No system changes are required for the CLTS Waiver's contracted Third Party Administrator (TPA) claims processing vendor, as CLTS participants are identified by their target group, not by their CMS approved waiver number. The Department updated the Factor C projections in Appendix J to reflect the absorption of participants transitioning from HCBS waiver #0413 and #0415.

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

The participants in waiver #0413 and #0415 have received a notice, dated February 15, 2017, from the Department that provides information that the three CLTS Waivers are being combined to serve all target groups under one waiver to streamline administrative functions.

#### CENTRALIZING PROVIDER ENROLLMENT

The Department is currently centralizing its waiver provider management system. The Department is implementing a statewide web-based CLTS provider registry and directory system for screening and enrolling qualified waiver providers, which is scheduled for full implementation by June 1, 2019. The Department's centralized management of waiver providers will:

- Certify any willing and qualified provider of CLTS Waiver Program covered services
- Allow waiver program applicants, participants and waiver agencies to view a directory of certified providers
- Allow CLTS Waiver applicants and participants to select willing, qualified and certified providers
- Allow county waiver agencies to establish local networks with certified providers determined by the Department to be willing and qualified

The Department assures the implementation of the WPM system, including notification to willing providers regarding the self-registration process, Wisconsin Medicaid Waiver Provider Agreement requirements, the centralized provider background check screening, and verification of provider training and credential requirements, will result in a public directory of willing and qualified waiver providers, eligible to receive payment upon the submission of completed claims for authorized services by the CLTS Waiver Program's third party administrator's claims processing vendor.

#### STATEWIDE RATE-SETTING METHODOLOGY

The Department is planning and implementing a three-year, comprehensive strategy to set consistent rates for all CLTS waiver services. This strategy includes creating a rate-setting methodology, as well as a provider management and claims processing system to ensure proper rate payments. The Department has created an external communications plan will be posting rate information on the DHS website. The Department intends to implement the statewide rate-setting strategy for additional waivers as they come up for renewal. The DHS approved rate-setting methodology will apply to all CLTS waiver allowable services. DHS will exercise direct financial oversight by ensuring that key fiscal staff works closely with the rate-setting vendor to establish a sound methodology. In addition, DHS will continue to use a contracted third party administrator (TPA) claims processing vendor that will allow DHS to validate payments against the CLTS Waiver Program's fee schedule. As the Rate Structure Project moves forward, DHS will communicate progress to CMS on a quarterly basis. The Department will complete outreach activities to CLTS stakeholders to understand system needs, member and provider impacts; methodology and administrative issues; an in-depth review of current DHS systems capabilities; an analysis of needed statutory changes (if applicable); budget development; and, a funding strategy. Beginning in 2017, DHS will work with the rate-setting vendor to conduct detailed financial impact modeling. The main purpose of the financial impact modeling is to understand how rates will change throughout the state and the potential redistribution impacts of the rate-setting methodology on providers, counties and participants. Secondly, the financial impact modeling will help DHS assess the need for a phased-in approach of the new rates, beginning January 1, 2019. The state based rates go into effect July 1, 2019. Once the rate-setting methodology is established,



DHS will work with the rate-setting vendor to create an ongoing process to update rates as necessary.

#### ALIGNMENT OF THE CLTS WAIVER PROGRAM BENEFIT PACKAGE

The CMS issued guidance which directed states covering autism treatment services through their federal Home and Community-Based Services (HCBS) waiver programs to transfer coverage of these treatment services to their Medicaid State Plan benefit. As a result, the Department is successfully transitioning coverage of autism treatment services from the CLTS Waiver Program to a behavior treatment benefit under the ForwardHealth Medicaid card. Close collaboration and coordination occurred between DHS, the county waiver agencies, providers and families to ensure a smooth transition for children. Similar to the behavior treatment transition, DHS will be initiating a phased transition plan for other services from the CLTS Waiver Program's benefit package that are covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. In Wisconsin, the EPSDT benefit is known as "HealthCheck." HealthCheck is a health screening benefit for any child under 21 years covered by Medicaid. The Department will coordinate with county waiver agencies to identify children currently receiving CLTS Waiver Program funded services that are also included as a covered HealthCheck benefit. The Department will collaborate closely with county waiver agencies and providers to initiate a phased transition plan that ensures the seamless delivery of necessary services and supports to a fully functioning EPSDT Medicaid State Plan solution.

Upon the initiation of the approved transition plan, the county waiver agency's Support and Service Coordinator (SSC) will review and update the child's existing service plan to reflect the prohibition on covering any EPSDT covered services with CLTS funding. When the SSC holds the CLTS waiver participant's six-month face-to-face contact appointment with the family, EPSDT covered services that are currently included on the child's Individual Service Plan (ISP) will be identified. The Department will provide written notice to each parent/guardian of an affected participant regarding the EPSDT transition plan, including the services covered under EPSDT, the transition timeline, and their appeal rights.

Authorized CLTS waiver funded services will no longer include any EPSDT benefits within a six-month transition period following the child's new recertification period, to allow sufficient time for the transitioning the service to ForwardHealth, any appeal process, and obtaining the prior authorization approval for the EPSDT covered benefit. These EPSDT covered services will be phased out during the upcoming CLTS waiver period, up to June 30, 2018.

#### **Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

Applicability: Wisconsin's Statewide Transition Plan laid out in this document applies to the Medicaid Home and Community-Based Services (HCBS) waivers under s. 1915(c) of the Social Security Act that provide the authority for the Children's Long-Term Support (CLTS) Waiver Program, as well as Wisconsin's other approved HCBS waiver programs.

The DHS has issued a public notice regarding this transition under the Wisconsin State Register published November 15, 2014.

Assessment of Compliance: Wisconsin will use a multi-phase process to assess compliance with the HCBS settings requirements. This approach includes:

- an assessment of all waiver settings for compliance with the rule;
- an assessment of the regulatory and policy framework for residential settings with regard to compliance with the rule;
- provider self-assessment;
- validation of the self-assessment response; and
- on-going monitoring and re-evaluation of settings.

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

Preliminary assessment of settings. The Wisconsin DHS conducted a preliminary assessment of existing HCBS settings for compliance with HCBS characteristics. Settings assessments were classified as:

- Yes - meets requirements,
- No - does not meet requirements, or
- Needs Provider Self-Assessment and Validation by the DHS.

The DHS considers any services provided in the waiver participant's own home, or family home, are home and community-based. Per the HCBS final rule, services provided in the following settings are not considered home and community-based:

- Nursing facility
- Institution for mental diseases
- Intermediate care facility for individuals with intellectual disabilities
- Hospital

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

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

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

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

Provider self-assessment. Wisconsin will use a single standardized tool to conduct a provider self-assessment of all residential settings. Residential providers will need to respond to the assessment for each location when the provider operates multiple sites. Providers will be required to provide documentation of the accuracy of their responses upon request of the DHS or the Waiver Agency.

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

as determined necessary by the DHS.

The DHS will release the self-assessment tool to providers in both an on-line format and as a paper document. The DHS will use several methods to ensure that all covered providers have an opportunity to respond to the self-assessment. These include outreach using:

- Provider information from claims and encounter systems;
- Licensure records;
- County Waiver Agency provider lists; and
- Through notice on the DHS website.

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

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

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

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

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

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

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

Description of heightened scrutiny process: The DHS anticipates that some settings that are presumed not to be home and community-based per the regulation, may be able to document to the DHS that they meet the requirements of the regulation. These include:

- Settings in a publicly or privately-owned facility providing inpatient treatment;
- Settings on grounds of, or adjacent to, a public institution; and
- Settings with the effect of isolating individuals from the broader community of individuals not receiving Medicaid HCBS waiver services.

Determinations on such settings will be made on a case-by-case basis. Any setting that meets the above definition will be invited

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

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

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

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

Timeframe and Milestones: The DHS established timeframes with the following priorities:

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

The plans differ on some interim steps and timelines. The following timeline encompasses that program variation. All HCBS settings must be compliant by March 17, 2019.

Milestone, Target Start Date, Target End Date

Preliminary Assessment of Services and Residential Settings - includes time for public comment March 31, 2015

Development of Residential Provider Assessment Tool - January 30, 2015

Development of Non-Residential Provider Assessment tool - April 1, 2015

Residential Provider Self Assessment 15 December 31, 2015

Non-Residential Provider Self Assessment May 2015, November 2015

Provider Self Assessment Validation May 2015, June 2016

Release results of Provider Self Assessment Process, July 15, 2016

Provider Remediation Plans Submitted June 2016, August 2016

Validation of Provider Remediation: As providers implement plans - no later than June 2017, December 31, 2017

Participant Transition As soon as Waiver Agencies are aware that provider will not comply - no later than September 30, 2018, September 30 2018

Full Compliance Achieved, March 17, 2019

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

The Department of Health Services assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the state's approved Statewide Transition Plan. The state will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

## **Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

## Appendix A: Waiver Administration and Operation

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

**The waiver is operated by the state Medicaid agency.**

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

**The Medical Assistance Unit.**

Specify the unit name:

*(Do not complete item A-2)*

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

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

The Division of Long Term Care

*(Complete item A-2-a).*

**The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

## Appendix A: Waiver Administration and Operation

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**2. Oversight of Performance.**

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

The Department of Health Services (DHS) is the designated Wisconsin State Medicaid Agency. The Governor appoints the DHS Secretary, and the Department utilizes a Division structure under the authority of the Secretary to carry out the Department's mission and to assure compliance with federal and state regulations as they relate to the administration of programs within the Department.

DHS, under Wisconsin Act 55, is implementing a reorganization, which has merged the Division of Long Term Care and the Division of Health Care Access and Accountability into one combined division, the Division of Medicaid Services (DMS) by January 2017. The Department's proposed DMS organizational model can be accessed at this website link: <https://dhsworkweb.wisconsin.gov/reorg/docs/dms-plan-overview.pdf>

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

**b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

**As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.**

## Appendix A: Waiver Administration and Operation

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**3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

**Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

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

## Appendix A: Waiver Administration and Operation

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

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

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

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

In Wisconsin, designated county waiver agencies perform some of the functions of the State Medicaid Agency on behalf of, and under the administrative guidance and supervision of, the Department. Under the Wisconsin Constitution, a county department serves as an arm or political subdivision of the State, primarily performing delegated state operational functions at the local level. The functions of Wisconsin's county agencies to operate the approved HCBS Waiver Program's operations are specified in Wisconsin statutes and administrative rules and are consistent with the approved waivers.

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

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

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

## Appendix A: Waiver Administration and Operation

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- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

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

The performance of the county waiver agencies is also evaluated through the Wisconsin Single State Audit, CLTS Waiver Program record review protocols, as well as other quality assurance and monitoring functions. The DHS monitor the county waiver agencies that are identified as having quality issues through on-site review and audit protocols. County waiver agencies that fail to comply with the Department's established program requirements are provided technical assistance and guidance, along with direct follow-up. If the compliance factors represent broader system issues, DHS develops a corrective action plan (CAP) with the county waiver agency, with measurable outcomes and timelines. The CAP is monitored by DHS until all corrections are in place.

## Appendix A: Waiver Administration and Operation

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**6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:



The DHS provides stringent financial and programmatic oversight of HCBS waiver programs through the State of Wisconsin's Single State Audit process, which is administered through the Department of Administration (DOA). The DOA's State Controller's Office provides overall coordination of the state's single audit activities. The State of Wisconsin has adopted the federal audit requirements in CFR Part 200 Subpart F, "Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards", hereafter known as "Uniform Guidance" for recipients of funding from the State. The State Single Audit Guidelines implement the federal audit requirements for certain state programs and federal programs passed through state agencies. The Single State Audit is performed on an annual basis. The Single State Audit are completed by designated auditors who must:

- Be licensed by the State of Wisconsin as a certified public accountant, as required by Wis. Stat. 442 and Government Auditing Standards. Mobility and Wisconsin Statute 442 (4) allows for licensees of other states to perform audits if all conditions of referenced paragraph are met.
- Possess the technical qualifications to perform an audit involving government programs, including continuing professional education, as required by auditing standards generally accepted in the United States of America and Government Auditing Standards.
- Undergo an external quality control review (peer review) at least once every three years and make the report on the quality control review available to the auditee and to granting agencies upon request, as required by Government Auditing Standards.

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

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

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

The Bureau of Children's Long Term Support Services is also responsible for conducting other monitoring and quality assurance strategies, including the review of data system reports, and randomly selected samples of county CLTS Waiver Program records to ensure compliance with the approved performance measures, and analyze trends and systemic issues. The CLTS Waiver Program's monitoring protocol includes a record review process as detailed below:

A randomly selected sample of CLTS Waiver participant records are reviewed to ensure compliance with the approved performance measures, including the health, safety and welfare of participants. Additional system data is also reviewed, such as:

- the accuracy of the child's level of care, as determined by the CLTS Functional Screen
- Frequency and utilization of waiver services paid by the DHS third party administration (TPA) claims processing vendor
- provider qualifications

Reporting of incidents is an additional requirement of all county waiver agencies. Any incident that is current and continues to pose a risk to the waiver participant must be reported to DHS within one business day (24 hours). Every

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

The Department provides regular oversight for each of the CLTS Waiver Program functions listed below, which has been contracted to the "Local Non-State Entity." DHS methods includes detailing the CLTS Waiver Program requirements in the State and County Contract for Social Services and Community Programs, regular technical assistance by the BCS county-assigned Children's Services Specialists and BLTCF fiscal staff, as well regular monitoring and enforcement through IT system, quality assurance and auditing activities. A new Bureau desk review process includes the following:

- Participant waiver enrollment: Track the timely removal of a child's name from CLTS Wait List and included it on the CLTS Waiver enrollment database, CLTS quality assurance record reviews
- Enrollment managed against approved limits: Conduct regular reviews of CLTS enrollment reports to review timeliness
- Waiver expenditures managed against approved levels: Conduct regular reviews of CLTS claim expenditures
- Level of care evaluation: Conduct regular reviews of CLTS Functional Screen system eligibility reports and record reviews
- Review of participant service plans: Conduct regular reviews of ISPs during application process, ISP updates occurring as a result of incident reports, and the annual onsite record reviews
- Prior authorization of waiver services: CLTS Third Party Administrator (TPA) claim processing system edits requiring match of claim to participant and an approved prior authorization record, annual onsite record reviews
- Utilization management: Regular reviews of CLTS claim reports
- Qualified provider enrollment: Track signed Medicaid Waiver Provider Agreements and provider registration, CLTS onsite record reviews, Single State Audit activities
- Quality assurance and quality improvement activities: CLTS trend reports, system reviews, annual record reviews, on-site field activities, annual Single State Audit, selected program for CMS Payment Error Rate Measurement (PERM) Audit

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

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

## Appendix A: Waiver Administration and Operation

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**7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Local Non-State Entity
Participant waiver enrollment		
Waiver enrollment managed against approved limits		
Waiver expenditures managed against approved levels		
Level of care evaluation		
Review of Participant service plans		
Prior authorization of waiver services		
Utilization management		
Qualified provider enrollment		
Execution of Medicaid provider agreements		
Establishment of a statewide rate methodology		
Rules, policies, procedures and information development governing the waiver program		
Quality assurance and quality improvement activities		

## Appendix A: Waiver Administration and Operation

### Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

#### a. Methods for Discovery: Administrative Authority

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

#### i. Performance Measures

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

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

*Where possible, include numerator/denominator.*

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

#### Performance Measure:

**County waiver agencies respond to CLTS Waiver Program fair hearing decisions with remand orders by the Division of Hearing and Appeals within 10 day requirements.**

**Numerator= Number of fair hearing remand orders completed within 10 days.**

**Denominator= Number of all fair hearing decisions with remand order overturning county waiver agency's action.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<input type="checkbox"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="checkbox"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The performance measure in this section relates to administrative authority will ensure that the county waiver agencies implement their program operations as required under their DHS State-County contract, and the established policies and procedures. Performance measures within other appendices in this application will also be used to ensure administrative oversight in the implementation of program operations, policies and procedures, as indicated under the Department’s CLTS Waiver Program established requirements, but are not duplicated in this section. Additional discovery methods related to administrative oversight include issues that arise during the county waiver agency’s program operations are those that are self-identified, or through complaints and other discovery methods employed by other sections within the Division related to oversight of related program operations such as Level of Care (LOC) determinations and Encounter data reporting.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Department directly monitors the county waiver agencies to correct any issues discovered through ongoing administrative oversight activities. County waiver agencies are responsible for correcting any issues that are discovered. Issues are tracked from the county waiver agency’s initial identification to the final resolution. The department may also recommend development of a corrective action plan (CAP) The Department may also require immediate remedial action and impose CAPs to address serious or unresolved issues.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="checkbox"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix B: Participant Access and Eligibility**

**B-1: Specification of the Waiver Target Group(s)**

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
		Aged			
		Disabled (Physical)	0	21	
		Disabled (Other)	0	21	
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism	0	21	
		Developmental Disability	0	21	
		Intellectual Disability	0	21	
<b>Mental Illness</b>					
		Mental Illness			

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
		Serious Emotional Disturbance	0	21	

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

CLTS Waiver participants must meet the functional and support needs criteria, as set forth in the Children’s Long-Term Support Functional Screen (CLTS FS), meet Medicaid financial and non-financial requirements, and reside in allowable living situations within the community. Allowable living situations within the community for participants include children who are living with their parents in the family’s private residence, whether owned or rented. Allowable living situations also include participants who are living in the home of a relative or guardian, including foster care providers. For CLTS waiver participants who are 18 years or older, an allowable living situation also includes an adult family home (AFH).

**c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

**Not applicable. There is no maximum age limit**

**The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

*Specify:*

County waiver agencies must plan for the child's transition to adult waiver services by the time the child is 17 years and 6 months old. These transition plans must be documented within the individual’s record and reasonable steps must be taken to assure continuity of services as the youth reaches adult status. Limited exceptions to this exist, including when a court has ordered placement for an 18-year old child residing in a foster home.

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

For youth age 18-21 years who reside in the six remaining counties that operate the Adult “Legacy Waiver” programs (Community Integration Program and Community Option Program waivers) and do not currently operate Family Care, Partnership or the IRIS waiver programs, the county waiver agency must refer the participant to the local ADRC by age 21.5 years for enrollment into one of the adult legacy waiver programs, if the participant meets the functional and Medicaid financial and non-financial eligibility criteria. Wisconsin continues expansion to the Managed Care model of long-term care, at which time the Legacy Waivers will no longer be operational and will be replaced by Family Care, Partnership, or IRIS on a statewide basis. At that time, all youth age 18 years who are functionally and financially eligible for adult long-term care services must transition to those services upon their 18th birthday.

## Appendix B: Participant Access and Eligibility

### B-2: Individual Cost Limit (1 of 2)

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and

community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

**No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

**Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

**The limit specified by the state is (*select one*)**

**A level higher than 100% of the institutional average.**

Specify the percentage:

**Other**

*Specify:*

**Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

**Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

*Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

**The cost limit specified by the state is (*select one*):**

**The following dollar amount:**

Specify dollar amount:

**The dollar amount (*select one*)**

**Is adjusted each year that the waiver is in effect by applying the following formula:**

Specify the formula:

**May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

**The following percentage that is less than 100% of the institutional average:**



Specify percent:

**Other:**

*Specify:*

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## Appendix B: Participant Access and Eligibility

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### B-2: Individual Cost Limit (2 of 2)

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**Answers provided in Appendix B-2-a indicate that you do not need to complete this section.**

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**b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

**c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

**The participant is referred to another waiver that can accommodate the individual's needs.**

**Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

**Other safeguard(s)**

Specify:

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## Appendix B: Participant Access and Eligibility

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

**a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

**Table: B-3-a**

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	7972
Year 2	10881
Year 3	13015
Year 4	13654
Year 5	14209

**b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*) :

**The state does not limit the number of participants that it serves at any point in time during a waiver year.**

**The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (2 of 4)**

**c. Reserved Waiver Capacity.** The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

**Not applicable. The state does not reserve capacity.**

**The state reserves capacity for the following purpose(s).**

**Appendix B: Participant Access and Eligibility**

**B-3: Number of Individuals Served (3 of 4)**

**d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

**The waiver is not subject to a phase-in or a phase-out schedule.**

**The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in**

**the waiver.**

**e. Allocation of Waiver Capacity.**

*Select one:*

**Waiver capacity is allocated/managed on a statewide basis.**

**Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

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

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

The Department is responsible for the equitable distribution of CLTS Waiver funds to release to county waiver agencies to enroll eligible children in the CLTS Waiver Program on a statewide first-come, first-served basis. The Department assigns a waiver allocation, or "slot" for the next applicant who is placed on the CLTS Wait List.

1. The county waiver agency (CWA) must document the date the family, applicant or referral source contacted the agency about CLTS Waiver Program eligibility. This date is used as the child's placement on the CLTS Wait List.
2. The county waiver agency must make a preliminary determination of the applicant's Medicaid non-financial/financial eligibility, functional eligibility and the need for CLTS waiver services. A referral to the county's Income Maintenance consortia must occur when applicable.
3. The county waiver agency must offer to complete a home visit to complete the child's CLTS Functional Screen, along with an assessment of the child and family's needs within 45 days. If the family agrees, the assessment may be delayed until a time nearer to when funds for CLTS waiver services will become available.
4. The county waiver agency must provide each applicant placed on the CLTS Wait List with a notification of her/his status, as well as an estimate of when funding for services may become available every six months.
5. When the child's name moves to the top of the CLTS Wait List, the county waiver agency must re-assess functional and financial eligibility, complete an assessment based on the child and family's needs, and determine CLTS Waiver Program enrollment within 30 days.

When enrolling children from the CLTS Wait List, the following requirements apply:

1. The child must receive all of the services necessary to meet assessed needs, as identified in his/her current assessment.
2. The Department will issue funding slots as CLTS Waiver allocations become available, and the designated county's Support and Service Coordinator must complete an updated functional level of care determination via the CLTS FS, and ensure the child is eligible for a Medicaid State Plan program.
3. Once the Department confirms the waiver funds will be allocated to the county waiver agency, the county waiver agency must promptly complete the necessary steps to remove the child's name from the CLTS Wait List and enroll the child in the CLTS Waiver Program.
4. The Support and Service Coordinator must complete an assessment and issue the family-centered Individual Service Plan (ISP).
5. The county waiver agency must complete the applicant's ISP and submit it to the Department within 60 days from enrollment.

Exceptions to the First-Come, First-Served Medicaid Waiver Wait List Policy: Crisis Needs:

The only allowable exception to the first-come, first-served CLTS Wait List policy is when a child or parent/guardian meets one of the crisis need criteria. This Department established criteria must be applied in all such circumstances and may not be modified or expanded by the county waiver agency. The following reasons are the only permissible times a child may bypass the CLTS Wait List and be served out of the first-come, first-served order:

1. Crisis conditions are present in the child's life situation. The need shall be classified as a crisis if an urgent need is identified as a result of any of the following:
  - a. Substantiated abuse, neglect or exploitation of the child in the current living situation; or
  - b. Death of the child's primary caregiver or the sudden inability of that caregiver/support person to provide necessary

- supervision and support and there no alternative caregiver available; or
- c. Lack of an appropriate residence or placement for the child due to a loss of housing; or
  - d. Child has a documented terminal illness and has a life expectancy of less than six months, based upon the opinion of a medical professional appropriately qualified to make such a determination; or
  - e. A sudden change in the child's behavior or the discovery that the child has been behaving in a manner that places the child, or the people with whom he or she shares a residence, or the community at large at risk of harm.
2. A determination by the county waiver agency that the health and safety of the child is in jeopardy due to the primary caregiver's physical or mental health status; or
3. A determination by the county waiver agency that the child is at imminent risk of a more restrictive placement in an ICF-IID, nursing home or other institutional setting; or
4. A finding by the county waiver agency that other emergency or urgent conditions exist that place the child, family or community at risk of harm and a variance is approved by the Children's Services Specialist.

## Appendix B: Participant Access and Eligibility

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

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

## Appendix B: Participant Access and Eligibility

### B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

**§1634 State**

**SSI Criteria State**

**209(b) State**

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

**No**

**Yes**

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

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

**Low income families with children as provided in §1931 of the Act**

**SSI recipients**

**Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**

**Optional state supplement recipients**

**Optional categorically needy aged and/or disabled individuals who have income at:**

*Select one:*

**100% of the Federal poverty level (FPL)**

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

Specify percentage:

**Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in**

**§1902(a)(10)(A)(ii)(XIII) of the Act)**

**Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**

**Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**

**Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

**Medically needy in 209(b) States (42 CFR §435.330)**

**Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

*Specify:*

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

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

---

*Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

---

**No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**

**Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

*Select one and complete Appendix B-5.*

**All individuals in the special home and community-based waiver group under 42 CFR §435.217**

**Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

*Check each that applies:*

**A special income level equal to:**

*Select one:*

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

**A dollar amount which is lower than 300%.**

Specify dollar amount:

**Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

**Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

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

Select one:

**100% of FPL**

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

Specify percentage amount:

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

Specify:

Medically Needy with Spend Down:

For persons who have a physical disability, the State Medicaid Agency will use the average monthly cost for private patients in nursing facilities as used for assessing a transfer of assets penalty to reduce an individual's income to an amount at or below the medically needy income limit.

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

For persons who have a severe emotional disturbance the State Medicaid Agency will use the average of the monthly rated charged for inpatient care at a psychiatric hospital.

## Appendix B: Participant Access and Eligibility

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

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

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

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

**Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses spousal post-eligibility rules under §1924 of the Act.**

*Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.*

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

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

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

**Use spousal post-eligibility rules under §1924 of the Act.**

*(Complete Item B-5-b (SSI State) and Item B-5-d)*

**Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**

*(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)*

**Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-**

**eligibility rules for individuals with a community spouse.**  
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

## Appendix B: Participant Access and Eligibility

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

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

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

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

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

**The following standard included under the state plan**

Select one:

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

(select one):

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state Plan**

Specify:

**The following dollar amount**

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

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

Specify:

**Other**



Specify:

---

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

---

**Not Applicable (see instructions)**

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

**The amount is determined using the following formula:**

Specify:

---

**iii. Allowance for the family (select one):**

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

**The amount is determined using the following formula:**

Specify:

**Other**

Specify:

---

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

---

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

**The state does not establish reasonable limits.**

**The state establishes the following reasonable limits**

*Specify:*

## Appendix B: Participant Access and Eligibility

---

### B-5: Post-Eligibility Treatment of Income (3 of 7)

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

**c. Regular Post-Eligibility Treatment of Income: 209(B) State.**

---

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

---

## Appendix B: Participant Access and Eligibility

---

### B-5: Post-Eligibility Treatment of Income (4 of 7)

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

**d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

---

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

---

## Appendix B: Participant Access and Eligibility

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

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

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

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

---

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

---

**The following standard included under the state plan**

*Select one:*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

(select one):

**300% of the SSI Federal Benefit Rate (FBR)**

**A percentage of the FBR, which is less than 300%**

Specify the percentage:

**A dollar amount which is less than 300%.**

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state Plan**

Specify:

**The following dollar amount**

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

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

Specify:

The basic needs allowance, indexed annually by the percentage increase in the state's SSI-E payment; plus an allowance for employed individuals equal to the first \$65 of earned income and 1/2 of remaining earned income; plus special exempt income which includes court ordered support amounts (child or spousal support) and court ordered attorney and/or guardian fees; plus a special housing amount that includes housing costs over \$350 per month. The total of these four allowances cannot exceed 300% of the SSI federal benefit.

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

**Other**

Specify:

---

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

---

**Not Applicable**

**The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

**The amount is determined using the following formula:**

*Specify:*

---

**iii. Allowance for the family (*select one*):**

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

Specify dollar amount:  The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

**The amount is determined using the following formula:**

*Specify:*

**Other**

*Specify:*

---

**iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:**

---

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

**The state does not establish reasonable limits.**

**The state establishes the following reasonable limits**

*Specify:*

## **Appendix B: Participant Access and Eligibility**

### **B-5: Post-Eligibility Treatment of Income (6 of 7)**

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

**f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

---

**Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.**

---

## **Appendix B: Participant Access and Eligibility**

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

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

**g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.**

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

**i. Allowance for the personal needs of the waiver participant**

*(select one):*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

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

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

*Specify formula:*

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

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

**Other**

*Specify:*

**ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.**

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

**iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:**

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

**Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

**The state does not establish reasonable limits.**

**The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

## **Appendix B: Participant Access and Eligibility**

### **B-6: Evaluation/Reevaluation of Level of Care**

*As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.*

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the

reasonable indication of the need for services:

**i. Minimum number of services.**

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

**ii. Frequency of services.** The state requires (select one):

**The provision of waiver services at least monthly**

**Monthly monitoring of the individual when services are furnished on a less than monthly basis**

*If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:*

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

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

**Directly by the Medicaid agency**

**By the operating agency specified in Appendix A**

**By a government agency under contract with the Medicaid agency.**

*Specify the entity:*

Wisconsin’s county waiver agencies are responsible for performing the child’s level of care evaluations and re-evaluations via the web-based automated CLTS Functional Screen, as detailed in the Department of Health Service’s State / County contact.

**Other**

*Specify:*

**c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Following the successful completion of the DHS approved web-based training program curricula and competency examination, which is administered by the University of Wisconsin-Oshkosh, Support and Service Coordinators (SSCs), as also defined in Appendix C, is permitted access to the Department's Children's Long-Term Support Functional Screen Information Access (FSIA) system.

The Support and Service Coordinator provider qualifications include the following requirements:

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

The county waiver agency is currently responsible for verifying the SSC's qualifications, conducting OIG Exclusion List and caregiver background checks, making appropriate hiring decisions, and terminating employment and if the SSC is no longer qualified. DHS monitors and conducts annual reviews to ensure county waiver agencies have appropriately screened and verified the SSCs' qualifications.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care determination for the CLTS Waiver is based on Federal Medicaid institutional admission criteria for relevant institutional settings. A child with an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Level of Care has a permanent cognitive disability, resulting in substantial functional limitations and a need for active treatment. The level of care criteria is based upon the child having needs that are similar to individuals who reside in an ICF/IID. The intensity and frequency of required interventions to meet the child's functional limitations must be so substantial that without the intervention, the child is at risk for institutionalization within an ICF/IID.

A child with a Psychiatric Hospital/Severe Emotional Disturbance (SED) Level of Care has a long-term, severe mental health condition diagnosed by a licensed psychologist or psychiatrist and demonstrates persistent behaviors that create a danger to self or others and requires ongoing therapeutic support in order to live at home. Without the required ongoing therapeutic support, the child is at risk of inpatient psychiatric hospitalization.

A child with a Nursing Home/Physical Disability (PD) Level of Care has a long-term medical or physical condition, which significantly diminishes his/her functional capacity and interferes with the ability to perform age appropriate activities of daily living at home and in the community. This child requires an extraordinary degree of daily assistance from others to meet every day routines and special medical needs. The special medical needs warrant skilled nursing interventions that require specialized training and monitoring that is significantly beyond that which is routinely provided to children. The level of care criteria is based upon the child having care needs similar to people in a nursing home. The intensity and frequency of required skilled nursing interventions must be so substantial that without direct, daily intervention, the child is at risk for institutionalization within a nursing home.

A detailed and thorough description of Wisconsin's level of care requirements is included in the Institutional Level of Care for Children's Long-Term Supports Programs, which is available at:  
<https://www.dhs.wisconsin.gov/waivermanual/clts-loc.pdf>.

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

**The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

**A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**



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

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

The Support and Service Coordinator completes the children's functional screen at initial intake and annually thereafter. The functional screen incorporates information obtained during face-to-face interviews with the child and the family, as well as friends and other people who are significant in the child and family's lives. The assessment includes a review of pertinent records and related information obtained from medical, educational and other service providers.

The following list includes the topical areas that are reviewed and documented as a part of the assessment:

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

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

The annual reevaluation is the same process as the initial evaluation.

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

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

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

**The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**

**The qualifications are different.**

*Specify the qualifications:*

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

Several complementary quality assurance practices assure the timely re-evaluation of the CLTS FS level of care. Support and Service Coordinators are responsible for ensuring that the CLTS Waiver participant re-evaluations are updated as needed, based upon any substantial change in the child's or family's condition, and at least on an annual basis.

The Bureau's county-assigned Children's Services Specialists review the CLTS FS during their monitoring of any participant's incident reports, to ensure the child's functional level of care and services have been updated to reflect the child's situation. The Bureau also conducts regular CLTS enrollment database queries and review matching CLTS FS queries. County waiver agencies follow the DHS established re-certification protocol for each participant, which follows the annual completion of the LOC re-evaluation, and confirms that all required re-determination activities have been completed. The CLTS Functional Screen is also reviewed as a data source, as it displays the dates of screen calculations for waiver participants. This data is used to identify waiver participants whose functional eligibility has not been determined within the 12-month re-evaluation timeline.

The Department is also developing implementation of a new quarterly desk review quality assurance process which will include the selection of a representative random sample of CLTS waiver applications, re-certifications and terminations, to ensure the timely and accurate re-evaluation of the participant's CLTS FS level of care.

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

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

## Appendix B: Evaluation/Reevaluation of Level of Care

### Quality Improvement: Level of Care

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

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

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

**i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

**Number of applicants with initial CLTS functional screens completed by the SSC according to DHS established timelines. Numerator = Number and percent of new enrollees with completed initial CLTS functional screen LOC determination, according to DHS established timelines Denominator = Total number of new enrollees.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**CLTS Functional Screen data matched to data from CLTS enrollment database**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+ / - 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Number of CLTS Waiver Program application LOC denials appropriately determined based on the SSC's Not Functionally Eligible screening result. Numerator= Number of completed CLTS functional screens with Not Functionally Eligible results that were not overturned by DHS. Denominator= Number of completed CLTS functional screens with a Not Functionally Eligible result.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**CLTS Functional Screen automated system**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
---	--	--

<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Other</b> Specify: <input type="text"/>

**b. Sub-assurance:** *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

**Performance Measures**

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

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

**Performance Measure:**

**Participants' level of care, as determined by the CLTS Functional Screen is re-evaluated annually, at a minimum. Numerator = Number of participants whose CLTS FS was completed annually. Denominator = Total number of participants reviewed in the sample.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**CLTS Functional Screen System**

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+ / - 5%"/>
<b>Other</b>	<b>Annually</b>	<b>Stratified</b>

Specify: <input type="text"/>		Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

*c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

**Performance Measures**

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

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

**Performance Measure:**

**Applicant's initial CLTS FS was completed by the SSC according to the clinical instructions resulting in an appropriate LOC determination. Numerator = Number of initial applications where the SSC completed the CLTS FS appropriately according to the clinical instructions resulting in applicable LOC. Denominator = Total number of initial applications with a completed CLTS FS.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Children's Long-Term Support Functional Screen**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+ / - 95%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**



**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 95%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

When an individual problem is identified through the process described above, DHS directly contacts the certified screener and/or the county waiver agency's supervisor to gather more information and determine a solution. Specifically, in the event that DHS discovers multiple screens being calculated for an individual over a short period of time, the DHS CLTS Functional Screen Coordinator quality consultant contacts the screener directly to discuss the reasons. If it is determined that the screener is inappropriately utilizing the eligibility calculation function, the screener's certification may be revoked until the screener successfully re-completes the screener training. In other cases, DHS is able to determine that the screener could show sufficient understanding of the process and certification revocation is not required; instead targeted technical assistance is provided to the screener. Should it appear that the county waiver agency has more systemic problems related to utilization of the functional screen by their certified screeners; a corrective action plan may be required to rectify the situation. DHS maintains documentation of all actions taken to resolve a specific individual problem. Any formal corrective action plan is developed in coordination between the waiver agency and DHS. functional screen data combined with CLTS enrollment data indicates that re-determinations of eligibility are not completed within waiver timelines, this information is shared with the designated Children's Services Specialist (CSS) assigned to the specific county and the CSS follows up with the waiver agency. County waiver agencies are responsible for correcting any individual issues discovered and informing their assigned CSS of their actions. Issues are tracked within the CLTS Enrollment database, from identification to final resolution.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>Other</b> Specify:  <input data-bbox="320 331 794 416" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input data-bbox="866 618 1340 703" type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

**Freedom of Choice.** As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

**a. Procedures.** Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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

**b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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

## Appendix B: Participant Access and Eligibility

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

**Access to Services by Limited English Proficient Persons.** Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Following the "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against national Origin Discrimination Affecting Limited English Proficient Persons" the Department's Limited English Proficiency (LEP) Administrative Directive requires each Division to ensure the needs of LEP persons are met through both the interpretation and translation of materials. In addition, each program must develop and implement a plan for the written translations of vital documents after considering these four factors:

1. Number or proportion of LEP persons likely to be encountered by the program;
2. Frequency with which LEP individuals come in contact with the program;
3. Nature and importance of the program, activity, or service provided by the program to people's lives; and
4. Resources and costs available to the program.

In addition, as required by Wisconsin's Contract Compliance Law under Wis. Stat. § 16.765 and Wis. Admin. Code ch. ADM 50, the Department's State-County contract includes requirements for every grantee to agree to equal employment and affirmative action policies and civil rights and translation compliance practices in its programs. County waiver agencies operating the CLTS Waiver Program have access to an Language Line, which has 150 different languages for interpretation over the phone; the service also translates individual documents as needed. The Department has translated the following waiver program documents, which are routinely issued to CLTS Waiver Program participants, into Spanish and Hmong:

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

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

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

## Appendix C: Participant Services

### C-1: Summary of Services Covered (1 of 2)

**a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service
Statutory Service	Consumer Education and Training
Statutory Service	Day Services

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

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Education

**Alternate Service Title (if any):**

Consumer Education and Training

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09020 caregiver counseling and/or training

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

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

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

This service excludes payment for hotel and meal expenses while participants or their legal representatives attend allowable training/education events.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin’s income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Consumer Education and Training**

---

**Provider Category:**

Individual

**Provider Type:**

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the target group.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List and completing caregiver background checks upon the provider's authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

---

**Service Type: Statutory Service**

**Service Name: Consumer Education and Training**

---

**Provider Category:**

Agency

**Provider Type:**

Any agency appropriately qualified as approved by the State and as related to the unique service being provided to the child.

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Each provider must have demonstrated skills related to the specific area of training and the applicability of that information to children with disabilities and their families.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List and completing caregiver background checks upon the provider's authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Statutory Service

**Service:**

Day Habilitation

**Alternate Service Title (if any):**

Day Services



**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04020 day habilitation

**Category 2:**

04 Day Services

**Sub-Category 2:**

04070 community integration

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Day Services are the provision of services that provide children with regularly scheduled activities for part of the day. Services include coordination and intervention directed at skill development and maintenance, physical health promotion and maintenance, language development, cognitive development, socialization, social and community integration, and domestic and economic management. Services are typically provided up to five days per week in a non-residential setting and may occur in a single physical environment or in multiple environments, including natural settings in the community. Coordination activities may involve the implementation of components of the child's family-centered and individualized service plans and may involve family, professionals, and others involved with the child as directed by the child's plan.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service that could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Group Child Care Center
Individual	Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.
Agency	Family Child Care Center

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Day Services**

**Provider Category:**

Agency

**Provider Type:**

Group Child Care Center

**Provider Qualifications**

**License (specify):**

DCF 251

**Certificate (specify):**

**Other Standard (specify):**

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

Staff in a Child Care setting who works directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List and completing caregiver background checks upon the provider's authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Day Services**

**Provider Category:**

Individual

**Provider Type:**

Any persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Child specific training

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List and completing caregiver background checks upon the provider's authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Day Services**

**Provider Category:**

Agency

**Provider Type:**

Family Child Care Center

**Provider Qualifications**

**License** (*specify*):

DCF 20

**Certificate** (*specify*):

**Other Standard** (*specify*):

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or 1 year experience working in a program serving children.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List and completing caregiver background checks upon the provider's authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Respite

**Alternate Service Title (if any):**

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09012 respite, in-home

**Category 2:**

09 Caregiver Support

**Sub-Category 2:**

09011 respite, out-of-home

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Respite care services are services provided for a child on a short-term basis to ease the child's family or other primary caregiver(s) from daily stress and care demands. Respite care can be provided in any of the provider settings listed in the provider category section of this application.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Residential Facility
Agency	Foster Homes
Agency	Respite Agency
Agency	Residential Care Center (RCC) for Children and Youth
Individual	Family Child Care Center
Agency	Group Homes for Children
Agency	Shelter Care Facilities
Agency	Group Child Care Center
Individual	Adult Family Home
Individual	Other person appropriately qualified as approved by the State and as related to the unique service being provided
Agency	Day Camps

## Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite

Provider Category:

Agency

Provider Type:

Community-Based Residential Facility

Provider Qualifications

License (specify):

Ch. 50, Wisconsin Statutes, DHS 83, Administrative Code

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List upon the provider's authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Foster Homes

**Provider Qualifications**

**License (specify):**

Wisconsin Statute 48, DCF 56 Wisconsin Admin Code

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List upon the provider's initial authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Respite Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):



Training specific to meeting the person's support and care needs. The provider shall complete required training within six months of beginning employment unless training is needed before providing service is specified in the person's individualized service plan. Persons providing respite must meet the DHS training requirements for Supportive Home Care. This includes training on at least the following subjects pertaining to the person(s) served:

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

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

##### **Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List and completing caregiver background checks upon the provider's initial authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## **Appendix C: Participant Services**

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Agency

**Provider Type:**

Residential Care Center (RCC) for Children and Youth

**Provider Qualifications**

**License** (*specify*):

§48.68 Wisconsin Statute, DCF 52 Wisconsin Admin Code

**Certificate** (*specify*):

**Other Standard** (*specify*):

RCC respite staff shall have respite care training designed around the unique needs related to the child's mental health needs and the psychiatric/behavioral treatment plan or individual medical care plan of the child.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List and completing caregiver background checks upon the provider's initial authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Individual

**Provider Type:**

Family Child Care Center

**Provider Qualifications**

**License** (*specify*):

250, DCF Administrative Code

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List and completing caregiver background checks upon the provider's initial authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Group Homes for Children

**Provider Qualifications**

**License** (*specify*):

48.67, Wisconsin Statutes, DCF 57, Administrative Code

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized proves via implementation of the WPM system, targeted for January 2018.

**Frequency of Verification:**

The county waiver agency must conduct a provider licensure verification search upon and a search of the U.S. DHHS Exclusions List, upon initial authorization of the provider and every four years at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized proves via implementation of the WPM system, targeted for January 2018.

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## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Agency

**Provider Type:**

Shelter Care Facilities

**Provider Qualifications**

**License** (*specify*):

DCF 59, Administrative Code

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List upon the provider's initial authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Group Child Care Center

**Provider Qualifications**

**License (specify):**

ch. 48, Wisconsin Statutes, DCF 251, Wisconsin Administrative Code

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List upon the provider's authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Adult Family Home

**Provider Qualifications**

**License** (*specify*):

Chapter 50, Wisconsin Statutes, DHS 88, Administrative Code for 3 or 4 beds

**Certificate** (*specify*):

Certified under DHS 82, Administrative Code for 1 or 2 beds

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List upon the provider's authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Respite**

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**Provider Category:**

Individual

**Provider Type:**

Other person appropriately qualified as approved by the State and as related to the unique service being provided

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Training specific to meeting the person's support and care needs. The provider shall complete required training within six months of beginning employment unless training is needed before providing service is specified in the person's individualized service plan. Persons providing respite must meet the DHS training requirements for Supportive Home Care. This includes training on at least the following subjects pertaining to the person(s) served:

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List upon the provider's authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Day Camps

**Provider Qualifications**

**License (specify):**

DCF 252

**Certificate (specify):**

**Other Standard (specify):**

- Accredited by a nationally recognized entity
- Comparable training specific to the target groups as for similar services

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**



The county waiver agency must conduct a provider credential verification search and complete screening activities by conducting a search of the U.S. DHHS OIG Exclusion List upon the provider's initial authorization and every four years, thereafter, at a minimum.

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized proves via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Case Management

**Alternate Service Title (if any):**

Support and Service Coordination

**HCBS Taxonomy:**

**Category 1:**

01 Case Management

**Sub-Category 1:**

01010 case management

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

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

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

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

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** *(check each that applies):*

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

**Legally Responsible Person**

Relative

Legal Guardian

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Support and Service Coordination**

**Provider Category:**

Individual

**Provider Type:**

Social Worker

**Provider Qualifications**

**License** (*specify*):

Chapter 457 Wisconsin Statutes

**Certificate** (*specify*):

Chapter 457.09 Wisconsin Statutes

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Support and Service Coordination**

**Provider Category:**

Individual

**Provider Type:**

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

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Supported Employment

**Alternate Service Title (if any):**

Supported Employment – Individual

**HCBS Taxonomy:**

**Category 1:**

03 Supported Employment

**Sub-Category 1:**

03021 ongoing supported employment, individual

**Category 2:**

03 Supported Employment

**Sub-Category 2:**

03010 job development

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

Individual employment supports may include support to maintain self-employment, including home-based self-employment. Individual employment supports may also include services and supports that assist the participant in achieving self-employment; however, Assistance for self-employment may include:

- aid to the participant in identifying potential business opportunities;
- assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business;
- identification of the supports that are necessary in order for the participant to operate the business; and
- ongoing assistance, counseling and guidance once the business has been launched.

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

The cost of transportation for a participant to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider, or may reimbursed under specialized (community) transportation, but not both.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Supported Employment Agency
Individual	On the job support person

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Supported Employment – Individual**

**Provider Category:**

Agency

**Provider Type:**

Supported Employment Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

The provider must have the ability and qualifications to provide this service, demonstrated in at least one of the following ways :

- Accreditation by a nationally recognized accreditation agency.
- Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
- Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
- Comparable experience for a qualified entity, including a minimum two years of experience working with the target population providing integrated employment services in the community.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Supported Employment – Individual**

**Provider Category:**

Individual

**Provider Type:**

On the job support person

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

The provider must have the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Holding the Certified Employment Support Professional accreditation.
- Meeting the ASPE Quality Indicators for Supported Employment Personnel.
- Comparable experience for a qualified individual, including a minimum of two years of experience working with the target population providing supported employment. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PHIP and member shall ensure that the individual provider has the member-specific competencies to effectively provide the service.

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**



The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Statutory Service

**Service:**

Home Health Aide

**Alternate Service Title (if any):**

Supportive Home Care

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08040 companion

**Category 2:**

08 Home-Based Services

**Sub-Category 2:**

08050 homemaker

**Category 3:**

08 Home-Based Services

**Sub-Category 3:**

08060 chore

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Supportive home care (SHC) is the provision of services to directly assist people with daily living activities and personal needs and to assure adequate functioning and safety in their home and community.

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

b. Providing supervision necessary for safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, arranging and using transportation, checking out library books, ordering food from a menu, and paying for tickets to events.

c. Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event for reasons of health and safety or the need to assure the youth's continued community living.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services.

The personal care service component of SHC services has been identified as an EPSDT covered service, and will be eliminated following a phased transition plan. Between April 2017 and October 2017, the Support and Service Coordinator will assess the CLTS waiver participant's service needs, as part of his or her recertification, and will review the service plan. It is anticipated that the transition between the provision of waiver services and the state plan EPSDT service access could include as much as six months, with an optimal completion date of April 2018. The additional 60 days between this and the proposed June 2018 transition date, allows for unforeseen challenges, including securing provider agreements, changes to access methods, submission of EPSDT prior authorizations by the provider, as well as allowing for the participant's due process appeal rights.

In addition, the CLTS Waiver Program is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (check each that applies):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (check each that applies):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
<b>Individual</b>	<b>Personal Care Worker</b>
<b>Individual</b>	<b>Registered Nurse</b>
<b>Individual</b>	<b>Nurse Aide</b>

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

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Supportive Home Care**

**Provider Category:**

Individual

**Provider Type:**

Personal Care Worker

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

DHS 105.17(3)(a) Wis. Admin Code

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**  
**Service Name: Supportive Home Care**

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**Provider Category:**

Individual

**Provider Type:**

Registered Nurse

**Provider Qualifications**

**License** (*specify*):

Chapter 441.06 Wis. Stats

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**  
**Service Name: Supportive Home Care**

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**Provider Category:**

Individual

**Provider Type:**

Nurse Aide

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

Chapter 50, Wis. Stats, Admin Code 129

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized proves via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

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**Service Type: Statutory Service**

**Service Name: Supportive Home Care**

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**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License** *(specify):*

Chapter 50.49 Wis. Stat; 42 CFR 484, Admin Code DHS 131

**Certificate** *(specify):*

**Other Standard** *(specify):*

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

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**Appendix C: Participant Services**

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

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**Service Type: Statutory Service**

**Service Name: Supportive Home Care**

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**Provider Category:**

Individual

**Provider Type:**

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

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

1. Policies, procedures, and expectations of the county waiver agency and/or contract agency including training on person and provider rights and responsibilities; record keeping and reporting; and other information deemed necessary and appropriate.
2. Information about the person(s) to be served, including information specific to disabilities, abilities, needs, functional deficits, and strengths of the person. This training should be person-specific for the people to be served.
3. Information about recognizing and appropriately responding to all conditions that might adversely affect the person's health and safety, including how to respond to emergencies and Critical Incidents as defined in CLTS Waiver Program Manual.
4. Developing needed interpersonal and communications skills and appropriate attitudes for working effectively within the population to be served. These skills include: understanding the principles of family-centered services; participant rights; respect for age; cultural, linguistic and ethnic differences; active listening, responding with emotional support and empathy; ethics in dealings with people, including: family and other providers; conflict resolution skills; ability to deal with death and dying; and other topics relevant to the specific population to be served.
5. Information regarding confidentiality and privacy laws and rules.
6. Information related to procedures for handling complaints.
7. Information specifically regarding the person who needs support, including personal hygiene needs, preferences, and techniques for assisting with activities of daily living including, where relevant, bathing, grooming, skin care, transfer, ambulation, exercise, feeding, dressing, and use of adaptive aids and equipment.
8. Information related to homemaking and household services, meal planning and preparation, shopping, housekeeping techniques and proper maintenance of a clean, safe and healthy living environment.
9. Information on the personal health and wellness-related needs of the person needing supports, including nutrition, dietary needs, exercise needs, and weight monitoring and control.

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

#### **Verification of Provider Qualifications**

##### **Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

##### **Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Supportive Home Care**

**Provider Category:**

Individual

**Provider Type:**

Licensed Practical Nurse

**Provider Qualifications**

**License** (*specify*):

Chapter 441.10 Wisconsin Statutes

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**



Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

[Empty text box for alternate service title]

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-direction

Category 2:

[Empty text box for Category 2]

Sub-Category 2:

[Empty text box for Sub-Category 2]

Category 3:

[Empty text box for Category 3]

Sub-Category 3:

[Empty text box for Sub-Category 3]

Service Definition (Scope):

Category 4:

[Empty text box for Category 4]

Sub-Category 4:

[Empty text box for Sub-Category 4]

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

This service also includes paying bills authorized by the participant or their guardian, keeping an account of disbursements and assisting the participant to ensure sufficient funds are available for his or her needs.

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

Excludes payments to court-appointed guardians or court-appointed protective payees if the court has directed them to perform any of these functions. Excludes payment for the cost of room and board.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**

**Service Name: Financial Management Services**

**Provider Category:**

Individual

**Provider Type:**

Accountant

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Chapter 442 Wisconsin Statutes

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**

**Service Name: Financial Management Services**

**Provider Category:**

Individual

**Provider Type:**

Other persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Supports for Participant Direction**

**Service Name: Financial Management Services**

**Provider Category:**

Agency

**Provider Type:**

Fiscal Intermediary Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Adaptive Aids

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

Examples of Adaptive Aids may include:

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

This service may also include the initial purchase of a service animal and routine veterinary costs for a service animal. Wisconsin Statute § 106.52 (1) (fm) states: "Service animal" means a guide dog, signal dog, or other animal that is individually trained or is being trained to do work or perform tasks for the benefit of a person with a disability, including the work or task of guiding a person with impaired vision, alerting a person with impaired hearing to intruders or sound, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items.

As per the Americans with Disabilities Act, service animals are dogs (and in some cases, miniature horses) trained to perform major life tasks to assist people with physical disabilities. For a person to legally qualify to have a service dog, he/she must have a disability that substantially limits his/her ability to perform at least one major life task without assistance.

To qualify as a service dog, the dog must be individually trained to perform that major life task. All breeds and sizes of dogs can be trained as service animals. The federal American Disabilities Act (ADA) does NOT require certification or registration of service animals.

While no special accreditation is required by the state of Wisconsin, it is recommended that the Waiver Agency strongly consider service dog certification training to realize the full potential of the assistance provided by the service animal.

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

Excludes food, grooming, and non-routine veterinary care for service animals based on DHS guidelines.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services.

The following components of the Adaptive Aids service have been identified as an EPSDT covered service: prosthetic devices, patient lift, eating and cooking utensils, grabbers, toilet risers, shower chair, grab bar, lift chair, wheelchair, cane, walker, specialized furniture/mattress. These services will be eliminated as a CLTS waiver covered service following a phased transition plan.

Between April 2017 and October 2017, the Support and Service Coordinator will assess the CLTS waiver participant's service needs, as part of his or her recertification, and will review the service plan. It is anticipated that the transition between the provision of waiver services and the state plan EPSDT service access could include as much as six months, with an optimal completion date of April 2018. The additional 60 days between this and the proposed June 2018 transition date, allows for unforeseen challenges, including securing provider agreements, changes to access methods, submission of EPSDT prior authorizations by the provider, as well as allowing for the participant's due process appeal rights.

In addition, the CLTS Waiver Program is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Adaptive Aids**

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**Provider Category:**

Agency

**Provider Type:**

Other providers appropriately qualified

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adaptive Aids**

**Provider Category:**

Individual

**Provider Type:**

Durable Medical Equipment Provider

**Provider Qualifications**

**License** (*specify*):



**Certificate** (*specify*):

**Other Standard** (*specify*):

Providers appropriately qualified to distribute Durable Medical Equipment.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Adaptive Aids**

---

**Provider Category:**

Agency

**Provider Type:**

Pharmacy

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Adult Family Home

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02011 group living, residential habilitation

**Category 2:**

02 Round-the-Clock Services

**Sub-Category 2:**

02013 group living, other

**Category 3:**

02 Round-the-Clock Services

**Sub-Category 3:**

02021 shared living, residential habilitation

**Service Definition** (*Scope*):

**Category 4:**

**Sub-Category 4:**

02 Round-the-Clock Services

02031 in-home residential habilitation

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

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

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

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

Specific target group requirements:

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

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

For AFH services, transportation services may be included under this service or separately billed under the service Transportation so long as there is no duplicate billing for any unit of service.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin’s income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

Specify whether the service may be provided by (check each that applies):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adult Family Home**

**Provider Category:**

Individual

**Provider Type:**

Other persons appropriately qualified as approved by the State and as related to the unique service being provided to the child.

**Provider Qualifications**

**License (specify):**

DHS 88 or DHS 82

**Certificate (specify):**

**Other Standard (specify):**

The Department of Health Services, Division of Quality Assurance or another approved licensing agency must license adult family homes for three or four persons. Wisconsin Administrative Code DHS 88, contains the regulations and standards governing this waiver service.

All one to two bed adult family homes shall be certified pursuant to standards established by the Department. Wisconsin Administrative Code DHS 82, contains the regulations and standards governing this waiver service. Adult Family Home standards are also described in the publication: Medicaid Waiver Standards for Adult Family Homes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adult Family Home**

**Provider Category:**

Agency

**Provider Type:**

Adult Family Home

**Provider Qualifications**

**License (specify):**

DHS 88 or DHS 82

**Certificate (specify):**

**Other Standard (specify):**

The Department of Health Services, Division of Quality Assurance or another approved licensing agency must license adult family homes for three or four persons. Wisconsin Administrative Code DHS 88, contains the regulations and standards governing this waiver service.

All one to two bed adult family homes shall be certified pursuant to standards established by the Department. Wisconsin Administrative Code DHS 82, contains the regulations and standards governing this waiver service. Adult Family Home standards are also described in the publication: Medicaid Waiver Standards for Adult Family Homes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Child Care Services

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04020 day habilitation

**Category 2:**

04 Day Services

**Sub-Category 2:**

04070 community integration

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Child Care services includes the provision of supplementary child care staffing necessary to meet the child's exceptional care needs above and beyond the cost of basic child care that all families with young children may incur.

Child care services may include supplementary supports and supervision services to address exceptional emotional or behavioral needs, or physical or personal care needs for eligible participants.

This covered child care waiver service may include supplementary supports and supervision services to address exceptional physical, emotional, behavioral or personal care needs of a child. Child care waiver services may include, but are not limited to services offered by the Department of Children and Families (DCF) licensed or certified family day care, group day care, day camps. In addition, child care services may be delivered by providers chosen by the parent/guardian that meet the DHS child care waiver training and work experience qualification requirements.

CLTS waiver funding may be used to cover costs for child care services when a child has aged out of his or her traditional child care settings (typically up to age 12), but due to the child's disability continues to require care or supervision when the parent/guardian is working or training. Examples include school and community-based settings that children of that age typically participate (e.g., after school programs, 4-H clubs, family residence etc.). The entire cost of child care for participants age 12 years and over may be covered under the CLTS Waiver Program.

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

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

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** *(check each that applies):*

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Family Child Care Center
Individual	Individual - Parent/Guardian Selected Provider
Agency	Group Child Care Center
Individual	Certified Child Care Provider

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Child Care Services**

**Provider Category:**

Agency

**Provider Type:**

Family Child Care Center

**Provider Qualifications**

**License (specify):**

DCF 250

**Certificate (specify):**

**Other Standard (specify):**

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

Staff in a Child Care setting who work directly with children must have a combination of one year of training in child development or one year experience working in a program serving children.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.



## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Child Care Services**

**Provider Category:**

Individual

**Provider Type:**

Individual - Parent/Guardian Selected Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Providers that are selected by the parent/guardian that are not licensed or certified by DCF must complete appropriate training, as approved by DHS, related to the child's unique needs to effectively address each child being served and to ensure their health, safety and welfare. If the child's unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's approved behavioral treatment plan. In addition, the provider must have 1 year of experience in working in a program that serves children.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

---

**Service Name: Child Care Services**

---

**Provider Category:**

Agency

**Provider Type:**

Group Child Care Center

**Provider Qualifications**

**License (specify):**

DCF 251

**Certificate (specify):**

**Other Standard (specify):**

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

Staff in a Child Care setting for Children who work directly with children must have a combination of one year of training in child development or one year experience working in a program serving children.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Child Care Services**

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**Provider Category:**

Individual

**Provider Type:**

Certified Child Care Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

DCF 202

**Other Standard** (*specify*):

Providers are required to have specialized training related to the child's unique needs in order to effectively address the needs of each child served in a particular program, and to ensure their health, safety and welfare. If these unique needs are generally related to emotional and behavioral needs the providers must have training specific to the child's needs and specific psychiatric/behavioral treatment plan.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Children's Foster Care

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02011 group living, residential habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

A Foster Home is a family-oriented residence operated by a person licensed under s.48.62 of the Wisconsin Statutes and DCF 56 of the Wisconsin Administrative Code as a Foster Home.  
This service includes supplementary intensive supports and supervision services beyond the maintenance payment made to foster parents and is to address exceptional emotional or behavioral needs, or physical or personal care needs.

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

This service excludes the cost of room and board provided by the foster home provider. CLTS funding cannot supplant IV-E funding.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin’s income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual Family Foster Provider
Agency	Level 5 Exceptional Foster Home

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Children's Foster Care**

**Provider Category:**

Individual

**Provider Type:**

Individual Family Foster Provider

**Provider Qualifications**

**License** (*specify*):

§48.62, Wisconsin Statutes, DCF 56, Administrative Code.

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider DCF licensure verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Children's Foster Care**

**Provider Category:**

Agency

**Provider Type:**

Level 5 Exceptional Foster Home

**Provider Qualifications**

**License** (*specify*):

§48.62, Wisconsin Statutes, DCF 56, Administrative Code.

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider DCF licensure verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Communication Aids/Assistive Technology/Interpreter Services

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

17 Other Services

**Sub-Category 2:**

17020 interpreter

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Communication aids/assistive technology aids means an item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain or improve functional capabilities of children at home, work and in the community. Assistive technology service means a service that directly assists a child/youth in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:

- a. the evaluation of the assistive technology needs of a child, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the child in the customary environment of the child;
- b. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for children;
- c. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;
- d. coordination and use of necessary therapies, interventions or services with assistive technology devices, such as therapies, intervention or services, associated with other services in the service plan;
- e. training or technical assistance for the child/youth, or where appropriate, the family members, guardians, advocates or authorized representatives of the child; and
- f. training or technical assistance for professionals or other individuals, who provide services to, employ or are otherwise substantially involved in the major life functions of children.

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

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

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

Electronic devices must meet UL or FCC standards.

Individual interpreters must be on the state or national interpreter registry.

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



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

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual Interpreters
Agency	Providers of Communication Aids

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Communication Aids/Assistive Technology/Interpreter Services**

**Provider Category:**

Individual

**Provider Type:**

Individual Interpreters

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** *(specify):*

Individual interpreters must be on the state or national interpreter registry.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Communication Aids/Assistive Technology/Interpreter Services**

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**Provider Category:**

Agency

**Provider Type:**

Providers of Communication Aids

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Communication aids vendors must be Medicaid certified providers.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Community Integration Services

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04020 day habilitation

**Category 2:**

04 Day Services

**Sub-Category 2:**

04070 community integration

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

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

1. The minimum service requirements are that providers shall attend quarterly team reviews or sooner (or more frequent if requested) if requested by the SSC that would include the child parent or responsible person and child (if deemed appropriate) relevant service provider agency staff/supervisor (when applicable), the overseeing SSC and that person's supervisor.
2. Community Integration providers shall complete a written report every six months or sooner if the child's condition changes or warrants and updated progress towards and identified outcome that details the participant's past and current level of functioning, as well as the intended outcome and obstacles that stand in the way of those outcomes. This report shall be provided to the county waiver agency SSC.
3. Excludes experimental or adverse treatments as defined by the Medicaid State Plan
4. Excludes residential services as part of the community integration program see relevant residential service definitions foster care or adult family care or institutional respite.
5. If providers are transporting a child, the county waiver agency must have written documentation on file that the provider has a current valid driver's license, current liability insurance coverage and the vehicle is mechanically sound as defined under the Transportation services standards. The cost of transportation may be included in the rate paid to the provider of this service, or may be covered and reimbursed under transportation service, but not both. All providers shall ensure that all standards described in the Transportation service are met.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** *(check each that applies):*

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Community Integration Services**

**Provider Category:**

Individual

**Provider Type:**

Individual Provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Community Integration Services**

**Provider Category:**

Agency

**Provider Type:**

Daily Living Skills Training

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Community Integration Services**

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**Provider Category:**

Agency

**Provider Type:**

Social Worker

**Provider Qualifications**

**License** (*specify*):

Chapter 457 Wisconsin Statutes

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Counseling and Therapeutic Services

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11040 nutrition consultation

**Category 2:**

11 Other Health and Therapeutic Services

**Sub-Category 2:**

11020 health assessment

**Category 3:**

11 Other Health and Therapeutic Services

**Sub-Category 3:**

11130 other therapies

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

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

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

Services may include assistance with interpersonal relationships, music therapy, art therapy, hippotherapy, equine assisted therapy, and day/summer camp. Counseling and therapeutic services must meet clearly defined outcome, be proven effective for the child's condition or outcome and be cost effective.

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



Counseling and therapeutic supports and services may not be experimental or aversive in nature nor may they otherwise jeopardize the health and safety of the participant.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services.

The following components of Counseling and Therapeutic services have been identified as an EPSDT covered service: behavior therapy, speech therapy, occupational therapy, physical therapy. These services will be eliminated as a CLTS waiver covered service following a phased transition plan.

Between April 2017 and October 2017, the Support and Service Coordinator will assess the CLTS waiver participant's service needs, as part of his or her recertification, and will review the service plan. It is anticipated that the transition between the provision of waiver services and the state plan EPSDT service access could include as much as six months, with an optimal completion date of April 2018. The additional 60 days between this and the proposed June 2018 transition date, allows for unforeseen challenges, including securing provider agreements, changes to access methods, submission of EPSDT prior authorizations by the provider, as well as allowing for the participant's due process appeal rights.

In addition, the CLTS Waiver Program is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Counseling and Therapeutic Services**

**Provider Category:**

Individual

**Provider Type:**

Art Therapist

**Provider Qualifications**

**License** (*specify*):

Chapter 440 Wisconsin Statutes

**Certificate** (*specify*):

**Other Standard** (*specify*):

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.

Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.

Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

---

**Service Name: Counseling and Therapeutic Services**

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**Provider Category:****Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):**

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.

Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.

Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

**Verification of Provider Qualifications****Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

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**Appendix C: Participant Services**

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

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

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**Provider Category:****Provider Type:**

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

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

**Frequency of Verification:**

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person’s hire and every four years, thereafter, at a minimum.  
  
The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Counseling and Therapeutic Services**

**Provider Category:**

Individual

**Provider Type:**

Hippotherapist

**Provider Qualifications**

**License** (*specify*):

Chapter 440 Wisconsin Statute

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Counseling and Therapeutic Services**

**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License** (*specify*):

Chapter 50.49 Wisconsin Statutes  
42 CFR 484 Code of Regulations  
Administrative Rules DHS 131 and DHS 12 including Appendix A

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

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

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**Provider Category:**

Agency

**Provider Type:**

Other providers appropriately qualified

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Providers of counseling and therapeutic services shall maintain current state licensure or certification in their field of practice.

Providers of counseling and therapeutic services shall provide services limited to their areas of formal education and training, as directed by their professional code of ethics.

Services provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification must be reviewed, authorized, and endorsed by a licensed or certified professional.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Counseling and Therapeutic Services**

**Provider Category:**

Individual

**Provider Type:**

Equine-Assisted Therapist

**Provider Qualifications**

**License (specify):**

Chapter 440 Wisconsin Statute

**Certificate (specify):**

**Other Standard (specify):**

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

**Frequency of Verification:**

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person’s hire and every four years, thereafter, at a minimum.  
  
The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Daily Living Skills Training

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08010 home-based habilitation

**Category 2:**

**Sub-Category 2:**



**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Daily living skills training services provide education and skill development or training to improve an individual's ability to independently perform routine daily activities and effectively utilize community resources. Services are instructional, focused on skill development and are not intended to provide substitute task performance. This service includes funding for educational or training services that are of a direct benefit to the child.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Daily Living Skills Training**

**Provider Category:**

Agency

**Provider Type:**

Providers of Daily Living Skills Training

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

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

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Daily Living Skills Training**

**Provider Category:**

Individual

**Provider Type:**

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

**Provider Qualifications**

**License** *(specify):*

**Certificate** *(specify):*

**Other Standard** *(specify):*

Providers of daily living skills training must have a minimum of two years' experience working with the target population.

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

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

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Home Modification

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Home modifications include services designed to assess the need for, arrange for and provide modifications and/or improvements to a child’s residence that address a need identified to improve health, safety, accessibility or provide for the maximization of independent functioning. Home modifications are generally permanent fixtures/changes to a physical structure. Home modifications include the cost of the permit to authorize the changes, the materials, and services needed to complete the installation of specific equipment, the modification of the physical structure or the reconfiguration of essential systems within the home.

Home modifications may include adaptations, including, but not limited to:

- Ramps (fixed), ramp extensions and platforms
- Porch/stair lifts
- Doors/doorways, door handles/door opening devices
- Adaptive door bells, locks/security items or devices
- Plumbing, electrical modifications related to adaptations
- Medically necessary heating, cooling or ventilation systems
- Shower, sink, tub and toilet modifications
- Faucets/water controls
- Accessible cabinetry, counter tops or work surfaces
- Grab bars (see exception below), handrails, accessible closets
- Smoke/fire alarms and fire safety adaptations
- Adaptive lighting/light switches
- Flooring and/or floor covering to address health and safety
- Wall protection

Modifications not specifically described above may be approved if the item or service meets the definition and the standards for allowable home modifications.

Home modifications increase self-reliance and independence, or ensure safe, accessible means of ingress/egress to a participant's living quarters, or otherwise provide safe access to rooms, facilities or equipment within the participant’s living quarters, or adjacent buildings that are part of the residence.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Home Modification**

**Provider Category:**

Individual

**Provider Type:**

Electrician

**Provider Qualifications**

**License** (*specify*):

**Certificate (specify):**

Chapter 443 Wisconsin Statute

**Other Standard (specify):**

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

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Home Modification**

**Provider Category:**

Agency

**Provider Type:**

Independent Living Center

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Home Modification**

**Provider Category:**

Individual

**Provider Type:**

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

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Home Modification**

**Provider Category:**

Individual

**Provider Type:**

Plumber

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Chapter 443 Wisconsin Statute

**Other Standard (specify):**



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

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Home Modification**

**Provider Category:**

Agency

**Provider Type:**

Contractor

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Home Modification**

**Provider Category:**

Individual

**Provider Type:**

Engineer

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Chapter 433 Wisconsin Statutes

**Other Standard (specify):**

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

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Home Modification**

**Provider Category:**

Individual

**Provider Type:**

Heating & Air Conditioning

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Chapter 443 Wisconsin Statute

**Other Standard (specify):**

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

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Home Modification**

**Provider Category:**

Agency

**Provider Type:**

Building Supply Company

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

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

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Housing Counseling

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17030 housing consultation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Housing Counseling is the provision of services to waiver participants to provide comprehensive guidance on housing opportunities available to meet their needs and preferences. This service includes guidance on how a participant may gain access to available public and private resources to assist the person to obtain or retain safe, decent, accessible, and affordable housing and avoid institutionalization.

Housing Counseling includes planning, guidance and assistance in accessing resources related to home ownership, financing, accessibility and architectural services and consultation, as well as health and safety evaluations of physical property.

The provider delivers consultation by meeting with the participant and their family and collecting individual specific information. This information is used to provide guidance and assistance which is appropriate to the individual situation.

The depth of knowledge required to provide this service will typically include an expertise in a housing-related field and is often found in providers who have background and expertise in housing and disabilities.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method (check each that applies):**

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by (check each that applies):**

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Housing Counseling Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Housing Counseling**

**Provider Category:**

Agency

**Provider Type:**

Housing Counseling Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

A qualified provider must be an agency or unit of an agency that provides Housing Counseling as a regular part of its mission. Counseling must be provided by staff with specialized training and experience in any of the following housing issues; home ownership, both pre and post purchase, home financing and refinancing, home maintenance, repair and improvements including abating environmental hazards, rental counseling, not including any cash assistance, accessibility and architectural services and consultation, weatherization evaluation and assistance in accessing these services, lead-based paint abatement evaluation, low-income energy assistance evaluation, access to transitional or permanent housing, accessibility inventory design, health and safety evaluations of physical property, debt/credit counseling, and homelessness and eviction prevention counseling.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Mentoring

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04020 day habilitation

**Category 2:**

04 Day Services

**Sub-Category 2:**

04070 community integration

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Mentoring services are supports intended to improve the CLTS waiver participant's ability to interact in their community in socially appropriate ways. The mentor provides the participant with such services as peer interaction, social/recreational and employability skill-building opportunities. The mentor supports the participant by practicing, modeling, guiding and shadowing them in the community. Interventions are spontaneous and in real-life situations, rather than in a classroom-type environment. Covered expenses may include meals, admission fees, and transportation for the mentor related to participation in community events that address the objectives and meet the identified outcomes of the child's service plan.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.



**Service Delivery Method** (check each that applies):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (check each that applies):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Mentoring**

**Provider Category:**

Individual

**Provider Type:**

Mentors

**Provider Qualifications**

**License** (specify):

**Certificate** (specify):

**Other Standard** (specify):

Providers of mentoring services must be 18 years or older. The waiver agency must ensure that the provider receives child specific training provided by the agency, SSC and parent/guardian, and there must be documentation of this training in the child’s record.

Individual mentors must receive child specific training provided by the case manager, service coordinator, parent, guardian, and/or other relevant professional who is knowledgeable of the participant’s daily needs. Providers shall be involved in frequent and ongoing communication with the case manager/support and service coordinator, agency, and family, regarding child specific updates, information, and concerns.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Mentoring**

**Provider Category:**

Agency

**Provider Type:**

any agency appropriately qualified as approved by the State and as related to the unique service being provided

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Providers of mentoring services must be 18 years or older. The waiver agency must ensure that the provider receives child specific training provided by the agency, SSC and parent/guardian, and there must be documentation of this training in the child's record. Providers shall be involved in frequent and ongoing communication with the SSC, agency, and family, regarding child specific updates, information, and concerns.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Nursing Services

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05020 skilled nursing

**Category 2:**

05 Nursing

**Sub-Category 2:**

05020 skilled nursing

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Nursing services are those medically necessary, skilled nursing services that may only be provided safely and effectively by a nurse practitioner, a registered nurse, or a licensed practical nurse working under the supervision of a registered nurse. The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act and are not otherwise available to the participant under the Medicaid state plan or Healthcheck/EPSDT. Nursing services may include periodic assessment of the participants medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers. Services may also include regular, ongoing monitoring of a participants fragile or complex medical condition as well as the monitoring of a participant with a history of noncompliance with medication or other medical treatment needs. The need for skilled nursing services must be recommended or prescribed by the participants physician and reviewed by the support and service coordination.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. Nursing services are identified as an EPSDT covered service and will be eliminated as a CLTS waiver covered service following a phased transition plan.

Between April 2017 and October 2017, the Support and Service Coordinator will assess the CLTS waiver participant’s service needs, as part of his or her recertification, and will review the service plan. It is anticipated that the transition between the provision of waiver services and the state plan EPSDT service access could include as much as six months, with an optimal completion date of April 2018. The additional 60 days between this and the proposed June 2018 transition date, allows for unforeseen challenges, including securing provider agreements, changes to access methods, submission of EPSDT prior authorizations by the provider, as well as allowing for the participant’s due process appeal rights.

In addition, the CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin’s income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** *(check each that applies):*

- Participant-directed as specified in Appendix E**
- Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

- Legally Responsible Person**
- Relative**
- Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Licensed Practical Nurse
Individual	Registered Nurse
Individual	Nurse Practitioner
Agency	Home Health Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Nursing Services**

**Provider Category:**

Individual

**Provider Type:**

Licensed Practical Nurse

**Provider Qualifications**

**License** (*specify*):

Chapter 441 Wisconsin Statutes

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Nursing Services**

**Provider Category:**

Individual

**Provider Type:**

Registered Nurse

**Provider Qualifications**

**License** (*specify*):

Chapter 441 Wisconsin Statutes

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Nursing Services**

**Provider Category:**

Individual

**Provider Type:**

Nurse Practitioner

**Provider Qualifications**

**License** (*specify*):

Chapter 441 Wisconsin Statutes

**Certificate** (*specify*):

**Other Standard** (*specify*):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

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**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Nursing Services**

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**Provider Category:**

Agency

**Provider Type:**

Home Health Agency

**Provider Qualifications**

**License (specify):**

42 CFR 484 Code of Federal Regulations  
50.49, Wisconsin Statutes  
DHS 131, Administrative Code

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Personal Emergency Response System (PERS)

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14010 personal emergency response system (PERS)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**



Personal emergency response system (PERS) provides a direct telephonic, global positioning system (GPS) or other electronic communications link between someone living in the community and health professionals to secure immediate response and assistance in the event of a physical, emotional or environmental emergency. This service may include devices and services necessary for operation of PERS when otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as appropriate. Electronic devices must meet Underwriters Laboratories® (UL) Standards. Telephonic devices must meet Federal Communications Commission (FCC) regulations.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (check each that applies):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (check each that applies):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Community Based Electronic Communications Unit
Individual	Telephone service including cellular

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response System (PERS)**

**Provider Category:**

Individual

**Provider Type:**

Community Based Electronic Communications Unit

**Provider Qualifications**

**License** (specify):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Underwriters Laboratory and/or Federal Communication Commission or equivalent standard.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

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**Service Type:** Other Service

**Service Name:** Personal Emergency Response System (PERS)

---

**Provider Category:**

Individual

**Provider Type:**

Telephone service including cellular

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Underwriters Laboratory and/or Federal Communication Commission or equivalent standard.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Relocation Services

**HCBS Taxonomy:**

**Category 1:**

16 Community Transition Services

**Sub-Category 1:**

16010 community transition services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Relocation services are services and essential items needed to establish a community living arrangement for children who are relocating from an institution, foster home or who are moving out of the family home to a less restrictive or independent setting. This service includes person-specific services, supports or goods that will be put in place in preparation for the child/youth relocation to a safe, accessible and affordable community living arrangement.

Relocation services may include the purchase of necessary furniture, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings and kitchen appliances not otherwise included in a rental arrangement if applicable.

Relocation services may include the payment of a security deposit, utility connection costs and telephone installation charges. This service includes payment for moving the child/youth personal belongings to the new community living arrangement and general cleaning and household organization services needed to prepare the selected community living arrangement for occupancy.

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

Services or items covered by this service may not be purchased more than 180 days prior to the date the child/youth relocates to the community living arrangement. Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.).

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin’s income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** *(check each that applies):*

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Moving companies, public utilities, real estate agencies, vendors of home furnishings
Individual	Individual movers/individual landlords

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Relocation Services**

**Provider Category:**

Agency

**Provider Type:**

Moving companies, public utilities, real estate agencies, vendors of home furnishings

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Reputable contractor with Compliance history. Compliance history with Wisconsin or any other state's licensing requirements or federal certification requirements, including any license revocation or denial. Fraud or substantial or repeated violations of applicable laws and rules in the operation of any business. Financial history and financial stability, including:  
- Financial history and financial viability of the owner or related organization.  
- Outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.  
  
The Department will be transitioning the responsibility from the county waiver agency to a State, centralized provider screening, credential verification, and enrollment process as part of the implementation of the Wisconsin Provider Management (WPM) system, targeted for January 2018.

**Frequency of Verification:**

The county waiver agency shall conduct a licensure/credential search with the Department of Safety and Professional Services upon, a search of the federal DHHS OIG Exclusion List, and complete a caregiver background check upon the person's hire and every four years, thereafter, at a minimum.  
  
The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Relocation Services**

**Provider Category:**

Individual

**Provider Type:**

Individual movers/individual landlords

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Provider with reputable compliance history. Compliance history with Wisconsin or any other state's licensing requirements or federal certification requirements, including any license revocation or denial. Fraud or substantial or repeated violations of applicable laws and rules in the operation of any business. Financial history and financial stability, including:

- Financial history and financial viability of the owner or related organization.
- Outstanding debts or amounts due to the department or other government agencies, including unpaid forfeitures and fines.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

**C-1/C-3: Service Specification**

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

**Service Type:**

Other Service

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

**Service Title:**

Specialized Medical and Therapeutic Supplies

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

14 Equipment, Technology, and Modifications

**Sub-Category 2:**

14032 supplies

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Specialized medical and therapeutic supplies include items necessary to maintain the child’s health, manage a medical or physical condition, improve functioning or enhance independence. The cost of items, or devices provided, may be in excess of the quantity of medical equipment or supplies covered under the Medicaid state plan, when coverage of the additional items or devices is denied. Items or devices provided must demonstrate direct medical or remedial benefit to the participant.

Allowable items may include books and other therapy aids designed to augment a professional therapy or treatment plan. Room air conditioners, air purifiers, humidifiers and water treatment systems.

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

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services.

The following components of Specialized Medical and Therapeutic Services have been identified as an EPSDT covered service: incontinence supplies, wound dressings, IV or life support equipment, nutritional supplements, skin conditioning lotions. These services will be eliminated following a phased transition plan.

Between April 2017 and October 2017, the Support and Service Coordinator will assess the CLTS waiver participant's service needs, as part of his or her recertification, and will review the service plan. It is anticipated that the transition between the provision of waiver services and the state plan EPSDT service access could include as much as six months, with an optimal completion date of April 2018. The additional 60 days between this and the proposed June 2018 transition date, allows for unforeseen challenges, including securing provider agreements, changes to access methods, submission of EPSDT prior authorizations by the provider, as well as allowing for the participant's due process appeal rights.

In addition, the CLTS Waiver Program is the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

<b>Provider Category</b>	<b>Provider Type Title</b>
<b>Agency</b>	<b>Medical Supply Company</b>
<b>Individual</b>	<b>Authorized Dealers</b>
<b>Individual</b>	<b>Other providers appropriately qualified as approved by the State as related to unique service being delivered to the child</b>

## **Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Specialized Medical and Therapeutic Supplies**

**Provider Category:**

Agency

**Provider Type:**



Medical Supply Company

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

DHS 105 Wisconsin Administrative Code

**Other Standard** (*specify*):

Underwriters Laboratory and/or Federal Communication Commission.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Specialized Medical and Therapeutic Supplies**

**Provider Category:**

Individual

**Provider Type:**

Authorized Dealers

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Underwriters Laboratory and/or Federal Communication Commission.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

**Appendix C: Participant Services**

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

**Service Type:** Other Service

**Service Name:** Specialized Medical and Therapeutic Supplies

**Provider Category:**

Individual

**Provider Type:**

Other providers appropriately qualified as approved by the State as related to unique service being delivered to the child

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

**Other Standard** (*specify*):

Underwriters Laboratory and/or Federal Communication Commission.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Supported Employment - Small Group

**HCBS Taxonomy:**

**Category 1:**

03 Supported Employment

**Sub-Category 1:**

03022 ongoing supported employment, group

**Category 2:**

03 Supported Employment

**Sub-Category 2:**

03010 job development

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

Supported Employment - Small Group services are services and training activities provided in a regular business, industry or community setting for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small group employment support must be provided in a manner that promotes integration into the workplace and integration between members and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experiences leading to further career development and individual integrated community-based employment for which a member is compensated at or above the minimum wage, but not less than the customary wage level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Small group employment support services may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. Also included are other workplace support services not specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Small group employment support services may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker or other personnel and these individuals meet the qualifications established below for individual providers of service. Employers may be reimbursed for supported employment services provided by co-workers. Participants receiving small group employment support may also receive educational, pre-vocational, and/or day services and career planning services. However, different types of non-residential services may not be billed for the same period of time.

The cost of transportation for a participant to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider, or may be covered and reimbursed under specialized (community) transportation, but not both.

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

Supported employment services may not include personal care assistance or transportation assistance as components of this service for the same period of time.

Small group employment support does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** *(check each that applies):*

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	On the Job Support Person
Agency	Supported Employment Agency

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Supported Employment - Small Group**

**Provider Category:**

Individual

**Provider Type:**

On the Job Support Person

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The provider must have the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Holding the Certified Employment Support Professional accreditation.
- Meeting the ASPE Quality Indicators for Supported Employment Personnel.
- Comparable experience for a qualified individual, including a minimum of two years of experience working with the target population providing supported employment. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PHIP and member shall ensure that the individual provider has the member –specific competencies to effectively provide the service.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Employment - Small Group**

**Provider Category:**

Agency

**Provider Type:**

Supported Employment Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The provider must have the ability and qualifications to provide this service, demonstrated in at least one of the following ways :

- Accreditation by a nationally recognized accreditation agency.
- Existence of a current contract with the Division of Vocational Rehabilitation (DVR) for provision of supported employment services.
- Submission of written documentation that evidences that the agency meets all DVR Technical Specifications related to supported employment.
- Comparable experience for a qualified entity, including a minimum two years of experience working with the target population providing integrated employment services in the community.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Training for Parents/Guardians & Families of Children with Disabilities

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09020 caregiver counseling and/or training

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

The Training for Parents/Guardians and Families of Children with Disabilities sessions provides support and training strategies to help reduce the stress, demands and challenges to successfully raise children with disabilities. The training sessions include a focus on techniques for supporting children with and without disabilities, keeping family balance and harmony in the home, and effective communication. Parents/guardians, siblings and other family members are taught how stress affects individual family members and the family unit, and are provided techniques that can be used to work through difficult and stressful times.

Research indicates that children with disabilities may be at higher risk for abuse or neglect than children without disabilities. There are steps that parents/guardians and other family members can take to protect children with disabilities from abuse or neglect. Parents/guardians and family members of children and youth with emotional, behavioral, and mental health challenges obtain training on needed supports and services so that children grow up healthy and able to maximize their potential. These children are continually at risk of disciplinary actions at school, exclusion from family and community life, bullying, and the long-term effects of multiple negative experiences. Positive behavior support for parents/guardians and other family members assist in experience frustration in their attempt to change their children's problem behaviors by traditional methods of discipline. The training sessions offer a practical curriculum that teaches core strategies for engaging the child and explains how and why the strategies impact the child's development. These training sessions may also include parent support or mentoring groups. Caregivers who have similar information needs and educational issues can support each other while they learn about research-based best practices specific to their children's disability. Ongoing instruction and support for parents and family members who are implementing support interventions in their homes. The sessions are held in a location where parents/guardians, siblings, grandparents, and other family members can attend together to support their shared challenges and experiences in raising a child/youth with developmental, physical, emotional, behavioral, or mental health issues.

This service includes, but is not limited to, in-person training, conferences, resource materials, and on-line training sessions. Training includes the costs of registration and training fees associated with formal instruction in areas relevant to the needs identified in the child's support plan.

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

- This service does not cover training to be a paid caregiver.
- This service does not cover training focused to the waiver participant's training needs.
- This service excludes payment for lodging and meal expenses incurred while attending a training event or conference.
- This service does not cover teaching self-advocacy to waiver participants which is covered under consumer education and training services.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** *(check each that applies):*

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** *(check each that applies):*



**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Professional Services
Agency	Training/Service Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Training for Parents/Guardians & Families of Children with Disabilities**

**Provider Category:**

Individual

**Provider Type:**

Professional Services

**Provider Qualifications**

**License** (*specify*):

Licensed accredited professionals who maintain current credentials in their field of practice. For example, the training, peer-support sessions could be provided by licensed family professionals.

**Certificate** (*specify*):

Certified or accredited professionals who maintain current credentials in their field of practice. For example, training or peer support sessions could be provided by certified family professionals.

**Other Standard** (*specify*):

Training or experience in working with children with disabilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Training for Parents/Guardians & Families of Children with Disabilities**

**Provider Category:**

Agency

**Provider Type:**

Training/Service Agency

**Provider Qualifications**

**License** (*specify*):

Licensed accredited professionals who maintain current credentials in their field of practice. For example, the training, peer-support sessions could be provided by licensed family professionals.

**Certificate** (*specify*):

Certified or accredited professionals who maintain current credentials in their field of practice. For example, training or peer support sessions could be provided by certified family professionals.

**Other Standard** (*specify*):

Training or experience in working with children with disabilities.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

### C-1/C-3: Service Specification

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

**Service Type:**

Other Service

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

**Service Title:**

Transportation

**HCBS Taxonomy:**

**Category 1:**

15 Non-Medical Transportation

**Sub-Category 1:**

15010 non-medical transportation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Service Definition (Scope):**

**Category 4:**

**Sub-Category 4:**

transportation maintains, or improves, the child’s mobility in the community, increases inclusion, independence and community participation, including to authorized waiver services. The term “community” is broadly defined, and is not limited to the boundaries of any particular municipality. The CLTS Waiver Program transportation services funds coverage of non-medical, non-emergency transportation needs.

Transportation services may include the pre-purchase or provision of such items as bus tickets, train passes, taxi vouchers or other fare or may include a direct payment to providers covering the cost of transportation excluding parents.

Transportation may also be approved as mileage according to the Federal IRS rules related to mileage reimbursement and DHS established limits. Mileage is calculated based on the starting and ending points and is approved by the number of miles needed.

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

- Transportation cannot be used to pay for transportation that is the obligation of the school district.
- The transportation service does not cover the participant driving himself/herself to a location.
- The mileage reimbursement rate may not be supplemented to cover vehicle operating, maintenance or repair costs.
- Vehicle adaptations and modifications are excluded (they would be funded as adaptive aids).
- Excludes transportation services to and from medical providers.
- Costs for the participant or their family to maintain a vehicle are excluded.

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

Federal requirements prohibit the CLTS Waiver Program from funding any service could be furnished under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid, or the Medicaid State Plan services. The CLTS Waiver Program is also the payer of last resort and coordination of benefits (COB) must occur with private health insurance, special education services funded under the Individuals with Disabilities Education Act (IDEA), or vocational rehabilitation services funded under section 110, as amended in 2014, of the Rehabilitation Act of 1973 (29 U.S.C. 730), and Wisconsin's income maintenance programs, as appropriate, including Wisconsin Shares Child Care Subsidy Program, Wisconsin Home Energy Assistance Program (WHEAP), and FoodShare Wisconsin. Documentation must be maintained in the file of each CLTS waiver participant demonstrating that the service does not supplant or duplicate supports or services that are otherwise available through one of these other funding sources.

**Service Delivery Method** (*check each that applies*):

**Participant-directed as specified in Appendix E**

**Provider managed**

**Specify whether the service may be provided by** (*check each that applies*):

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Public Carriers e.g. taxi cabs, mass transit
Individual	Private Drivers
Agency	Specialized Transportation Agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Transportation**

**Provider Category:**

Agency

**Provider Type:**

Public Carriers e.g. taxi cabs, mass transit

**Provider Qualifications**

**License** (*specify*):

Operator's License issued by the Department of Transportation

**Certificate** (*specify*):

**Other Standard** (*specify*):

Operator is insured

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Transportation**

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**Provider Category:**

Individual

**Provider Type:**

Private Drivers

**Provider Qualifications**

**License** (*specify*):

Operators License issued by the Department of Transportation

**Certificate** (*specify*):

**Other Standard** (*specify*):

Driver is insured and vehicle is insured, is in good repair with all operating and safety systems functioning.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Transportation**

**Provider Category:**

Agency

**Provider Type:**

Specialized Transportation Agency

**Provider Qualifications**

**License (specify):**

Operators License from the Department of Transportation

**Certificate (specify):**

**Other Standard (specify):**

Operator is insured, and vehicle is insured, is in good repair with all operating and safety systems functioning.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

The county waiver agency is currently responsible for conducting provider screening and credential verification activities.

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

**Frequency of Verification:**

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

The Department will transition responsibility from the county waiver agency for the provider screening and credential checks to a State centralized process via implementation of the WPM system, targeted for January 2018.

## Appendix C: Participant Services

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### C-1: Summary of Services Covered (2 of 2)

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

**As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

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### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

The requirement for the completion of Wisconsin's caregiver background checks applies to all paid service providers who are listed on the Individual Service Plan (ISP), meet the definition of a caregiver, and are authorized to deliver services to a CLTS Waiver participant. Under Wisconsin's Caregiver Law, s. 50.065, and s. 48.685, caregivers are defined as those persons who have regular, direct contact with participants. "Regular" means contact that is scheduled, planned, expected or otherwise periodic. "Direct" means face-to-face physical proximity to a participant that affords the opportunity to commit abuse or neglect or to misappropriate participant property.

Examples of service providers who meet the definition of a caregiver include:

counseling and therapeutic services providers, foster care providers, supportive home care providers, and respite providers. Generally, a provider who delivers outside chores and does not have direct access to the CLTS waiver participant, such as snow removal provider does not meet the definition of a caregiver.

When a request is made for a Wisconsin caregiver background check, it triggers an automated inter-departmental search via the DHS Integrated Background Information System (IBIS) of criminal, professional and paraprofessional registries and databases and produces the following:

1. Results from a search of Wisconsin's Department of Justice criminal history records
2. Results from a search of Wisconsin's Caregiver Misconduct Registry, maintained by the Wisconsin Department of Health Services regarding substantiated findings of abuse, neglect and misappropriation of property by noncredentialed caregivers
3. Results from findings of abuse, neglect or misappropriation in another state (if known)
4. Results from search of the status of professional credentials, licenses or certifications maintained by the Department of Safety and Professional Services
5. Denials of revocations of operating licenses for adult programs regulated by the DHS Division of Quality Assurance
6. Denials or revocation of operating licenses for child programs (e.g., day care centers, foster care providers, etc.) regulated by the Department of Children and Families

A search of the U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG) Exclusions List (LEIE) is also required, as part of the required screening activities.

Currently, county waiver agencies and their sub-contracted agencies must ensure that a caregiver background check and OIG LEIE search is completed for all persons working as caregivers. The required checks must be completed upon the authorization of a caregiver and repeated every four years, at a minimum.

With the implementation of the Wisconsin Provider Management (WPM) system, targeted for January 2018, the Department will be the responsible entity for conducting the OIG LEIE screening and completion of caregiver background checks.

In addition, the State of Wisconsin oversees a Single State Audit process for county departments of human/social/community services. The CLTS Waiver Program includes requirements for the auditors to assure compliance with the caregiver background checks, as part of the CLTS Waiver Program audit requirements. The county waiver agencies must maintain documentation of all required documentation to ensure that prior to authorizing providers to deliver services to waiver participants, the agency has verified there are no barring offenses (e.g., substantiated finding of abuse or neglect or criminal history record indicating felony for the applicable waiver participant).

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

**No. The state does not conduct abuse registry screening.**

**Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been



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

(a) The Department of Health Services (DHS) requires county waiver agencies to complete a caregiver background check for all waiver providers who meet the definition of a caregiver. The DHS maintains a caregiver misconduct registry which is available to the public. The Wisconsin Caregiver Misconduct Registry is a record of the names of nurse aides, personal care workers, and other non-credentialed caregivers with substantiated findings of caregiver misconduct (abuse or neglect of a client, or misappropriation of a client's property). This information must be reviewed regularly to determine appropriate hiring and employment decisions. The county waiver agencies must also conduct a search of the U.S. Department of Health and Human Services Office of Inspector General Exclusions Database.

(b) The requirement for the completion of caregiver background checks, which includes an automated search of both Wisconsin's criminal history record information, the Wisconsin Caregiver Misconduct Registry and several other children and adult provider licensure databases, must be conducted for all paid service providers who are authorized to deliver services listed on the waiver participant's Individual Service Plan (ISP) and meet the definition of a caregiver. Under Wisconsin's Caregiver Law, s. 50.065 and s 48.685, caregivers are defined as those persons who have regular, direct contact with waiver participants. "Regular" means contact that is scheduled, planned, expected or otherwise periodic. "Direct" means face-to-face physical proximity to a participant that affords the opportunity to commit abuse or neglect or to misappropriate participant property. Examples of service providers who meet the definition of a caregiver include supportive home care workers, respite providers, child care providers, and foster care providers.

Currently, county waiver agencies and their subcontracted entities must ensure that all persons working as caregivers have had a completed caregiver background check. The process is triggered when a request is submitted to the Wisconsin Department of Justice for a caregiver background check. The DHS Integrated Background Information System (IBIS) conducts an automated interdepartmental search of criminal, professional and paraprofessional licensing registry databases and produces the following:

1. Results from a search of Wisconsin's Department of Justice criminal history records
2. Results from a search of DHS Wisconsin Caregiver Misconduct Registry regarding substantiated findings of abuse, neglect and misappropriation of property by noncredentialed caregivers
3. Results from findings of abuse, neglect or misappropriation in another state (if known)
4. Results from search of the status of professional credentials, licenses or certifications maintained by the Department of Safety and Professional Services
5. Denials or revocations of operating licenses for adult programs
6. Denials or revocation of operating licenses for child programs (e.g., day care centers, foster care providers, etc.)

The county waiver agency must complete the required checks upon hire or contract, and the check must be repeated every four years, at a minimum. Providers are also required to report any change in their criminal history record (arrest or conviction) to their employer or contractor.

The CLTS Waiver Program, under the Single State Audit process, requires an audit review to ensure compliance with provider caregiver background check requirement. The county waiver agencies must maintain documentation of all required caregiver background checks and the provisions of contracts related to this requirement. Auditors view the results of the mandatory screening for each paid service provider who meets the definition of a caregiver.

In addition, the CLTS Waiver Program will implement a comprehensive quality review process through an external quality review organization (EQRO), to ensure the county waiver agencies are in compliance with the provider background check requirements.

Effective January 2018, with the implementation of the Department's Wisconsin Provider Management (WPM) system, DHS will be responsible for conducting a centralized provider screening and credentialing verification process as part of the enrollment for all waiver providers.

Information regarding Wisconsin's caregiver background check requirements, including links to the federal HHS Office of Inspector General Exclusion Database, is available at:  
<http://www.dhs.wisconsin.gov/caregiver/INDEX.HTM>

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

**No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

**Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. **Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Shelter Care Facilities	
Child Group Home	
Residential Care Center (RCC)	

ii. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

The CLTS Waiver Program only allows respite services to be delivered in these settings. Required information is contained in response to C-5.

## Appendix C: Participant Services

### C-2: Facility Specifications

Facility Type:

Shelter Care Facilities

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Housing Counseling	
Respite	
Consumer Education and Training	
Adaptive Aids	
Personal Emergency Response System (PERS)	
Communication Aids/Assistive Technology/Interpreter Services	
Supportive Home Care	
Transportation	
Financial Management Services	
Mentoring	

Waiver Service	Provided in Facility
Children's Foster Care	
Nursing Services	
Day Services	
Supported Employment - Small Group	
Support and Service Coordination	
Counseling and Therapeutic Services	
Specialized Medical and Therapeutic Supplies	
Child Care Services	
Adult Family Home	
Community Integration Services	
Home Modification	
Daily Living Skills Training	
Supported Employment – Individual	
Training for Parents/Guardians & Families of Children with Disabilities	
Relocation Services	

**Facility Capacity Limit:**

As per 2013 Wisconsin Act 335, s. 48.63(1)(b), s. 958.22(2); no more than 20 days under a voluntary agreement.

**Scope of Facility Standards.** For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare**

of participants is assured in the standard area(s) not addressed:

## Appendix C: Participant Services

### C-2: Facility Specifications

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**Facility Type:**

Child Group Home

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Housing Counseling	
Respite	
Consumer Education and Training	
Adaptive Aids	
Personal Emergency Response System (PERS)	
Communication Aids/Assistive Technology/Interpreter Services	
Supportive Home Care	
Transportation	
Financial Management Services	
Mentoring	
Children's Foster Care	
Nursing Services	
Day Services	
Supported Employment - Small Group	
Support and Service Coordination	
Counseling and Therapeutic Services	
Specialized Medical and Therapeutic Supplies	
Child Care Services	
Adult Family Home	
Community Integration Services	
Home Modification	
Daily Living Skills Training	
Supported Employment – Individual	

Waiver Service	Provided in Facility
Training for Parents/Guardians & Families of Children with Disabilities	
Relocation Services	

**Facility Capacity Limit:**

5-8 bed capacity

**Scope of Facility Standards.** For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Residential Care Center (RCC)

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Housing Counseling	
Respite	

Waiver Service	Provided in Facility
Consumer Education and Training	
Adaptive Aids	
Personal Emergency Response System (PERS)	
Communication Aids/Assistive Technology/Interpreter Services	
Supportive Home Care	
Transportation	
Financial Management Services	
Mentoring	
Children's Foster Care	
Nursing Services	
Day Services	
Supported Employment - Small Group	
Support and Service Coordination	
Counseling and Therapeutic Services	
Specialized Medical and Therapeutic Supplies	
Child Care Services	
Adult Family Home	
Community Integration Services	
Home Modification	
Daily Living Skills Training	
Supported Employment – Individual	
Training for Parents/Guardians & Families of Children with Disabilities	
Relocation Services	

**Facility Capacity Limit:**

Ch. DCF 52, Wisconsin, Stats. The Statutes do not limit bed capacity of RCCs. The WI Department of Children and Families has the authority to approve or deny proposed expansion of an existing RCC.

**Scope of Facility Standards.** For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	

Standard	Topic Addressed
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

**No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

**Self-directed**

**Agency-operated**

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

**The state does not make payment to relatives/legal guardians for furnishing waiver services.**

**The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may perform specified CLTS waiver services if they are appropriately qualified and meet the following criteria:

- The child's assessed needs must warrant the proposed service to meet a child specific outcome; and
- The rate paid does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the department for the payment of personal care attendant services including all the administrative costs associated with that service;
- The relatives/legal guardians must maintain time sheets for hours to be paid and must submit them to the fiscal support entity on a biweekly or more frequent basis. The county waiver agency may make random, unannounced visits for the purpose of verification.

**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:



The Department of Health Service's (DHS) current waiver provider screening and enrollment process, and public access to a list of willing and qualified providers, is under a corrective action plan issued by the Centers for Medicare and Medicaid Services (CMS). In response, DHS is developing the Wisconsin Provider Management (WPM) system to manage its enrollment of all willing and qualified providers of Medicaid home and community-based waiver services. WPM encompasses the administration and communication with providers through the ForwardHealth portal, managed by Hewlett Packard Enterprise (HPE), the Department's contracted Medicaid Management Information System (MMIS) vendor, for open and continuous provider enrollment and certification. A robust communication plan will be carried out by DHS to ensure that county waiver agencies, providers and program participants are aware of the new certification process for providers of home and community-based services.

WPM will allow all willing providers to access the certification process via the internet. Upon entering the WPM portal, providers will access information on:

- how to navigate through the portal,
- the steps to become a certified provider,
- the qualifications required for each service category, and
- the requirement for all willing and qualified providers to sign a Wisconsin Medicaid Waiver Provider Agreement during the certification process.

The portal will direct providers through a WPM process to identify and record:

- the program and type of service(s) they wish to deliver,
- the geographic area they wish to serve,
- the information they wish DHS to publish about their availability, and
- their qualifications to perform each service they wish to deliver.

With the implementation of WPM, DHS will eliminate the current paper execution of Medicaid Waiver Provider Agreements and will conduct a centralized provider registration, screening and enrollment process. Once a willing and qualified provider signs the Medicaid Waiver Provider Agreement and is approved via the WPM certification process, the provider's information will be published on the online directory as an available willing and qualified provider. There will be no further barriers to prevent a provider from being selected by a waiver program participant to deliver authorized waiver services for which the provider is qualified. No provider will be enrolled or be included on the public provider directory until all background check screening and credential qualifications are verified.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

#### **a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

##### **i. Sub-Assurances:**

- a. Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

##### **Performance Measures**

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

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

**Performance Measure:**

**Providers initially meet required licensure and/or certification in accordance to state law prior to provision of services. Numerator = Number and percent of new providers who obtained appropriate licensure or certification in accordance to state law prior to provision of waiver services. Denominator = Number of licensed and/or certified providers reviewed in the sample.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**Wisconsin Provider Management system, once implemented (targeted in January 2018).**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Providers continuously meet required licensure and/or certification requirements in accordance to state law. Numerator = Number and percent of ongoing providers who continuously maintained licensure or certification in accordance to state law.**

**Denominator = Number of licensed and/or certified providers reviewed in the sample.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

		<input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Wisconsin Provider Management system, once implemented (targeted in January 2018).**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text"/> + / - 95%
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Numerator:** Number and percent of licensed/certified providers that signed and submitted the Medicaid Waiver Provider Agreement and registered via the Department’s online process prior to service delivery. **Denominator:** All licensed/certified providers reviewed in the sample.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Wisconsin Provider Management (WPM) system, once implemented (targeted January 2018)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>

	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; width: 100%; height: 20px; margin-top: 5px;"></div>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

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

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

**Performance Measure:**

**Non-licensed/non-certified providers meet applicable credentialing requirements.**  
**Numerator = Number and percent of non-licensed / non-certified waiver service providers whose credentialing requirements have been verified prior to being authorized to deliver waiver services to participants. Denominator = Total number of non-licensed / non-certified providers reviewed in the sample.**

**Data Source (Select one):**



**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Wisconsin Provider Management system, once implemented (targeted in January 2018).**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<input type="text"/>

**Performance Measure:**

**Numerator:** Number and percent of non-licensed/non-certified providers that signed and submitted the Medicaid Waiver Provider Agreement and registered via the Department’s online process prior to service delivery. **Denominator:** All non-licensed/non-certified providers reviewed in the sample.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/-5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Wisconsin Provider Management (WPM) system, upon implementation (targeted for January 2018)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text" value="+/-5%"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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

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

**Performance Measure:**

**Providers of waiver services meet State and waiver training requirements.**

**Numerator = number of waiver providers in the sample who meet state and waiver requirements. Denominator = all waiver providers reviewed in the sample.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b>

		Confidence Interval =  <input type="text" value="+/- 5%"/>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Wisconsin Provider Management system, once implemented (targeted in January 2018).**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <input type="text" value="+/- 5%"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The Department of Health Services enters into a State-County contract with each county waiver agency which details the CLTS Waiver Program's requirements. The contracts reference the DHS Home and Community-Based Services Waivers Manual which indicates the DHS established statewide policies and procedures to which the county waiver agencies must adhere.

All county waiver agencies are subject to the annual Single State Audit, in accordance with federal audit requirements. The CLTS Waiver Program has been identified as a state program that is subject to the Single State Audit. This audit guidance addresses CLTS Waiver Program requirements to ensure that waiver providers comply with all the training, work experience and licensure/certification standards, and that required caregiver background checks have been completed in a timely manner.

Upon the full implementation of the Department's Wisconsin Provider Management (WPM) system, targeted for January 1, 2018, interested and willing waiver providers will self-register via a web-based portal, electronically sign a Medicaid Waiver Provider Agreement, complete a Background Information Disclosure form, and upload their training, work experience, and licensure or certification credentials. DHS will implement a centralized provider background check screening process and verify the provider's credentials to ensure all qualified provider standards have been met. Once the provider is enrolled as a qualified provider, the provider details are posted on a public directory, and the data file is submitted to the contracted third party administrated for claim payment processing.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The Bureau of Children's Services (BCS), along with regional area administration staff, monitor and follow up with county waiver agencies that have been identified as having compliance issues related to willing and qualified providers. County waiver agencies that fail to comply with the qualified provider requirements receive technical assistance and guidance from DHS when individual problems are discovered. The BCS works directly with the county waiver agency and other entities as appropriate (e.g., the provider agency, Department or legal staff, etc.) to ensure that the specific issue is resolved. The county waiver agency currently retains documentation in the waiver participant's file. County waiver agencies are responsible for correcting any individual issues discovered and informing their assigned BCS of their actions. Issues related to specific waiver participants are tracked within the CLTS enrollment database, from identification to final resolution.

If it appears that there is a systems issue of concern, or if performance and compliance does not approve as a result of technical assistance and training, the BCS may recommend that a Corrective Action Plan (CAP) be developed with measurable outcomes, including timelines. This CAP is monitored by the BCS program integrity staff until compliance is achieved. Any formal corrective action plan is developed in coordination with DHS, and the department tracks all actions related to the CAP. The Department may also require immediate remedial action and impose CAPs to address these issues. The DHS collects and tracks information to ensure appropriate remediation has occurred.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>



<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<input type="checkbox"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="checkbox"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix C: Participant Services**

**C-3: Waiver Services Specifications**

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

**Appendix C: Participant Services**

**C-4: Additional Limits on Amount of Waiver Services**

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable -** The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.  
*Furnish the information specified above.*

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.  
*Furnish the information specified above.*

**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.  
*Furnish the information specified above.*

**Other Type of Limit.** The state employs another type of limit.  
*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, [HCB Settings Waiver Transition Plan](#) for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

HCBS Waiver Final Rule Transition Plan is located in Attachment #2.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

**State Participant-Centered Service Plan Title:**

Individual Service Plan (ISP)

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

**Registered nurse, licensed to practice in the state**

**Licensed practical or vocational nurse, acting within the scope of practice under state law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

Licensed or Certified under Chapter 457.09 of Wisconsin State Statute. This includes the following:  
A minimum of one year of employment working with persons of the specific target group for which they are employed.

**Other**

*Specify the individuals and their qualifications:*

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

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards.** *Select one:*

**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

DHS has submitted a 1915(b)(4) application as a companion to the CLTS Waiver program 1915(c) renewal application, to request approval for qualified individuals employed by county waiver agencies (or their sub-contracted case management agencies) to be the sole provider to deliver support and service coordination services.

The only services that county waiver agencies will be permitted to deliver to CLTS participants and seek CLTS claim payment, in addition to support and service coordination, includes the following:

- Allowable component of foster care services
- Purchased products and supplies from third party entities (typically web-based vendors) and the county waiver agency receives no benefit from the vendor
- Allowable services from subcontractors wherein the county waiver agency makes prepayment to the vendor

For all other CLTS waiver services, the SSC must provide full disclosure and assurance to participants to support their right to free choice of providers, as well as information about the full range of CLTS covered waiver services. The SSC must provide the opportunity to dispute whether another entity/provider could deliver the service through an alternative dispute resolution process. In addition, the county waiver agency must administratively separate the function and individual responsible for developing the ISP from that of the direct service functions for CLTS covered foster care services or products and supplies purchased from third party entities and vendors.

DHS requires for county waiver agencies to operate the CLTS Waiver Program in a manner that is free of conflict of interest, to the greatest extent possible. Where conflicts cannot be eliminated, they must be identified and their impact must be minimized by the intervention of the county waiver agency. Conflict of interest situations that must be addressed include both those that are present and those that may be perceived. Each county waiver agency must have a written description of how the agency will identify, resolve or mitigate conflicts of interest. If resolving or mitigating the conflict is not feasible, the county waiver agency must take action to minimize the effect(s) of the conflict. These efforts must be reported to the county's assigned Children's Services Specialist and are subject to DHS approval.

A conflict of interest is present whenever a person or any other entity involved in operating any part of the waiver has an interest in or the potential to benefit from a particular decision, outcome or expenditure. A single individual, agency or entity occupying several roles often signals that conflict of interest may be present. Potential conflict of interest situations include:

1. If the SSC who completes the comprehensive assessment and/or ISP for a participant also provides other services to the individual.
2. If a guardian is an employee of the county waiver agency or an employee of a provider that delivers services to participant and the guardian's employing agency or provider is at the same time funding or serving that guardian's ward.
3. If the SSC is also the person that manages the participant's finances (e.g., the SSC is the participant's representative payee.)
4. If the waiver agency, guardian or another entity that manages participant funds also makes any decision that results in the agency or entity receiving participant funds (e.g., cost share, room and board payment, etc.)
5. If the guardian or another legally established decision-maker for the participant is a paid waiver service provider.
6. If a county waiver agency employee is an alleged perpetrator of abuse, neglect or any other act defined as a reportable incident or violation of the participant's rights, and the county is, by rule or statute, responsible to conduct the investigation.

Each county waiver agency must establish a written policy that describes how it will identify, and resolve or mitigate conflicts of interest. The policy must identify all of the covered entities and address each conflict of interest scenarios described above. The county waiver agencies' policies must address each of the following effort areas:

1. Identify and avoid real or perceived conflict of interest
2. Resolve any identified conflict of interest
3. When resolving or avoiding the conflict of interest is not feasible, efforts to minimize the effect of the conflict of interest;
4. Ensure the assessment of participant needs occurs in a conflict free environment
5. Ensure participants are informed of identified conflicts of interest and involved in the effort to resolve them
6. Ensure all providers are informed of and operate under conflict of interest policies
7. Ensure high degree of organizational separation and autonomy in decision-making among the guardian, SSC and

other service providers

8. Ensure more than one qualified provider for all services to reduce potential conflict of interest due to lack of available choice

9. Address conflicts when an allegation involving the county waiver agency staff or affiliated entity for the following:

- Violation of participant rights
- Violation of statutory protections from abuse/neglect or unreasonable restraint
- Occurrence of reportable incident

The SSC must inform the parent/guardian and participant of any potential conflict of interest, as well as their right to use other providers to obtain needed services. If the parent/guardian and participant choose to receive direct services from the county waiver agency, the SSC works in partnership with them to develop a plan to monitor the situation.

The county waiver agencies' established conflict of interest policies are subject to the Department's review and approval. In addition, when a conflict of interest situation occurs, the parent/guardian and SSC must sign a document specifying the conflict of interest and the plan details for monitoring the situation.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The Individual Service Plan (ISP) is developed through a person-centered and family-centered assessment focused on identifying the child's needs and learning about the desired child and family's outcomes. Families are critical partners in the development of the desired outcomes for the child and the necessary supports and services required to achieve these outcomes in the home and community settings. The Support and Service Coordinator gathers information for the ISP by involving the people who know the child well, such as parents, other family members, friends, and other caregivers to gain a clear understanding of the child's strengths and needs. The child and family invite and include anyone they believe will be helpful in the ISP development process.

The Support and Service Coordinator provides information regarding the application process, waiver participation, freedom of choice, rights and responsibilities, and allowable supports and services under the CLTS Waiver Program, as well as other formal and informal community supports.

In cases of self-direction, while participants, family members, and guardians are included in the service plan development process, the county employed (or sub-contracted) Support and Service Coordinator (SSC) still serves as the case manager and developer of the plan.

Families are also able to access information regarding the CLTS Waiver Program requirements and covered services on the DHS Website: <https://www.dhs.wisconsin.gov/clts/index.htm>

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid

agency or the operating agency (if applicable):

The Department will be implementing a corrective action plan within 90 days of approval of the waiver to meet the updated HCBS waiver regulation requiring service providers to sign the ISP and receive a copy of the plan, according to applicable laws. Upon CMS approval of the Department's ISP corrective action plan, DHS will submit a technical amendment within 30 days to incorporate the corrective action plan into the CLTS Waiver Program.

The Department will begin phasing in the corrective action plan for this requirement following CMS approval of the ISP technical amendment for the corrective action plan. In November 2018, DHS will inform county waiver agencies (CWAs) that during the CLTS participant's next six-month face-to-face review, they must:

- Obtain the signature of all individuals and essential providers responsible for the Individualized Service Plan's (ISP) implementation. Essential providers are those who deliver waiver-funded services and have regular and direct contact with participants, as defined under program policy. For non-essential providers, the CWA will attach a copy of the provider's signed service contract, agreement or authorization to the ISP.
- Distribute a copy of the plan to the participant's parent/guardian, the participant if age 14 or older, and essential provider(s) that are responsible for the ISP's implementation, according to program policy.
- For non-essential providers, the CWA will attach a copy of the provider's signed service contract, agreement, or authorization to the ISP.

The Corrective Action Plan (CAP) will be fully implemented by December 2019 with record review validation beginning in January 2020, reviewing files from 2019.

The Individual Service Plan (ISP) Form F-20445, is developed by the county waiver agency's employed or sub-contracted Support and Service Coordinator (SSC) in partnership with the child's parent(s) or guardian, and the child, as appropriate to the child's age and ability. The purpose of the assessment is to gather current, comprehensive information about the person and their strengths and needs, including any unique to the child's environment to determine which services, supports and environmental modifications are necessary to enable the child or the child's family to meet or maintain their individual outcomes, and to safely and independently participate in the life of their community.

The content of the assessment must be family-centered and individualized. This includes identifying the child and family's needs as well as desired individual outcomes. The individual outcomes identified are child specific, based on the child and family's lifestyle, goals, ambitions, values, personal preferences and priorities.

The SSC who completes the assessment must have the skills needed to facilitate the child and family's identification of individual outcomes. This includes a focus on the whole child, not solely on functional deficits. An understanding of the child and family is essential to helping to translate a stated wish or goal or personal priority into an attainable individual outcome. The SSC assists the child and family to identify and include those with an important role in their life or knowledge of their situation to participate in the process.

The assessment process is structured to explore the applicant's preferences in such areas as service delivery, living arrangement, medical care, and community participation. The process also gathers information on abilities, needs, desired outcomes, current supports, and the range of choices and services that may be beneficial. The assessment forms the basis for the service plan development. This ensures that the ISP is tailored to meet child and family's outcomes and the identified needs of the child. The services and supports provide an alternative to institutional care.

The following topical areas are explored and documented as a result of this assessment:

- Background and social history,
- Physical and medical health history,
- Individual outcomes important to the child and family,
- Ability to perform physical activities of daily living,
- Ability to perform instrumental activities of daily living,
- Emotional and cognitive function,
- Behaviors that positively or negatively affect lifestyle or relationships,
- Social participation, friendships, existing formal and informal social supports,
- Cultural, ethnic and spiritual influences,
- Community participation and involvement
- Personal preferences, preferred daily activities/routines and their environment,
- Risks associated with choices made in living arrangement, activities and relationships and behaviors,

- Economic resources available and how they are managed,
- Formal and informal supports available to the child and family,
- Review of participant rights and responsibilities, and
- A review of the child and family's interest and ability to self-direct supports.

The ISP must be developed based on an assessment of the child's needs following enrollment into the CLTS Waiver Program. The ISP and Outcomes form must be completed and signed within 60 days of CLTS Waiver Program enrollment, and is submitted to the Department for review. The ISP and Outcomes form is a summary of the child's proposed package of formal and informal supports and services. It includes information related to the services provided, the identified provider, service costs, frequency, and funding sources. The ISP results from the assessment, utilizing the most cost-effective waiver and non-waiver funded resources available to bridge the gap between the needs identified in the assessment and the desired individual outcomes.

The services and the service providers listed on the ISP reflect the family and child's desired individual outcomes and preferences chosen by the family and to the extent possible the child through the course of an informed decision-making process. The ISP integrates the services listed with the individual outcomes.

The ISP represents an agreement between the waiver agency, the family and the child as to how the program will meet the identified needs of the person, and in so doing, help the child reach his/her desired outcomes. The ISP is an evolving instrument that can be adapted to meet changes in the child and family needs and preferences at any time. The ISP may also be adapted to address changing conditions among formal or informal supports, including waiver service providers. The ISP is updated to reflect a current, accurate description of the CLTS Waiver Program services interaction with the participant whenever changes occur in services provided or when there is a change in the provider of service. Updated ISPs are forwarded to the appropriate waiver program management quality assurance entity as required.

The ISP must be reviewed and updated every 12 months, at a minimum, by the SSC during the six-month face-to-face meeting with the child and family. This review is documented in the participant record. The case note indicates that the plan review was conducted, current services and support needs discussed and evaluated by the parent(s)/guardian, participant (based on the age of the child), and the SSC. The updated ISP will describe any changes that will be made (e.g., increases or decreases in service hours, change of service provider(s), addition or removal of services or supports). Changes are also made upon the identification of new or increased service needs that must be addressed or made as the review identifies new preferences or desired outcomes.

For participants who have a guardian, activated power of attorney, authorized representative or other legal representative, the six-month face-to-face meeting with the participant remains mandatory however, the guardian/legal representative must sign the updated ISP. The contact with the guardian/legal representative should be face-to-face as well.

The ISP serves as an agreement between the county waiver agency, the parent(s)/guardian, and the participant; therefore must list all waiver services and supports, including natural supports as well as other services that are currently in place. Within six months of any change to the service plan, a completed and signed updated ISP must be placed in the participant record. A copy of the updated ISP should be provided to the parent/guardian, the participant, if 14 years or older, essential providers, as identified by program policy, and the legal representative, if applicable.

The service plan contains individual demographic information and summarizes the individualized supports and services designed to address child and family's individual outcomes. The plan establishes the CLTS Waiver Program and service start dates, lists all service providers, service frequency, service costs and their respective funding source. The following information is required to be included on the ISP:

- a. The plan type (new, recertification, update, etc.)
- b. Date of plan development with the child and family
- c. The level of care
- d. The cost share amount, if applicable
- e. The parental payment liability fee, if applicable
- f. Personal discretionary funds available
- g. The estimated Medicaid card costs/day
- h. The total start up/one time waiver costs
- i. The daily waiver service costs



- j. All of the CLTS waiver, medical, formal and informal support services, necessary to maintain the child in the community including identification of those services that are preferred by the child and family
- k. The identified individual outcomes that the planned waiver services will address
- l. The federal procedure code for accurate waiver claim encounter reporting and name of each waiver funded service
- m. The state procedure code (if applicable) of each non-waiver funded service to be provided
- n. Each service provider's name, address, phone and e-mail
- o. Start dates of service delivery and end dates (if applicable)
- p. Costs per unit of service (i.e., the hourly or daily rate charged by the provider)
- q. The number of units of service to be delivered, including frequency and description for each service (e.g., 2 hours per day, 10 days/month);
- r. Funding sources for all waiver and non-waiver services listed (e.g., Medicaid card, CLTS Waiver Program, Children's Community Options Program, school education, natural supports, etc.)
- s. Services covered by the Medicaid State Plan (Medicaid card), including units of service
- t. The staff person and agency with Support and Service coordination responsibility
- u. The signature of the parent/guardian and child, if she or he is 14 years of age or older, indicating understanding of the choice between institutional and community-based services and agreement with the CLTS waiver service plan
- v. The signature of identified essential providers
- W. The signature of the Support and Service Coordinator

The county waiver agency obtains the signatures of all individuals, including the essential providers responsible for the ISP's implementation. The CWA will distribute a copy of ISP to the parent(s)/guardian, the participant (if applicable), and the essential provider responsible for the ISP's implementation, according to applicable program policies.

The Department will be implementing a corrective action plan within 90 days of approval of the waiver to meet the updated HCBS waiver regulation requiring service providers to sign the ISP and receive a copy of the plan, according to applicable laws. Upon CMS approval of the Department's ISP corrective action plan, DHS will submit a technical amendment within 30 days to incorporate the corrective action plan into the CLTS Waiver Program.

The Department will begin phasing in the corrective action plan for this requirement following CMS approval of the ISP technical amendment for the corrective action plan. In January 2018, DHS will inform county waiver agencies (CWAs) that during the CLTS participant's next six-month face-to-face review, they must:

- Obtain the signature of all individuals and essential providers responsible for the Individualized Service Plan's (ISP) implementation. Essential providers are those who deliver waiver-funded services and have regular and direct contact with participants, as defined under program policy. For non-essential providers, the CWA will attach a copy of the provider's signed service contract, agreement, or authorization to the ISP.
- Distribute a copy of the plan to the participant's parent/guardian, the participant if age 14 or older, and essential provider(s) that are responsible for the ISP's implementation, according to program policy.
- For non-essential providers, the CWA will attach a copy of the provider's signed service contract, agreement, or authorization to the ISP.

Should a family decline support and service coordination services through the county waiver agency and prefers to self-direct this service instead, DHS would require the family to work closely with their county waiver agency (CWA) to develop a person-centered ISP for self-directed services and access to appropriate funding supports for the child.

The family would work with the CWA and a selected Financial Management Fiscal Agent/Fiscal Intermediary provider to ensure qualified providers are identified for each service included on the child's ISP. DHS specifies minimum contact requirements between a participant/family and their service coordinator, and some families have requested a model of service coordination that allows for reduced contact requirements between the participant/family and the CWA. This model typically reduces CWA contact to two times per year, which includes the 6-month review of services and outcomes and the annual recertification. The family/participant self-directed model includes the following procedures:

1. Family/participant, in collaboration with the CWA representative, maintains ISP to ensure identified services continue to meet the child's outcomes.
2. Family/participant is responsible to notify the CWA if/when the child's needs change and services and outcomes need to be changed to meet those needs.
3. Family/participant is responsible to notify the CWA when a health and safety event has occurred so services can be adjusted to ensure the child's health and safety.

4. The self-directed support and service coordination services may include any of the following activities:
- Assistance to establish and maintain program functional and financial eligibility
  - Establishment and reevaluation of level of care
  - Ongoing assessment and periodic reassessment of participant health, safety and functional level of care capacity
  - Person-centered, family centered service planning and service plan development, service coordination and plan review,
  - Creation and development of effective provider network for the participant
  - Oversight of services: monitoring provider service systems specific to the participant's individual service plan,
  - Reviewing or completing ISPs at required intervals
  - Identify participant outcomes, arrange services; coordinate and manage multiple service providers and between providers (e.g., schools, Medicaid providers, respite staff, job coaches, personal care workers, volunteers, etc.) to meet individual outcomes
  - Ongoing evaluation of the effectiveness of services and maintenance of service provider qualifications
  - Monitor and review participant's progress toward meeting service or therapeutic goals and objectives and for CLTS outcomes in service plans
  - Compiling and maintaining required documentation
  - Quality assurance and follow along services to assure participant health and safety, including the use of outcome based methods as applicable
  - Communicating orally and in writing with service providers, county/state administration and interested members of the community
  - Providing advocacy, information and referral, crisis and critical incident intervention and resolution, protective and guardianship services
  - Assistance in locating safe and appropriate housing including the determination of the efficacy of substitute care settings
  - Assistance in accessing necessary medical care and treatment and coordination of benefits, as payer or last resort program
  - Assistance to participant's pursuit of vocational and/or educational opportunities, as appropriate
  - Providing instruction to independently obtain access to services and supports, regardless of funding source
  - Providing institutional discharge-related support and service coordination services up to thirty days prior to discharge, that does not duplicate discharge planning services expected from a hospital, ICF-IID or nursing home, if appropriate
  - Supporting participant programmatic and developmental transitions including planning got transition to adult waiver services.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Both the CLTS Waiver level of care (LOC) determination and the assessment process identify possible risks and concerns related to available community support and services. Any issues identified through these processes are addressed within the development of the ISP. The county waiver agency's Support and Service Coordinator must identify any potential risk that exists for the child and/or family. The Support and Service Coordinator, in coordination with the child, family, guardian, child welfare, court system, school, medical professionals, service providers, and others, as appropriate, develops a response plan to minimize, reduce or eliminate the potential of harm to the child's health, safety and welfare whenever risks are identified.

The Support and Service Coordinator must also determine whether any service may poses a risk to the child's health, safety, and welfare, if it is not provided as scheduled. Services which pose a risk to the child if not delivered in a timely manner, according to the agreed upon schedule, must be identified in the ISP and include back-up plans to assure the child's continued health and safety. The ISP back-up plan may include an on-call or crisis response system as available by either the provider or the county waiver agency.

## Appendix D: Participant-Centered Planning and Service Delivery

## D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Currently, county waiver agencies establish local provider networks, and issue information to families regarding qualified providers that are available and willing to deliver CLTS waiver supports and services to the child.

DHS intends to be updating the provider qualification process so that participants have information regarding willing and qualified providers via a public directory.

Wisconsin DHS is developing a CLTS Waiver Provider Registry and Directory system to manage its relationship with all willing and qualified providers of CLTS services. DHS in coordination with CWAs, will provide each program participant with information about the provider registry and how to access the online directory. Individual waiver program participants will be able to access the public provider directory via the internet to search for providers available in their geographic area. Participants who are unable to access the system due to lack of computer access or other limitation will be directly assisted by the local waiver agency to identify certified providers. Paper copies of provider information will be provided to participants, if requested. This will guarantee that program participants without internet access will have the same information as those who do have internet access. The public directory will only include qualified providers targeted for full implementation on June 1, 2019.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (7 of 8)

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The completed CLTS Waiver Program application packet, including the assessment and ISP is submitted by the Support and Service Coordinator to the DHS Bureau of Children Services (BCS) for newly enrolled waiver participants. An updated ISP is completed and signed by the appropriate parties during the 12-month face-to-face review (at a minimum) and whenever substantive changes are made.

The county waiver agencies must ensure that all ISP revisions and covered services are prior authorized and issued to both waiver providers and the CLTS Waiver Program TPA vendor, on a timely basis, to ensure scheduled service delivery to the participant and prompt payment to the provider.

The CLTS Waiver Program Manual includes instructions to county waiver agencies articulating the Department's authority to review any ISP, upon request.

A representative sample of the CLTS Waiver Program applications is reviewed by the Department's external quality review entity on an annual basis as part of the onsite record review protocol. A statistically significant representative sample of records is established as part of the record review protocol.

The CLTS Waiver Program's record review protocol also includes a review of the family-centered assessment, the health, safety and welfare of the child, including potential risk, and the services and supports included in the service plan to meet the assessed needs and outcomes of the child and family.

On an ongoing basis, the Department's children's services specialists work with county waiver agencies to assess whether or not a plan is reasonably appropriate to meet the child and family identified needs and outcomes, and offer technical assistance, as necessary.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

*Specify:*

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **D-2: Service Plan Implementation and Monitoring**

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

(a) The county waiver agencies or their sub-contracted agency, employ qualified Support and Service Coordinators (SSCs) who are responsible for the provision of CLTS Waiver Program covered services, and for assuring the participants' health and welfare with regard to those services. The SSC is also responsible for the coordination and remediation of identified problems within a child's service plan and the timely reporting of required incidents.

The county waiver agency (CWA) obtains the signatures of all individuals and providers responsible for the ISP's implementation. The CWA distributes the ISP to the parent/guardian and participant or provider responsible for the ISP's implementation, according to applicable laws.

Section D-1E Risk Assessment and Mitigation further describes Wisconsin's remediation of incidents and events.

(b) The county waiver agency is responsible for locating, managing, coordinating and monitoring all waiver program services, other services, (regardless of funding source), and informal community supports available to eligible children and families. The SSC is also required to assure that services are delivered in accordance with program requirements. This ensures the child's health and safety by enabling the child and family to receive a full range of appropriate services and supports consistent with assessed needs in a planned, coordinated, efficient and cost-effective manner. The SSC's role includes the primary responsibility to work with the child's parents or other legally responsible person to assure participant health and safety.

This service also includes an assessment of the family's needs so they may adequately support their minor child in the family home. The SSC also assures freedom of choice of providers. The SSC must document the family's choice of providers within the CLTS Waiver Program needs assessment.

Section D-2 Service Plan Implementation and Monitoring further describes the type and frequency of service coordination. The determination of the type and frequency of support and service coordination contacts with the child and family, as well as with providers, is based on the following variables:

1. The stability of the child's health
2. The ability of the child and the family to direct their own care
3. The strength of in-home supports and the child and family's informal support network
4. The stability of in-home care staffing (frequency and reliability of staffing, turnover, availability of emergency back-up staff)
5. The stability of the child's support plan (e.g., history of and/or anticipated frequency of change or adjustment to the plan)
6. The existence of a critical incident or a child protective referral
7. The child's family or guardian is active, interested and involved and is not a formal service provider

Based on the factors detailed above, the SSC works with the parent/guardian, participant and chosen providers to develop and monitor a "back-up plan" if necessary. This plan is coordinated and monitored and adjusted as necessary to meet the child and family's needs. The SSC is responsible to inform the Department's assigned Children's Services Specialist in a timely manner when an incident occurs and intervention is required. Wisconsin's incident reporting protocol is also described in Section D-1E of the HCBW renewal application: Risk Assessment and Mitigation Process.

(c) The minimum monitoring requirements regarding the provision of support and service coordination include:

- 1) Monthly collateral contact
- 2) Direct contact with the family every three months
- 3) Face-to-face contact with the child at least every six months
- 4) Annually, at least one of the face-to-face contacts shall be at the child and family's place of residence
- 5) More frequent contact may be required in response to individual needs identified in assessments or prior critical incidents to assure health and safety
- 6) Direct contact with the family includes written or electronic mail exchanges, telephone conversations, or face-to-face contact.
- 7) Collateral contact with the family includes written or electronic mail exchange, telephone conversation, or face-to-face contact with a child's family member, medical or social services provider, or other person with knowledge of the child's long-term support needs.

**b. Monitoring Safeguards.** *Select one:*

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

DHS requires for county waiver agencies to operate the CLTS Waiver Program in a manner that is free of conflict of interest, to the greatest extent possible. Where conflicts cannot be eliminated, they must be identified and their impact must be minimized by the intervention of the county waiver agency. Conflict of interest situations that must be addressed include both those that are present and those that may be perceived. Each county waiver agency must have a written description of how the agency will identify, resolve or mitigate conflicts of interest. If resolving or mitigating the conflict is not feasible, the county waiver agency must take action to minimize the effect(s) of the conflict. These efforts must be reported to the county's assigned Children's Services Specialist and are subject to DHS approval.

A conflict of interest is present whenever a person or any other entity involved in operating any part of the waiver has an interest in or the potential to benefit from a particular decision, outcome or expenditure. A single individual, agency or entity occupying several roles often signals that conflict of interest may be present. Potential conflict of interest situations include:

1. If the SSC who completes the comprehensive assessment and/or ISP for a participant also provides other services to the individual.
2. If a guardian is an employee of the county waiver agency or an employee of a provider that delivers services to participant and the guardian's employing agency or provider is at the same time funding or serving that guardian's ward.
3. If the SSC is also the person that manages the participant's finances (e.g., the SSC is the participant's representative payee.)
4. If the waiver agency, guardian or another entity that manages participant funds also makes any decision that results in the agency or entity receiving participant funds (e.g., cost share, room and board payment, etc.)
5. If the guardian or another legally established decision-maker for the participant is a paid waiver service provider.
6. If a county waiver agency employee is an alleged perpetrator of abuse, neglect or any other act defined as a reportable incident or violation of the participant's rights, and the county is, by rule or statute, responsible to conduct the investigation.

Each county waiver agency must establish a written policy that describes how it will identify, and resolve or mitigate conflicts of interest. The policy must identify all of the covered entities and address each conflict of interest scenarios described above. The county waiver agencies' policies must address each of the following effort areas:

1. Identify and avoid real or perceived conflict of interest
2. Resolve any identified conflict of interest
3. When resolving or avoiding the conflict of interest is not feasible, efforts to minimize the effect of the conflict of interest;
4. Ensure the assessment of participant needs occurs in a conflict free environment
5. Ensure participants are informed of identified conflicts of interest and involved in the effort to resolve them
6. Ensure all providers are informed of and operate under conflict of interest policies
7. Ensure high degree of organizational separation and autonomy in decision-making among the guardian, SSC and other service providers
8. Ensure more than one qualified provider for all services to reduce potential conflict of interest due to lack of available choice
9. Address conflicts when an allegation involving the county waiver agency staff or affiliated entity for the following:
  - Violation of participant rights
  - Violation of statutory protections from abuse/neglect or unreasonable restraint
  - Occurrence of reportable incident

The SSC must inform the parent/guardian and participant of any potential conflict of interest, as well as their right to use other providers to obtain needed services. If the parent/guardian and participant choose to receive direct services from the county waiver agency, the SSC works in partnership with them to develop a plan to monitor the situation.

The county waiver agencies' established conflict of interest policies are subject to the Department's review and approval. In addition, when a conflict of interest situation occurs, the parent/guardian and SSC must sign a document specifying the conflict of interest and the plan details for monitoring the situation.

## Quality Improvement: Service Plan

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

### a. Methods for Discovery: Service Plan Assurance/Sub-assurances

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

#### i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

#### Performance Measures

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

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

#### Performance Measure:

**Most recent ISP addresses participant assessed needs, health and safety risks, personal goals and outcomes through provision of waiver and other services.**

**Numerator = Number of most recent ISPs completed by SSC addressing assessed needs, health and safety risks, personal goals and outcomes through waiver and other services. Denominator = Total number of most recent ISPs reviewed in the sample.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:



<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.**

**Performance Measures**

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

*For each performance measure, provide information on the aggregated data that will enable the State to*

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

**Performance Measure:**

**DHS monitors ISP development in accordance with established CLTS waiver policies and procedures. Numerator = Total number of ISPs completed by the SSC that meets DHS established CLTS waiver policies and procedures Denominator = total number of CLTS participants' ISPs reviewed in the sample**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

c. *Sub-assurance: Service plans are updated/revise at least annually or when warranted by changes in the waiver participants needs.*

**Performance Measures**

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

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

**Performance Measure:**

**ISPs are updated/revise by the SSC at least annually or as warranted by changes in the waiver participant needs. Numerator = ISPs reviewed indicate they were updated by the SSC at least annually or as warranted by change. Denominator = all ISPs reviewed in the sample.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid</b>	<b>Weekly</b>	<b>100% Review</b>

<b>Agency</b>		
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<input style="width: 100%; height: 20px;" type="text"/>

**d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

**Performance Measures**

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

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

**Performance Measure:**

**Services delivered according to type, scope, amount, duration and frequency, as specified in the ISP by the SSC. Numerator = Number of records where evidence indicates SSC authorized and scheduled waiver services in accordance with the type, scope, amount, duration and frequency as detailed on the ISP. Denominator = Total CLTS authorization/claim records reviewed in the sample, compared to ISP.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; display: inline-block; margin-top: 5px;">+/- 5%</div>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**CLTS encounter claim records**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b>	

	Specify:  <input style="width: 100%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

**Most recent ISP completed by the SSC authorized waiver and non-waiver services with appropriate frequency to address the participant's assessed needs, health and safety risks, personal goals and outcomes. Numerator = Number of ISPs include details to reflect SSC authorized services to address participant's assessed needs and goals Denominator = Totals number of selected ISPs reviewed in sample**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>

<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>



e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

**Performance Measures**

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

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

**Performance Measure:**

**Participants, parents and/or guardians were afforded choice between and among waiver services and providers. Numerator = number of records reviewed that includes clear documentation that the SSC offered choice of waiver services and providers. Denominator = all records reviewed in the sample.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify:	

	<input style="width: 100px; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

**Performance Measure:**

DHS survey issued to parents/guardians to gather data regarding their experience in providing input to the SSC for the ISP development based on the child and family's needs and goals. Numerator = Number of surveys reflecting parent/guardian input used to develop the ISP Denominator = Total number of selected participant parents/guardians issued surveys

**Data Source** (Select one):

**Participant/family observation/opinion**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative

		<b>Sample</b> Confidence Interval = <input type="text" value="+ / - 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text" value="bi-annually"/>	

**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text" value="bi-annually"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The county waiver agency is responsible for administering all aspects of service plan initial development, update/revision at least annually, or whenever there are changes in the participant's needs or community living situation.

The Department has administrative oversight of the county waiver agencies and monitors these processes through performance measures and other reporting requirements. The primary discovery method employed by DHS in overseeing ISPs is the CLTS Waiver Program record review process. A representative sample of initial enrollment and recertification records are reviewed to ensure level of care, ISPs and other factors.

The Department will develop a survey during 2017 to gather data from parents and guardians regarding their experience in being able to provide input to their child's SSC during the development of the ISP, based on the assessed needs of the child and family, and personal outcomes and goals. The survey will be issued in 2018 and on a bi-annual basis during subsequent years.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DHS directly monitors county waiver agencies when the need to correct any issues is discovered through the review of service plans. For example, if BCS notes a concern with an initial service plan submitted for a new waiver enrollee, the BCS will contact the waiver agency to discuss the potential issue and identify any needed remedial action. County waiver agencies are responsible for correcting any individual issues discovered and informing BCS. Issues are tracked from identification to final resolution. The BCS may recommend development of a corrective action plan in some cases where there appears to be a systems issue. The Department may also require immediate remedial action and impose corrective action plans to address these issues.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

## Appendix E: Participant Direction of Services

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**Applicability** (from Application Section 3, Components of the Waiver Request):

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (select one):

**Yes. The state requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The participant direction of the delivery of waiver services is designed to assist children and their families to build, strengthen or maintain informal networks of community supports. At the request and direction of the child and/or family, the specific participant activities noted below are implemented.

All CLTS waiver covered supports and services are permitted under the participant-directed delivery model, including, but not limited to: adaptive aids, communication aids, consumer education and training, counseling and therapeutic resources, daily living skills training, day services, personal emergency response, respite care, specialized medical and therapeutic supplies, supported employment, and supportive home care. The provider of each service must meet the DHS established provider qualifications for the specific service.

The method for arranging the provision of services and the supervision of these services includes the support and assistance to the child and family to support the child's inclusion in the community. Assistance is provided to the family to identify and access formal and informal support systems, to develop a meaningful child and family support plan; and to increase or maintain the child and family's capacity to direct formal and informal resources. This also includes completing activities that assist the child, family, and friends to determine future plans.

The goals of the family-directed supports are as follows:

- Developing and implementing a participant and family-centered support plan, which provides the direction, assistance and support to allow the child to live in the community, establish meaningful community associations, and make valued contributions to the community.
- Providing ongoing consultation, community support, training, problem-solving, and technical assistance to assure successful implementation of a participant and family-centered plan.
- Developing and implementing community support strategies, which aid and strengthen the involvement of community members who can assist the child to live in the community.

County waiver agencies must ensure that providers authorized to deliver services under the participant/family's direction have the skills and knowledge to carry out assigned responsibilities in a manner that lets the individual needs and preferences of the child and family, as specified in the ISP, and in a manner that ensures protection of the child's health and safety. Each county waiver agency will assure the following:

- Children, families and other natural supports were involved in developing the ISP and are involved in the ongoing oversight of the plan;
- Participants, families, other natural supports, and providers have access to information that describes family directed service;
- A flexible array of services and supports that meet the participant's identified needs and is able to provide choice as to nature, level and location of services;
- Participating children and their families, guardians and other natural supports are supported to know their rights; learn about the aspects of participant and family direction to permit greater control of decision-making and to develop skills to be more effective in identifying and implementing personal goals;
- Providers must meet the specific standards for any waiver services they are authorized to deliver, or meet provider qualifications that are based on the needs and characteristics of the specific individual or individuals served;
- Service plans developed with participant and family direction are based on the individual goals and preferences that allow the child to live in the community, establish meaningful community associations, and make valued contributions to the community;
- Outcome-based quality assurance methods;
- Consultation, problem-solving, and technical assistance to assist children and families in accessing and developing the desired support(s); and
- Assist in securing administrative and financial management assistance to implement the support(s).

County waiver agencies must establish a mechanism for allocating resources to CLTS waiver participants for purchasing services based upon identified factors. These factors may include the person's skills, his/her environment, the supports available to the person, and the specialized support needs of the person. The allocation of resources for individual budgeting that is subject to the Bureau's approval and continuous review at least annually.

## Appendix E: Participant Direction of Services

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## E-1: Overview (2 of 13)

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver.  
*Select one:*

**Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

**Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

**Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

**The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

## Appendix E: Participant Direction of Services

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### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

**Waiver is designed to support only individuals who want to direct their services.**

**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

Participant and family directed services and supports involve a number of components related to the child and family's ability to employ workers, manage a budget, locate services, direct services, and obtain independent advice and support.

Regardless of the level of choice for participant or family direction for services and supports, Support and Services Coordinators will provide assistance to assist with navigation of the system. Each child and family has access to the assistance of a Support and Service Coordinator to aid in the management of their budget and securing needed services and supports.

Waiver participants and their parents/guardians who choose to participate in family direction must demonstrate the following:

- The skills to direct service providers to assure quality service delivery;
- The ability to maintain quality records to document delivered services;
- The ability to manage within a specified budget;
- The ability to direct providers to meet the individual needs of their child; and
- The ability to work within a team and direct their team in an effective manner.

## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The county waiver agency's Support and Service Coordinator will share information regarding the components of participant/family directed services to the child and his/her representative at the time of assessment planning. As the county waiver agency's Support and Service Coordinator works with the family to complete the needs assessment, informal and formal supports will be identified. The Support and Service Coordinator will review all possible service options available under the CLTS Waiver Program.

Families are encouraged to review the allowable CLTS waiver services to assist with the service planning process. This gives families the opportunity to consider all allowable services, the provider requirements and any limitations.

Families and participants are able to actively partner in the planning process because of this knowledge. Support and Service Coordinators must discuss the benefits, responsibilities and potential liabilities of utilizing this option with the participant and family.

## Appendix E: Participant Direction of Services

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### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

**The state does not provide for the direction of waiver services by a representative.**

**The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

**Waiver services may be directed by a legal representative of the participant.**

**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the



participant:

## Appendix E: Participant Direction of Services

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### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Housing Counseling		
Respite		
Consumer Education and Training		
Adaptive Aids		
Personal Emergency Response System (PERS)		
Communication Aids/Assistive Technology/Interpreter Services		
Supportive Home Care		
Transportation		
Financial Management Services		
Mentoring		
Nursing Services		
Day Services		
Supported Employment - Small Group		
Counseling and Therapeutic Services		
Specialized Medical and Therapeutic Supplies		
Child Care Services		
Community Integration Services		
Home Modification		
Daily Living Skills Training		
Supported Employment – Individual		
Training for Parents/Guardians & Families of Children with Disabilities		
Relocation Services		

## Appendix E: Participant Direction of Services

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### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

**Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

**Governmental entities**

**Private entities**

**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** Do not complete Item E-1-i.

## Appendix E: Participant Direction of Services

### E-1: Overview (8 of 13)

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

**FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

Financial Management Services

**FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

This service involves a person or agency that is responsible to pay service providers after the parent/guardian or participant authorizes payment to be issued for prior authorized, delivered services included on the participant's approved ISP. Financial Management Services providers, sometimes referred to as fiscal intermediaries, are organizations or individuals that write checks to pay bills for personnel costs, tax withholding, worker's compensation, health insurance and other taxes and benefits appropriate for the specific provider consistent with the individual's ISP. This service also includes paying bills authorized by the participant or their guardian, keeping an account of disbursements and assisting the participant ensure that sufficient funds are available for needs. The Financial Management Services provider is accountable for ensuring compliance with all federal and state laws associated with tax withholding, unemployment insurance, and all other employee benefits.

The Financial Management Services provider must be subject to an audit to ensure all transactions have been properly executed. This service excludes payments to court appointed guardians or court appointed representative payees if the court has directed them to perform these functions.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS administrative costs are considered costs related to the delivery of services chosen by the child's family. Typically FMS agencies charge a small monthly fee that compensates the agency for costs related to processing of individual service providers time sheets and the costs related to state and federal with holdings and employee benefits. The FMS submit their waiver service claims to the CLTS Waiver Program contracted TPA vendor for payment.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

**Assist participant in verifying support worker citizenship status**

**Collect and process timesheets of support workers**

**Process payroll, withholding, filing and payment of applicable federal, state and local employment-**

**related taxes and insurance**

**Other**

*Specify:*

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Supports furnished when the participant exercises budget authority:

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**Maintain a separate account for each participant's participant-directed budget**

**Track and report participant funds, disbursements and the balance of participant funds**

**Process and pay invoices for goods and services approved in the service plan**

**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

**Other services and supports**

*Specify:*

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Additional functions/activities:

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**Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

**Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

**Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

**Other**

*Specify:*

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

(a) monitor and assess the performance of the FMS agency: In addition to the discovery methods DHS employs for ALL waiver services, which are outlined throughout this application, the waiver agency support and service coordinator works closely with the child's family to monitor performance of the FMS agency. The county waiver agency's Support and Service Coordinator monitors the integrity of the financial transactions on a monthly basis. This is done by reviewing submitted time sheets and confirming directly with the child's family to ensure services were delivered as expected. In addition, the CLTS Third Party Administrator (TPA) claims vendor reviews, processes, and adjudicates provider claims. The TPA vendor brings any claim anomalies or trends to the Department's attention for further investigation.

(b) entities for monitoring: the support and service coordinator as well as DHS using discovery methods described in this application for all waiver services.

(c) how frequently performance is assessed: The county waiver agency's Support and Service Coordinator monitors the integrity of the financial transactions on a monthly basis. DHS employs discovery and remediation activities as described in this application for all CLTS Waiver Program services.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

**Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

#### **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Housing Counseling	
Respite	
Consumer Education and Training	
Adaptive Aids	
Personal Emergency Response System (PERS)	
Communication Aids/Assistive Technology/Interpreter Services	
Supportive Home Care	
Transportation	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Financial Management Services	
Mentoring	
Children's Foster Care	
Nursing Services	
Day Services	
Supported Employment - Small Group	
Support and Service Coordination	
Counseling and Therapeutic Services	
Specialized Medical and Therapeutic Supplies	
Child Care Services	
Adult Family Home	
Community Integration Services	
Home Modification	
Daily Living Skills Training	
Supported Employment – Individual	
Training for Parents/Guardians & Families of Children with Disabilities	
Relocation Services	

**Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*

## Appendix E: Participant Direction of Services

### E-1: Overview (10 of 13)

**k. Independent Advocacy** (*select one*).

**No. Arrangements have not been made for independent advocacy.**

**Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

## Appendix E: Participant Direction of Services

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### E-1: Overview (11 of 13)

**l. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Voluntary termination of participant direction can occur anytime a participant or parent/guardian determines they no longer wish to participate in this service delivery model.

The Support and Service Coordinator is responsible to transition all service delivery activities to the county waiver agency so that the participant can engage in a traditional service delivery model. Services are not discontinued or disrupted during this transition period, thus ensuring service continuity and participant health, safety and welfare.

## Appendix E: Participant Direction of Services

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### E-1: Overview (12 of 13)

**m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Involuntary termination of participant/family direction can occur after remediation strategies fail under the following circumstances:

- The child's health and safety, or another person's safety is threatened;
- Individual expenditures are inconsistent with the budget and the plan;
- Conflicting interests of another person are taking precedence over the desires and interests of the child; or
- Funds have been used for illegal purposes.

In the event that funds have been used for illegal purposes the county waiver agency's Support and Service Coordinator must contact their County Corporation Counsel to begin an investigation at the local level and submit an Incident Report to DHS. If the local investigation confirms a finding of fraud, the county contacts the DHS Office of Inspector General (OIG) who engages Wisconsin's Department of Justice in prosecution and recoupment activities regarding Medicaid fraud. Any provider found guilty of Medicaid fraud is placed on the caregiver misconduct registry and is reported to the U.S. Department of Health and Human Services OIG Exclusions List, and is barred from the ability to deliver Medicaid funded services.

If a county waiver agency restricts or terminates a child and family's ability to self-direct, then the child and family receive information regarding the specific steps necessary for the restrictions or termination to be withdrawn. If the level of family-direction is restricted, then the county waiver agency also informs the child and family about his or her right to file a grievance, request DHS review, or request a Fair Hearing if he or she disagrees with the limitation. The county waiver agency is required to have written policies and procedures in place as to how it would assist children and families in attaining or regaining family-directed authority.

The Support and Service Coordinator is responsible to transition all service delivery activities to the county waiver agency so the participant can engage in a traditional service delivery model. Services are not discontinued or disrupted during this transition period, thus ensuring service continuity and participant health and welfare.

## Appendix E: Participant Direction of Services

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### E-1: Overview (13 of 13)

**n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="1116"/>
Year 2	<input type="text"/>	<input type="text" value="1523"/>
Year 3	<input type="text"/>	<input type="text" value="1822"/>
Year 4	<input type="text"/>	<input type="text" value="1912"/>
Year 5	<input type="text"/>	<input type="text" value="1989"/>

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Private financial management agencies and fiscal intermediary local government agencies and any other appropriately qualified to provide financial management services

**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

**Recruit staff**

**Refer staff to agency for hiring (co-employer)**

**Select staff from worker registry**

**Hire staff common law employer**

**Verify staff qualifications**

**Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Caregiver background check costs are considered an administrative cost to the county waiver agency and are arranged for and reimbursed directly by the waiver agency.

**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

**Determine staff wages and benefits subject to state limits**

**Schedule staff**

**Orient and instruct staff in duties**

**Supervise staff**

**Evaluate staff performance**

**Verify time worked by staff and approve time sheets**

**Discharge staff (common law employer)**

**Discharge staff from providing services (co-employer)**

**Other**

Specify:

## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

**Reallocate funds among services included in the budget**

**Determine the amount paid for services within the state's established limits**

**Substitute service providers**

**Schedule the provision of services**

**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

**Identify service providers and refer for provider enrollment**

**Authorize payment for waiver goods and services**

**Review and approve provider invoices for services rendered**

**Other**



Specify:

## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (3 of 6)

#### b. Participant - Budget Authority

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The county waiver agency's Support and Service Coordinator (SSC) works with the family to assess the child's disability-related support needs and to identify the services necessary to meet the assessed needs in order to develop the child's CLTS Individual Service Plan (ISP).

Two approaches are utilized for service budget development for family direction:

1. If the child has received services and supports through agency-managed services, then historical data for cost under traditional service provision arrangements are used as the budget.
2. If historical data does not exist, the waiver agency will assign costs to each service based on the fiscal experience with the chosen service providers. If a particular service has not been previously provided, so the waiver agency does not have historical data, the waiver agency will work with the new provider to establish an acceptable rate as defined by the Allowable Cost Manual Guidelines.

As the child's ISP is developed in partnership with the child and family, the SSC will explain the rate methodology used by the county waiver agency to determine the service cost. Once the rate is established and final costs are determined, the SSC informs the family of the budget limits. This information is discussed verbally and written on the child's CLTS Individual Service Plan, which the parent authorizes.

Once services are being delivered, the Department's third party administrator (TPA) claims vendor issues weekly provider claims reports to assist the county waiver agencies to monitor their budgets. This information helps the SSC identify and respond to increasing service utilization and costs, so that they can work with the family to both help bring expenditures under control and ensure that the changing needs of the child are adequately addressed. The SSC has the authority to adjust the budget based upon the child's unique or changing needs.

## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

**iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Once the comprehensive assessment is completed and a service plan is developed, the waiver agency's SSC establishes a budget based on historical data for similar service and support costs. The SSC completes the Individual Service Plan document (F-20445, F-20445A) which outlines the specific budget for each service as well as for the entire plan once the budget is established. The child and family are partners in this process and are supported to take the lead on establishing needed supports and service providers. The details of service providers and other information are documented on the ISP. The child, when appropriate and possible, the parents or guardian and the SSC sign the ISP. This process serves as a formal contract between the child and family, and waiver agency.

Modifications to the participant directed budget must be preceded by a change in the service plan. When the child's family identifies a change in need or services the SSC adjusts the service plan to reflect the change in services. This is the case for participants using self-directed supports as well as those using traditional supports. DHS policy is that adjustments to a waiver participant's service plan must be based upon identified changes to the child's assessed needs. All changes or modifications to the child's services and/or budget must be reflected on the ISP and the Outcomes document. The State verifies, through the annual record review audit, that any changes to the child's ISP are identified jointly with the child and family and are documented in the child's record.

When a participant utilizing self-directed supports has changes to their service plan, the waiver agency Support and Service Coordinator works closely with the child and family to monitor ongoing costs to assure these remain within the individual budget and to ensure health and safety needs are met. Waiver agencies are expected to manage their available funding sources to meet the unique needs of their CLTS waiver participants. If an individual's budget requires adjustment in order to ensure health and safety, the waiver agency works with their fiscal staff, and with DHS fiscal staff when necessary, to determine the source of the needed funding.

During the annual onsite record review process, any participant requests or other information in the child's file is reviewed to ensure that changes in the child's needs are reflected by updates and changes to the child's ISP.

If a participant's request for budget adjustment is denied or outcome of the budget is reduced, the participant has the opportunity to request a Fair Hearing as outlined in Appendix F:1. Parents, or other legal representatives, receive the document entitled, Participant Rights and Responsibilities, which explains the fair hearing process, at initial application, upon service plan development and at least annually thereafter. Parents, or other legal representatives, also receive this document whenever eligibility or services are changed, reduced or denied. The SSC has the additional obligation of explaining these rights and responsibilities and assuring that parents, or legal representative, as well as the child when appropriate, understand the information contained in the notification.

## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

##### iv. Participant Exercise of Budget Flexibility. *Select one:*

**Modifications to the participant directed budget must be preceded by a change in the service plan.**

**The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

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## E-2: Opportunities for Participant-Direction (6 of 6)

### b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The SSC works closely with the child and family to monitor ongoing costs to ensure these are within the individual budget and that they will not be depleted prematurely. The Department's contracted TPA claims vendor issues a weekly provider claims reports to assist county waiver agencies to monitor their budget allocations.

Each county waiver agency identifies at least one staff person who has the authority to receive and review the weekly TPA claims report. In addition at least one agency staff person, identified by the agency, will have security privileges to access their agency's adjudicated encounter claims data, which is stored in the DHS data warehouse. In addition, the SSC uses the weekly provider claim reports and the monthly encounter claim reports to monitor whether services are delivered as authorized to meet the child's needs.

In addition, the TPA claims vendor flags potential over expenditure or budget underutilization to the attention of the Department; e.g., insurance coordination of benefits, authorization problems, provider claim modifiers, etc.

Providers have 90 days from the date of service provision to submit their claims to the TPA. When claims are submitted first to another funding source (e.g., private health insurance), providers have 90 days after the coordination of benefits to submit their claims for waiver reimbursement.

The SSC identify and respond to increasing service utilization and costs, and can both help bring expenditures under control and ensure that the changing needs of the child are adequately addressed and provide real time data on underutilization or claims above the authorized amounts. The SSC also maintains regular direct contact with the child's family to monitor the quality of services provided and to verify that the level of services continues to meet the child's needs.

The waiver agency support and service coordinator is responsible to provide the necessary authorizations of services to the FMS agency to ensure the child has funding available to reimburse the child's directed services. The TPA weekly claims reports assist the support and services coordinator in tracking the expended funds and services that have been delivered. The waiver agency is responsible to ensure that the participant's funds are spent appropriately.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Specific rights protect individuals applying for the CLTS Waiver Program, as well as children and families, or other legal representatives, participating in those programs. Along with these rights, the applicant or children and families, or legal representatives, have responsibilities as a condition of participation in the Medicaid home and community-based services waiver. The CLTS Waiver Program is part of a system of long-term supports in Wisconsin which includes both Medicaid funded and state funded programs and services.

The Model Rights and Responsibilities Notification document (see below) details these rights and responsibilities. Parents, or other legal representatives, receive this document at application, upon service plan development and at least annually thereafter. Parents, or other legal representatives, also receive this document whenever eligibility or services are changed, reduced or denied. The Support and Service Coordinator has the additional obligation of explaining these rights and responsibilities and assuring that parents, or legal representative, as well as the child when appropriate, understand the information contained in the notification. The child and family, or legal representative, at initial application and annually each year thereafter sign the document. The child and family, or legal representative, receive a copy and the original signed document is in the child's file with the waiver agency.

Wisconsin's Children's Long-Term Support Functional Screen (CLTS-FS) has system logic to determine functional eligibility for the CLTS Waiver Program, based on the data entered by trained and certified screeners. If a child is determined not functionally eligible for the CLTS Waiver Program, the waiver agency screener notifies the family verbally and in writing of their right to request a Fair Hearing. If a child and family's services are terminated, reduced or changed, the SSC also notifies the family verbally and in writing of their right to request a Fair Hearing. This notice details the denial or discontinuation of eligibility and provides specific information about the hearing request process, as well as relevant timelines and the effective date of the action taken. The notification clearly details the grievance process and state appeals procedures. The information on the right to appeal includes the name and address of the Department of Administration, Division of Hearings and Appeals. The notice also informs the child and family of the right to contact Disability Rights Wisconsin for assistance and advocacy.

A county waiver agency may not take any adverse action to a CLTS Waiver Program participant's eligibility or authorized service, without issuing the participant a ten-day notice of the action, as well as the appeal information previously noted. When informing a participant of his/her due process right to file an appeal, the county waiver agency must cite chapter 227 of State Statutes and 42 CFR Part 431, Subpart E.

If the child has previously been determined eligible and is receiving services, then eligibility and services must continue pending an appeal, as long as the child and family, or legal representative, appeals the decision before the date of the adverse action stated in the notice letter. The waiver agency retains original documentation of the adverse action and notification of the right to a Fair Hearing, with a copy sent to the Department of Health Services.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

## Appendix F: Participant-Rights

## Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

## Appendix G: Participant Safeguards

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### Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A critical incident is any actual or alleged event or situation that creates a significant risk or serious harm to the physical, mental health, safety, or well-being of a child. Incidents that must be reported to the county waiver agency's Support and Service Coordinator (SSC) include:

- Any abuse or neglect of the child known or suspected.
- Errors in medical or medication management that result in a significant adverse reaction that requires medical attention.
- The initiation of an investigation by law enforcement of an event or allegation regarding a child as either a perpetrator or victim, unless such action is a component of an approved crisis or treatment plan.
- Significant and substantial damage to the residence of the child or service provider.
- Use of isolation, seclusion, or restraint by a service provider that is not included and approved as part of a behavior support plan.
- An unexpected event or behavior that causes a serious injury or risk to the child; which may include running away, setting a fire, violence, hospitalization resulting from an accident, suspected or confirmed suicide attempts.
- The death of the child.

Incidents must be reported immediately to the Bureau of Children's Services (BCS) if the child's safety was threatened to ensure that all necessary steps have been taken to protect the child. Families, other legal representatives, and providers are required to report incidents to the county waiver agency's SSC. County waiver agency staff, or an entity authorized by the county waiver agency, must conduct an immediate investigation to assess the health, safety and welfare of the waiver participant who is the subject of critical incidents. If there is evidence of immediate risk to the health, safety or welfare of a waiver participant, the waiver agency must take all reasonable steps to protect the person. A final report with all details and disposition of the Incident Report (IR) form is submitted to BCS within 30-days.

The Bureau reviews the IR upon receipt and determines if the county waiver agency handled the situation appropriately to assure the child's health, safety and welfare. The Bureau may:

- Conduct a targeted review for a first-hand assessment of the situation,
- Schedule such a review for a later time,
- Refer the allegation for further investigation to the Department of Children and Families, if the accused caregiver is an unlicensed caregiver, or to the Department of Safety and Professional Services if the caregiver is a licensed professional,
- Offer technical assistance as appropriate.

Any concerned individual can report suspected abuse or neglect directly to the county department's Child Protective Services (CPS) agency or law enforcement agency, if appropriate. County employees and professionals whose employment brings them into contact with children are mandated reporters and are required by law to report any suspected abuse or neglect or threatened abuse or neglect to a child seen in the course of their professional duties.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

The Bureau of Children's Services has developed material that has been issued to county waiver agencies to disseminate to participants, families, caregivers, and others regarding the protections from abuse, neglect and exploitation and how to notify the appropriate authorities.

County waiver agencies must provide and review this information with participants and families during their initial application and annual recertifications.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

County waiver agency's Support and Service Coordinators (SSCs) must address and resolve situations and implement systems to decrease the likelihood of a recurrence of an incident. DHS ensures the health, safety and welfare of CLTS Waiver Program participants by following up on each reported an IR as previously noted.

The Department details this responsibility with county waiver agencies by detailing it in the State-County contract by requiring county waiver agencies' compliance with the IR details including in the Home and Community-Based Services Waivers Manual. Chapter 9 of the Manual requires each county waiver agency to have an adequate system in place to ensure participants are adequately protected from physical, verbal and sexual abuse, maltreatment, neglect, financial exploitation and violations of their rights under law. Chapter 9 also requires counties to have an effective response system when incidents arise. The contract requires waiver agency staff to submit Incident Reports as outlined below.

Immediately upon learning of an allegation of an incident, the service provider determines whether the allegation is credible. If there is reasonable cause to believe that the report may be accurate, the service provider's first responsibility is to take immediate action to protect waiver participants from the potential of harm. In doing this, they should preserve possible evidence for an investigation if one is to be conducted. The provider must notify the Support and Service Coordinator or designated waiver agency staff of the allegation and results of any action taken. Agencies are required to notify local law enforcement authorities in any situation where there is a potential violation of criminal law. Agencies are also required to notify Child Protective Services, if applicable.

The SSC must assure that the parent or legally responsible guardian is informed of the incident. If an incident is serious or continues to pose a threat to the health, safety or welfare of the child, the SSC must immediately contact BCS. The county waiver agency staff or their agents/contractors who are involved should promptly determine if the incident occurred and if the persons with on-site responsibility have taken the necessary steps to ensure the child's health, safety and welfare as required by the waiver. County waiver agency staff should also determine if the service provider's procedures and responses were adequate. The county waiver agency must take action to ensure any remedial action needed implemented.

If the county waiver agency determines the incident or event occurred, they should next determine if a long-term, substantive response or change is warranted. County waiver agency staff must take all actions necessary to make the changes needed including termination of the provider, substitution of provider, increased supervision, or other action as appropriate. These actions may occur after the initial IR was submitted to DHS, but shall be reported in updates to the initial IR. The county waiver agency uses the IR to summarize the details of the incident, the county waiver agency's response and actions, the participant outcomes, and any remediation. Each incident is reviewed as a test of the adequacy of the waiver agency's response system.

County waiver agency staff submits the completed IR form to the Bureau within 30 days of the incident (or earlier, if warranted). If county waiver agency staff are unable to gain access to certain findings or records within the 30-day period due to concurrent investigations or other extenuating circumstances beyond their control, the county waiver agency must send in all available information, indicating the report is incomplete and the target date when the submission of the completed report is anticipated, if that can be predicted. County waiver agencies are responsible for "closing" all critical incident reports. Closing means submitting a report and any necessary updates so that all pertinent information about the event and the response are included in the report. Follow-up visits or future targeted reviews are usually not part of the report unless they occur within a short time frame. County waiver agency staff must complete all other required reporting procedures such as child abuse reporting and the timelines of other required reports remain in force and are not replaced or superseded by this process.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department's Bureau of Children's Services staff review all Incident Reports. This review is intended to determine whether:

- The child's health, safety and welfare are now adequately protected;
- The response to the situation and event was reasonable and appropriate;
- The waiver agency's procedures and system for responding to such incidents were adequate;
- The child and family's service plan is adequate;
- Relevant steps were taken to prevent similar incidents from occurring;
- All service providers or staff involved in the incident appear to be adequately trained or that additional training needed is to be provided pursuant to the report; and
- Coordination across systems responsible for care and protection of children.

Wisconsin's statewide Child Protective Services (CPS) also includes reporting, investigation and case management, are delivered through a state-supervised, county-administered system. Mandated reporter must report any allegation of child abuse, neglect or maltreatment to local county CPS agencies, which collaborate with the designated county waiver agency.

DHS collects all relevant information pertaining to unexplained deaths to conduct a thorough review to assure the child received standard quality of care. An unexplained death of a child is also investigated by the county waiver agency in conjunction with their county child protective services unit and the Department of Children and Families."

DHS issues an appropriate response, as necessary, which may include informal follow up, site visits, formal plan of correction, or a licensing referral. DHS also reviews the IR data on a scheduled basis to identify county, regional or statewide trends, which allows for the development of training or technical assistance interventions to decrease the likelihood of recurrence.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).



DHS allows for the use of restraint, isolation and seclusion in very limited situations. In addition to HCBS Medicaid Waiver requirements, Wisconsin Administrative Code DHS 94.10 states: "Isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s.51.61(1)(i)2., Stats. For a community placement, the use of isolation, seclusion or physical restraint shall be specifically approved by the Department on a case-by-case basis.

The Department uses multiple approaches to assure safeguards are in place to prevent the use of unnecessary and/or unauthorized use of restrictive interventions. The DHS reviews a representative sample of waiver applications for restrictions on participant movement, participant access to other individuals, locations or activities, participant rights concerns or aversive methods to modify behavior. All concerns are addressed and resolved prior to approval. Incident reporting is monitored at both the waiver agency and the DHS for patterns and trends specific to a child or more general that may suggest additional training needs.

County waiver agency's Support and Service Coordinators (SSCs) meet with families on a regular basis to identify changing needs of the child, increases in behaviors and methods being used to address significant or challenging behaviors of the child. The SSC provides families with the supports to address the needs of the child and assure that the least restrictive measures are being utilized. Department regional resources are available to provide additional consultations as needed to assure that children are living and playing in the least restrictive and most integrated settings.

The county waiver agency is responsible to ensure that restrictive measures are used only as a last resort and when there is imminent danger present. The Support and Service Coordinators may contact BCS to discuss the situation and to review alternative ways to handle the child to avoid the use of restrictive measures.

When DHS becomes aware of a child with behavioral needs, a behavioral specialist is recommended to provide an assessment and consultation for the child, family, and service provider to address how to handle these behavioral needs without the use of restrictive measures. A behavior support plan is typically written at this time, addressing the behavior and the methods that will be implemented to address them, as well as the training for the staff and parents and how the waiver agency will monitor this plan.

Documentation for the use of behavioral restrictive measures includes the behavior support plan, the behavior intervention plan, and the documentation sheets for tracking such. Additionally, the Incident Report form is submitted by the county waiver agency to BCS for each use of a restrictive measure prior to its approval through the restrictive measure application process. Also a part of this is the documentation and evidence of alternatives that have been used with the child, and what preventative methods are used to avoid the use of a restrictive measure.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The Bureau of Children Services (BCS) is the entity responsible for overseeing the use of restraints and ensuring that safeguards concerning their use are followed.

BCS reviews each application for the use of a restrictive measure as well as the behavior support plan in conjunction with the DHS Restrictive Measures Guidelines to verify that all elements of the application and behavior support plan are met prior to approval.

The BCS conducts a panel review of all applications requesting the use of restraint, isolation or seclusion. There are a minimum of three reviewers for each application. A representative from the Department of Children and Families jointly reviews each application if the child is in an out-of-home placement. A written letter of approval or denial is issued. All approved restrictive measures applications include the ability to demonstrate that there is adequate staff training, that less restrictive measures have been exhausted, and that the Department will be notified if the approved approaches are not effective. All approvals are time limited and include parameters requiring elimination of the need for a restrictive measure.

The county wavier agency monitors the use of the restrictive measure, assures the plan is being implemented appropriately and monitors effectiveness as well as assures training requirements are being maintained. Incident Reports are required if the use of a restrictive measure results in injury. This situation results in a target review; that is, a face-to-face contact with the child, family, provider and waiver agency service coordinator.

Incident Reports are also reviewed for potential unauthorized use of restrictive measures and followed up on with the waiver agency service coordinator.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

#### b. Use of Restrictive Interventions. *(Select one):*

##### **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

DHS allows for the use of restraint, isolation and seclusion in very limited situations. In addition to HCBS Medicaid Waiver requirements, Wisconsin Administrative Code DHS 94.10 states: "Isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s.51.61(1)(i)2., Stats. For a community placement, the use of isolation, seclusion or physical restraint shall be specifically approved by the Department on a case-by-case basis. For those children residing in Foster Care or Treatment Foster Care, Wisconsin Administrative Code outlines licensing requirements and restraint limitations (DCF 56 Adm. Code and DCF 38 Adm. Code, respectively).

The DHS has multiple approaches to assuring safeguards are in place to prevent the use of unnecessary and/or unauthorized use of restrictive interventions. The DHS reviews a representative sample of waiver applications for restrictions on participant movement, participant access to other individuals, locations or activities, participant rights concerns or aversive methods to modify behavior. All concerns are addressed and resolved prior to approval. Incident reporting is monitored at both the waiver agency and the DHS for patterns and trends specific to a child or more general that may suggest additional training needs.

County waiver agency Support and Service Coordinators meet with families on a regular basis to identify changing needs of the child, increases in behaviors and methods being used to address significant or challenging behaviors of the child. The waiver agency Support and Service Coordinator provides families with supports to address the needs of the child and assure that least restrictive measures are being utilized. Department regional resources are available to provide additional consultations as needed to assure that children are living and playing in the least restrictive and most integrated settings.

The county waiver agency is responsible to ensure that restrictive measures are used only as a last resort and when there is imminent danger present. The county's Support and Service Coordinators may contact their assigned Children's Services Specialist to discuss the situation and to review alternative ways to handle the child to avoid the use of restrictive measures.

When DHS becomes aware of a child with behavioral needs, it is recommended that a behavioral specialist provide an assessment and consultation for the child, the family, and the service provider to address how to handle these behavioral needs without the use of restrictive measures. A behavior support plan is typically written at this time, addressing the behavior and the methods that will be implemented to address them, as well as the training for the staff and parents and how the waiver agency will monitor this plan.

Documentation for the use of behavioral restrictive measures includes the behavior support plan, the behavior intervention plan, and the documentation sheets for tracking such. Additionally, the Incident Report form is submitted by the waiver agency to DHS via the Children's Incident Tracking and Reporting system for each use of a restrictive measure prior to its approval through the restrictive measure application process. Also a part of this is the documentation and evidence of alternatives that have been used with the child, and what preventative methods are used to avoid the use of a restrictive measure.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

BCS staff review applications for the use of restrictive measures. A written letter of approval or denial is issued. All approvals are time-limited, and require data collection and updates. Applications and implementation of restrictive measures are reviewed at least annually and more frequently for very restrictive measures. Unauthorized use of restrictive interventions is identified through monitoring by the waiver agency. BCS reviews all restrictive measure applications, monitor critical incident reporting and conduct random face-to-face waiver reviews.

DHS uses incident reports and the onsite record reviews as methods for detection of unauthorized, overuse, or inappropriate use of restraint or seclusion, and to ensure that all applicable state requirements are followed. In addition, as described above in the response to G-2-a, situations may also be identified during initial plan review or when a waiver agency contacts their Children's Services Specialist directly to discuss concerns about a specific child.

If unauthorized, overuse, or inappropriate use of restraint or seclusion is detected, the CSS follows up with the waiver agency to determine if it is a restrictive measure, to discuss other strategies for addressing the child's needs, and to identify how the issue is best addressed. This may result in the need for a behavior support plan and an application for the use of restrictive measures. If the waiver agency has a pattern of unauthorized overuse or inappropriate use of restraints or seclusion, the Department issues a request for corrective action plan.

The county waiver agency has 14 to 30 days to address any misuse of restrictive measures. The correction may be to discontinue the use of the restrictive measure, or to submit a restrictive measure application for review and approval. The Bureau notifies the county waiver agency of the timeline for correction, and monitors the situation. The Bureau tracks all instances of unauthorized, overuse, or inappropriate use of restraint and seclusion to determine if any trends exist.

The Bureau reviews CLTS Waiver Program applications and re-certifications to verify all assurances are met. A representative sample (with a +/- 5% confidence interval) of new CLTS Waiver Program applications and re-certifications are randomly selected throughout the calendar year of participants who are enrolled for at least 90 days. If any indication of the use of a restrictive measure is discovered during this review, the Bureau follows up with the county waiver agency. In addition, 100 percent of all incident reports are reviewed by the Bureau. If there is any indication of the use of a restrictive measure or restraint, the Bureau follows up with the county waiver agency.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Unless specifically indicated otherwise, all of the information provided below applies to restraints, restrictive measures, and seclusion.

Each application for a restraint/seclusion must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request for the restrictive measure. (References: Guidelines and Requirements for the Use of Restrictive Measures, pp.1-5; Application form – DHS F-00926, pp.5-6). Any use of seclusion that is not within the scope of the state Guidelines and Requirements is prohibited under any circumstance.

Unauthorized and /or emergency use of restraints/seclusion is to be reported as an incident by any person who observes such use or to whom such use is reported by the participant. Any report is to be investigated as a member incident.

The Bureau reviews and approves restraints/seclusion requests. For CLTS Waiver Program participants who reside in their own homes or in any unregulated facility, restraint/seclusion are first reviewed and approved by the respective waiver agency. Upon approval, the county waiver agency submits the application to the Bureau. A collaborative review and approval is completed by the Department.

Documentation requirements related to restraint/seclusion use are specified in the Guidelines and Requirements for the Use of Restrictive Measures. Each restraint/seclusion application must specify the monitoring and documentation plan.

Providers are required to report use of restraint/seclusion to the applicable waiver agency according to the “individualized protocol for provider reporting” as approved in the application. Monthly each county waiver agency reports data to the Bureau in accordance with the data reporting specifications.

All individuals involved in the administration of restraints/seclusion must be trained by the Department, a restrictive measures training expert and/or designated competent waiver agency staff. Restraints/seclusion may be approved for less than but no more than one year; a renewal request and review and approval is required.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

On a monthly basis, BCS collects data on approved restrictive measures from each county waiver agency. This data is analyzed to identify potential patterns and outcomes, for monitoring and possible quality improvement efforts.

The Bureau compiles a statewide county waiver agency monthly incident and restrictive measures data reports for monitoring restraint/seclusion trends and requests, as well as the use and effectiveness of approved restraints/seclusion. Follow-up consists of review of the report with the county waiver agency. Additional follow-up may include, but is not limited to, examination of individual participant data (as provided in the waiver agency monthly report) and/or individual participant record reviews depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by BCS.

Potential patterns concerning the unauthorized use of restraints associated with certain providers will be obtainable via analysis of the incident management system data. Unauthorized use of restraints (any type) or isolation/seclusion is captured as a member incident within the Incident Management System.

During the annual onsite record review process, the county waiver agency's restrictive measures tracking tool is reviewed to ensure timeliness of initial approval and annual renewal. If the review discovery leads to out-of-compliance timelines for initial or annual renewal approval, remediation of identified individual or systems issues takes place with follow-up by the Bureau. It may or may not need a corrective action plan, but the SMA Oversight Team would follow up in their regular meetings with the waiver agency.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

**No. This Appendix is not applicable** (*do not complete the remaining items*)

**Yes. This Appendix applies** (*complete the remaining items*)

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The Support and Service Coordinator, under the supervision of the county waiver agency's supervisor, is responsible for assessment of each child's strengths and needs and the services and supports that are needed to assure that the supports and services on the Individual Service Plan will address these needs and assure health, safety and welfare. This includes an assessment of the child's health and healthcare needs, including medication administration. If the child or young adult is in an out-of-home setting permitted under the CLTS Waiver Program, a comprehensive plan to address these needs is developed.

The administration of medication is defined under Adult Family Home and Children's Foster Care regulations found respectively in Wisconsin Administrative Codes DHS ch. 88 and DCF ch. 56.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

The majority of children enrolled in the CLTS Waiver Program reside with their parents who are responsible for the management of their children's medication management and are not under the jurisdiction of the Department or the county waiver agency.

In circumstances where children reside in regulated settings such as Adult Family Home (youth age 18 through 21) or Foster Care settings, the county waiver agency is responsible for assessing each child for his or her healthcare needs, including medication administration. If the child is in an out-of-home regulated setting, a comprehensive plan to address these needs is developed including medication administration plan. The administration of medication is regulated under Adult Family Home and Foster Settings license or certification regulations. The administration of medication is defined under Adult Family Home and Children's Foster Care regulations found respectively in Wisconsin Administrative Code DCF ch. 88 and DCF ch. 56

The CLTS Waiver Program permits two types of residential settings other than the child and family's home. These settings are Adult Family Home and Children's Foster Care. Adult Family Home settings are licensed facilities under Wisconsin Administrative Code DHS ch. 88 and Children's Foster Care is defined under Wisconsin Administrative Code DCF ch. 57. Medication Administration is regulated under these codes for individuals within these settings. Both codes define safety standards for administration, storage and disposal of all medications within the setting. Both standards define the required training and documentation associated with medication, including medication refusal. A licensee or service provider must have a written order from a physician and a properly labeled prescription, including the dosage, prior to dispensing medication. If the medication prescribed is given on an as-needed basis, then a clear definition of the circumstances under which the medication is to be administered must be provided as well. Staff administering medications must receive training related to medication administration specific to the child or young adult. The type of services provided and the capability of the staff that will be providing the service will determine the amount of that specific training. The training must be sufficient to assure the health and safety of the child or young adult. Medication errors such as a missed dose or wrong medication must be documented and if the error resulted in an adverse event, it must be reported as an incident.

The DHS Division of Quality Assurance, Wisconsin's designated State Survey Agency, and the Department of Children and Families, report any findings related to health and safety that are discovered in out-of-home settings that include a CLTS Waiver Program participant. Medication errors such as a missed dose, or wrong medication must be documented and if the error resulted in an adverse event, it must be reported as an incident on the Incident Report form. DHS Children's Services Specialists review all of the incident reports to ensure that appropriate steps are taken to prevent future errors or complications.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

##### i. Provider Administration of Medications. *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A service provider must have a written order from a physician and a properly labeled prescription, including the dosage, prior to dispensing medication. If the medication prescribed is given on an as-needed basis, then a clear definition of the circumstances under which the medication is to be administered must be provided as well. Staff administering medications must receive training related to medication administration specific to the child or adult. The type of services provided and the capability of the staff that will be providing the service will determine the amount of that specific training. The training must be sufficient to assure the health and safety of the child or adult. Medication errors such as a missed dose, or wrong medication must be documented and if the error resulted in an adverse event, it must be reported as an incident. BCS staff follow up with each Critical Incident Report.

In addition, licensed service settings are regulated by their licensure standards as defined in each service category as described under Appendix C.

**iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

Medication errors such as a missed dose or wrong medication must be documented and if this results in an adverse event, must be reported as an incident. Agencies providing these services are reviewed by the county waiver agency on at least an annual basis and more frequently if non-compliance has been identified in any area.

The identification of potentially harmful practices is reviewed during this process. The State agencies provide ongoing oversight of these practices and intervene if a pattern of error is discovered.

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.



A representative sample of the CLTS Waiver Program's applications are reviewed by the DHS external quality assurance entity, in consort with the Bureau. This includes a review of all medications taken by the child.

The narrative assessment and ISP must address the management of medications for the individual child including the administration of medications by providers other than the child's family. The DHS Division of Quality Assurance and the Department of Children and Families report any findings related to health and safety that are found in out-of-home settings that include a CLTS Waiver Program participant.

Medication errors such as a missed dose, or wrong medication must be documented and if the error resulted in an adverse event, it must be reported as an incident. The Bureau reviews all IRs to ensure that appropriate steps are taken to prevent future error and complications.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

#### a. Methods for Discovery: Health and Welfare

**The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.** (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

##### i. Sub-Assurances:

- a. **Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.** (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)

##### Performance Measures

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

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

##### Performance Measure:

**Reports of abuse, neglect and exploitation are remediated by the SSC to assure the health, safety and wellbeing of the participant. Numerator = number of reports of abuse, neglect and exploitations for which remediation occurred to assure child's health, safety and wellbeing. Denominator = number of all incidents of abuse, neglect and/or exploitation reported.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
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<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Children's Incident Tracking and Reporting (CITR) system, upon implementation (targeted for 4th quarter 2017)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence

		Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Reported abuse, neglect and maltreatment remediation by the SSC to prevent similar**

incidents from occurring, to extent possible. Numerator = Number of abuse, neglect, maltreatment incident reports that demonstrate incident was remediated in a manner to prevent similar incidents from occurring, to extent possible. Denominator = Total number of abuse, neglect and maltreatment incidents reported.

Data Source (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Source (Select one):

**Other**

If 'Other' is selected, specify:

**Children's Incident Tracking and Reporting system, upon implementation (targeted for 4th quarter 2017)**

Responsible Party for	Frequency of data	Sampling Approach
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<b>data collection/generation</b> <i>(check each that applies):</i>	<b>collection/generation</b> <i>(check each that applies):</i>	<i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**b. Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

**Performance Measures**

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

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

**Performance Measure:**

**Percent of critical incident reports that indicated that the incident was resolved in a manner that ensures the health and safety of the participant. Numerator = number of critical incidents reported in which the incident was resolved in a manner that ensures the health and safety of the participant. Denominator = total number of critical incidents reported.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample Confidence</b>

		Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Children's Incident Tracking and Reporting system, upon implementation (targeted for 4th quarter 2017)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Percent of abuse, neglect, exploitation and unexplained death incidents reported within DHS established timeframe. Numerator = number of incidents of abuse, neglect, exploitation or unexplained death reported in a timely manner Denominator = total number of critical incidents reported**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:



<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Children's Incident Tracking and Reporting system, upon implementation (targeted 4th quarter 2017)**

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100%</b>

		<b>Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

**Performance Measures**

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

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

**Performance Measure:**

All approved restrictive measures are reviewed annually by DHS and meet WI Restrictive Measures policies and protocols. Numerator = the percent of restrictive measures recertifications submitted to DHS in timely manner, according to WI Restrictive Measures protocol. Denominator = the percent of restrictive measures recertifications submitted which meet the requirements and are approved by DHS.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify:	<b>Annually</b>	<b>Stratified</b> Describe Group:

<input type="text"/>		<input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**Performance Measure:**

**Percent of unapproved restrictive interventions with a prevention plan developed as a result of an incident. Numerator = Number of unapproved restrictive measures submitted to DHS with a developed prevention plan. Denominator = Total number of incident reports submitted due to an unapproved restrictive measures intervention.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:	<b>Annually</b>

<b>Responsible Party for data aggregation and analysis</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<input type="text"/>	
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**d. Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.**

**Performance Measures**

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

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

**Performance Measure:**

**Parents or guardians are educated on the importance of an annual well visit with their primary care provider. Numerator = number of participant records reviewed that document parents or guardians were educated on the importance of an annual well visit with their primary care provider. Denominator = total number of participant records reviewed.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample Confidence</b>

		Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Strategies for discovering issues pertaining to the health, safety, and welfare of CLTS Waiver Program participants include the review of the participants' records, complaints, incident reporting, and restrictive measures applications. Incidents, including those that involve the death of a participant, are initially reported to the county waiver agency and then submitted to DHS for review and remediation. All deaths are reported to the county waiver agency and subsequently submitted to the Department. Reports of death are also tracked via CLTS Waiver Program disenrollment data. Wisconsin has a statewide policy on restrictive measures and uses a centralized process for reviewing and approving restrictive measures applications. Any medication errors reported through the incident reporting process will be monitored and trended during review of reports and analysis of data. The BCS Children's Services Specialist review the critical incident and death reports on an on-going basis.

**b. Methods for Remediation/Fixing Individual Problems**

- i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The county waiver agency is responsible for addressing individual issues related to the health, safety, and welfare of each CLTS Waiver participant. The support and service coordinator works with the appropriate agencies and officials, such as child protective services and law enforcement, to ensure appropriate and timely remediation occurs and to provide follow-up as needed. Incidents are currently tracked in the CLTS enrolment database for DHS to track the timeliness of the response, remediation and closure of the incident report. Dates include when the incident was discovered, when it was reported by the waiver agency to DHS, the alleged perpetrator, and when the incident was closed. As described in the associated Performance Measures, incident details are also regularly reviewed during the CLTS record review process and details regarding the waiver agency's response to the incident are tracked during that process. The State's role is to ensure that waiver agencies comply with all existing policies related to reporting incidents and that waiver agencies take all necessary steps to immediately respond to the incident prevent a reoccurrence of the incident. The BCS staff reviews the incident reporting data on a quarterly basis to monitor for any trends that might indicate a systems level issue. If a systemic issue is identified, then appropriate corrective action plan improvements are required. Issues or concerns related to restrictive measures may be discovered through various means and are documented accordingly. The BCS program integrity section compiles all data related to incidents and restrictive measures to monitor for trends.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:



Responsible Party( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
	<div style="border: 1px solid black; width: 100%; height: 100%;"></div>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

**No**

**Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

**Appendix H: Quality Improvement Strategy (1 of 3)**

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## **Appendix H: Quality Improvement Strategy (2 of 3)**

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### **H-1: Systems Improvement**

#### **a. System Improvements**

- i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The CLTS Waiver Program's Quality Improvement System (QIS) is designed to ensure that children with long-term support needs receive the appropriate services and supports to meet their assessed needs as well as the community needs of their family and desired outcomes. This is achieved by developing various quality improvement strategies to ensure the CLTS Waiver Program's policies and procedures are properly administered and implemented by county waiver agencies on a statewide basis.

The scope of the QIS includes the statewide implementation of the CLTS Waiver Program through county waiver agencies that have been delegated by the Department of Health Services and mandated by Wisconsin's Legislature, under state statutes, to operate the program. The QIS includes close oversight of the Department's delegated functions to the county waiver agencies, in addition to the oversight of other program-related functions, such as the utilization of the web-based CLTS Functional Screen (CLTS FS) used by trained and certified screening staff employed by county waiver agencies to determine the child's functional eligibility and appropriate level of care. Other functions within the QIS scope include the review children's timely CLTS Waiver Program enrollment, review of Individual Service Plans, and encounter-level claims data on allowable CLTS waiver services, and assurance that the services are delivered by screened and qualified providers.

The Department uses a variety of methods and processes for trending, prioritizing and implementing system improvements. Trends will be identified over time through consistent data collection, monitoring activities and program evaluation. Priorities for systems level improvements are determined based on multiple factors, including input from various stakeholder groups, other Wisconsin policy-makers such as the Governor and the Legislature. The expectations of CMS, DHS and the Bureau ultimately determine the priorities for systems improvements. Participant health, safety and welfare is a critical area and given high priority based on the extent that significant improvement can be achieved and sustained over time. Ensuring children and families have the information for making informed choices and having access to necessary supports and services, and maintaining cost-neutrality are other priority areas for the CLTS Waiver Program.

The DHS Bureau of Children Services (BCS) provides the administrative oversight for the CLTS Waiver Program. The BCS management team is responsible for the implementation of the QIS. This includes the development of an annual quality work plan that outlines quality improvement activities to be implemented, identifies priorities, and provides oversight to the quality assurance and improvement activities, ensures appropriate data and reporting trend and analysis, and presents recommendations for system improvement activities for management decision-making.

BCS has developed a revised CLTS Waiver Program record review process that will be utilized in 2017. The record review tool has been revised to reflect updated federal performance measures and expectations, and is being assessed during its utilization to track the results. Data collected during the 2017 record reviews will be reviewed and analyzed, and its efficacy will be known by mid-2018.

The Department selects CLTS waiver participant records using a stratified, representative random sample. Each county waiver agency is a strata to ensure that cases are reviewed from each county. The EQRO is using a 50% mean, as this will give the largest sample size. The bound error is 5%, resulting in accuracy of +/- 5%. The EQRO will also pull participant service claim data, which is used as the basis to conduct the review of qualified provider records.

The results will be evaluated in subsequent waiver years and the distribution level may be adjusted in consultation with CMS if appropriate. The record reviews will be conducted using a tool that incorporates criteria related to the performance measures defined in this application and take place on-site at county waiver agencies throughout the calendar year. The onsite record review process will be complemented by producing regular program data reports available via the Department's systems.

Data collection and reporting mechanisms related to performance measures are used to monitor and ensure compliance with waiver policies, processes and requirements within the six assurance areas defined by CMS. The performance measures are defined in this renewal application and also serve to ensure the county waiver agencies' program operations meet the Department's expectations, and therefore also ensure administrative oversight. These performance measures and reporting mechanisms will be in place and operational within the first quarter of 2017. Once fully in place, BCS will create a quality dashboard report using the performance measures to provide a monitoring and trending mechanism. Additionally, other reporting strategies will be used for quality monitoring

such as data to identify over- and under-utilization of waiver services, CLTS FS data, incident reporting, restrictive measures applications and fair hearing data.

The Bureau's staff are assigned to specific regions within Wisconsin and provide ongoing technical assistance, training and quality assurance activities for the county waiver agencies. The Bureau uses a SharePoint site to track any corrective action plans (CAPs) and remediation compliance with all aspects of the CLTS Waiver Program. The CSS provide technical assistance or follow-up training to the county waiver agencies and assist in documenting remediation activities. When trends or individual participant issues are discovered during this process, they are reported to the BCS program integrity section for determination of further corrective actions or sanctions.

The DHS contracts with an External Quality Review Entity which is responsible for carrying out the CLTS Waiver Program's record reviews process. The Review Agency conducts the on-site county waiver agencies' participant record reviews and reports all findings to DHS. The Bureau of Children Services provides oversight to county waiver agencies in addressing the issues that were discovered, providing follow-up to ensure that appropriate remediation occurs, and participating in the implementation of quality improvement activities as needed.

The BCS management team meets regularly to review and update the annual QIS work plan, as necessary. The BCS management team will be meeting quarterly to review the quality dashboard report. When trends are identified that indicate a quality concern, further analysis may be conducted to more clearly define the root cause issue and identify the system improvements needed. Methods for further analysis may include conducting targeted reviews, cause and affect diagramming, process mapping or flow-charting and failure mode and effects analysis. Results of analysis and recommendations for improvement are used to establish priorities for systems improvement. The results of systemic changes will be evaluated based on the quantitative data available that can demonstrate the effectiveness of change.

BCS management team meeting occur weekly to establish priorities and monitor progress related to the CLTS Waiver Program systems and procedures. Information and reports regularly reviewed within BCS include: wait list and enrollment/disenrollment data, quality dashboard/performance measures; incident reporting and mortality review; restrictive measures applications; waiver service utilization data and trends; appeals and fair hearing decisions, record review and audit findings, results of any corrective actions in place; policies and procedures; and recommendations from stakeholders.

The CLTS Council consists of members appointed by the DHS Secretary. It meets quarterly and quality reports are routinely shared with the CLTS Council. The membership consists of representatives from DHS and other statewide departments, advocacy organizations, county waiver agencies, participants' parents/guardians, and service providers. Meetings are open to the public, and public input is one method for establishing priorities. The Council provides DHS/BCS with input, feedback and recommendations to improve the CLTS Waiver Program service delivery. Information shared with committee members include progress updates on implementation and analysis of quality improvement activities. The Council's recommendations and feedback provided during these meetings are used by the Bureau in making policy and system improvements and priority setting.

Another advisory group, the Autism Council, is comprised of Governor-appointed members and provides input and guidance to DHS/BLTS. This council is specifically focused on the issues facing families of children with a diagnosis of Autism Spectrum Disorder. Members of the group include representatives from DHS, county waiver agencies, autism advocacy groups, autism researchers and autism service providers. During the 2016 transition of the CLTS Waiver coverage of autism treatment services to a covered ForwardHealth Behavioral Treatment Benefit, the Autism Council provided DHS with valuable input and recommendations to regarding the waiver supports and services that were still needed by children diagnosed with autism spectrum disorder.

## ii. System Improvement Activities

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify: <input type="text"/>	<b>Other</b> Specify: <input type="text"/>

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The CLTS Waiver Program accomplishes Continuous Quality Improvement (CQI) utilizing the “Design-Discovery-Remediation-Improvement” (DDRI) methodology to structure implementation (strategize), monitor progress, evaluate effectiveness of change, and determine if any additional changes or modifications are needed. The BCS quality management team manages and coordinates the implementation of systems improvement. Depending on the nature of the systems issue, improvement processes may include: process or performance improvement projects; development and implementation of training/education and technical assistance; development and implementation of additional resources for CLTS Waiver Program participants and families; corrective action plans that require larger system changes (e.g., agency infrastructure, roles/responsibilities of staff resources, significant process changes); modification of existing data collection and reporting mechanisms or development of new mechanisms; or modification of existing policies and procedures or development of new ones to address additional program needs.

As system changes are completed, the BCS management team will oversee the collection of data and reports from the new systems. The data analyst is responsible for the development, coordination, and implementation reporting mechanisms to obtain data related to performance measures, trend results, and other monitoring activities. The Bureau conducts an analysis of data and generates the quality dashboard report.

The BCS will document any system change activities in a report or summary format that can be shared and distributed as appropriate within DHS and to other stakeholders as needed or required depending on the nature of the change. This report will include a description of the issue, the desired change to be made, what steps or activities were implemented to achieve desired change, any indicators and measures related to activity, a summary of findings and conclusions drawn as a result.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Wisconsin's QIS is designed based upon current processes implemented during the initial waiver application and includes modifications to data collection and reporting mechanisms, incorporation of performance measures for each of the six assurance areas, and implementing strategies for more structured quality assurance and improvement activities. The QM team will conduct a preliminary evaluation after the first year of implementation to assess the current structure and processes in place to make modifications as three years of implementation, the BCS quality management team will conduct a more thorough evaluation of its QIS and summarize achievement of quality improvement efforts to demonstrate the strengths of the current system, identify challenges and barriers, and determine what additional changes need to be made to improve its effectiveness.

Program evaluation methodology will include summary of findings from performance measures and quality improvement activities. The Bureau is responsible for evaluating the impact and effectiveness of system design changes. Whenever feasible, indicators for improvement will be defined with corresponding measures and incorporated into the DDRI methodology so that the evaluation is built into the process up front. If the systems change relates to one of the six quality assurance areas and related performance measures, the performance measures will be trended over time to demonstrate if change resulted in improvement. Other methods may be used depending on the improvement activity. For example, if training and technical assistance (TA) is the improvement activity, then a process will be developed to measure the impact of training or TA, such as a pre-test/post-test.

## Appendix H: Quality Improvement Strategy (3 of 3)

### H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

## Appendix I: Financial Accountability

### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

*The Department's Division of Medicaid Services (DMS) (which has been reorganized and includes the Bureau of Long Term Care Financing (BLTCF) and the Bureau Children Services (BCS)), the Bureau of Fiscal Services (BFS), and the Office of Inspector General's (OIG) Audit Section, each have responsibilities in monitoring key aspects of financial accountability. These functions are described below.*

*DHS currently contracts with a third-party administrator (TPA) to process authorized CLTS waiver service claims. DHS provides fiscal oversight of the CLTS service utilization data. Service utilization data details are submitted to the Department through the encounter data reporting system. The TPA is the exclusive submitter of data to this system related to the CLTS Waiver Program. The encounter data system collects data submitted electronically through a standard .xml file format. The data is reconciled and certified by TPA staff before data is transmitted to DHS. Before accepting and uploading the data to the DHS Data Warehouse, DHS reviews and certifies the encounter data.*

*The Department's TPA claims process operates as follows:*

- County waiver agencies (CWA) prepare the participant Individualized Service Plans (ISPs) and authorize services for children based on their needs, which includes authorization and claims for support and service coordination.*
- CWAs submit service authorizations to the TPA vendor for acceptance into the system.*
- The provider receives the accepted service authorization, delivers the authorized service and submits claims to private health insurance, as appropriate, before submitting a claim to the TPA.*
- The TPA ensures coordination of benefits (COB) with the health insurance benefit. To assist in this process, Wisconsin's Medicaid fiscal agent/MMIS vendor sends the TPA a monthly third party liability (TPL) health insurance file, obtained from the Office of the Commissioner of Insurance. After adjudicating any COB, the TPA processes claims with the corresponding authorizations.*
- The TPA invoices DHS daily and the Department reviews and approves or denies the daily invoice. If approved, the provider receives payment. The TPA processes provider checks or electronic funds transfers and mails them to the rendering providers or deposits them in the providers' supplied account. If denied, the TPA reviews and resubmits the corrected invoice to the Department.*

*Following approval of the state based waiver rates, the TPA will update the system to validate authorizations and pay claims according to the approved statewide published rate schedule. DHS will monitor claims data to understand how the rate schedule is impacting service utilization and access. This includes analysis of how care levels and outlier rates are being applied. DHS will also utilize the existing review process to validate proper county application of the rate schedule while the TPA system transitions. DHS monitoring will also inform ongoing rate schedule maintenance and help determine if rates need to be adjusted to address participant access or budget issues.*

*Both the Department and CWAs conduct fiscal monitoring and an annual CLTS Waiver Program fiscal reconciliation.*

*On a monthly basis, DMS uploads claims data to the Community Aids Reporting System (CARS). CARS contains CLTS funding allocations by county and tracks county expenses compared to CLTS allocation amounts. This allows CWAs to compare the data with participant ISPs to ensure the authorized services match claims paid. Any variances must be clarified between the source documents referenced above with the TPA. If a claim was paid incorrectly, CWAs submit an overpayment request through the TPA. The CWA claims data review is an ongoing protocol embedded in the reconciliation process.*

*On a quarterly basis, DMS identifies CLTS claims that were paid for dates of service overlapping with a participant's institutional stay. Waiver services provided while a participant is in an institution are disallowed. DMS compiles the claims and sends each affected county waiver agency a report and notes that the CLTS expenses will be disallowed during the reconciliation process, unless the claim was erroneous and is corrected before the annual reconciliation process.*

*Using the daily invoices, Department staff verifies that the amount paid from the state centralized bank account matches the submitted claims and ensures it contains sufficient funds to cover the service claim payments. The TPA reconciles the state centralized bank account and shares a monthly bank reconciliation schedule with DHS. Finally, DMS conducts a final reconciliation process, which is used to ensure that CLTS participants were enrolled and eligible when they received services and that the appropriate funding source is applied to the appropriate services. The DMS reconciliation process occurs annually, after the end of the calendar year. CWAs verify that reconciliation totals tie out to their reporting.*

*CWAs monitor claims processing against their authorization systems. Issues with individual claims submissions to the TPA must be corrected through a reversal process or through the annual fiscal reconciliation process described above. The reversal process involves the CWA submitting documentation to reverse the claim and then processing the revised claim, if*

appropriate. CWAs may also submit a revision when the service was appropriate for the participant, but there was a coding error. The TPA has established edits to detect prescribed coding logic, which could result in instances of reversing the claim payment that would require a provider refund. With the implementation of the state based rate-methodology, the TPA system will validate authorizations and claims payments in alignment with the policies and procedures governing the state established rate schedule.

The Department has established three quality review processes to confirm billed services were actually rendered to participants.

1. Each month the child's support and service coordinator (SSC) must make collateral contacts to ensure the participant's needs are being fully met, including satisfactory delivery of all authorized services.
2. As part of the annual CLTS record review process, the DHS contracted external quality review organization (EQRO) receives a list of all TPA paid service claims for each selected participants. The EQRO reviews and compares the service claims to the participant's Individual Service Plan (ISP) to ensure the participant's needs have been met.
3. DHS issues annual surveys to all CLTS participants' parents and guardians which includes several questions regarding satisfactory service delivery to meet the child's needs.

DMS administers the TPA contract. The TPA submits contract invoices for administrative services to DMS, based on a per member per month expense calculated from CLTS enrollment data. Administrative services refer to the service the TPA vendor performs on behalf of the Department (i.e., the TPA's cost for processing claims), and do not include participant waiver service costs. The invoices are verified for accuracy and are then submitted to DMS for payment processing. The verification process includes ensuring the number of participants with claims is not greater than the number of enrolled participants, that the total claim amount does not exceed the anticipated claim amount, and that no unauthorized provider is paid.

DHS requires CWAs to have a contracted independent CPA firm perform the state single audits. The CPA firm conducts an audit of waiver agency operations, following the procedures provided in the State Single Audit Guidelines, which are written and approved each year by DMS and the DHS Office of Inspector General (OIG). These guidelines include requirements ensuring participants were eligible at time of service, that only qualified providers deliver authorized services, and that certain services are targeted for review, including high cost home and van modifications. The OIG's Audit Section also ensures that providers subject to the purchase of service contract requirements under § 46.036, Wis. Stats have an audit completed by an independent auditor, unless waived.

Under Wisconsin's statutory purchase of service (POS) contracting and audit regulations detailed at Wis. Stat. § 46.036(4)(c), both agency and sole proprietor providers receiving DHS funded services, are subject to an independent financial audit.

DHS contracts with a third party administrator (TPA), which requires the support and maintenance of internal quality assurance (QA) processes to detect and correct problems in all functional areas, and support and maintain internal quality improvement (QI) processes to detect and prevent quality issues from occurring. DHS staff are assigned to oversee the quality assurance processes and review evidence from these endeavors. DMS is responsible for program operations and approving payment to the TPA for administrative services. DMS is also responsible for assuring that the per member per month (PMPM) administrative charge to the Department from the TPA is appropriate.

DMS also has day-to-day accountability and integrity roles. DMS runs quarterly checks of encounter data, including ensuring waiver agencies and providers are properly billing only participants who are eligible for the waiver at the time that services were billed, and authorizing the daily invoice from the TPA. DMS also conducts year end waiver agency contract reconciliation, which runs a year end check to ensure that service claims were appropriate, disallowing them if they were not and ensuring the correct funding source was used for participants.

Additionally, DMS ensures the accuracy and integrity of the data submitted by the TPA, including checking for appropriate coding for encounter reporting.

## **Appendix I: Financial Accountability**

### **Quality Improvement: Financial Accountability**

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



**a. Methods for Discovery: Financial Accountability Assurance:**

**The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.** (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

**i. Sub-Assurances:**

**a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

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

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

**Performance Measure:**

**Encounter claims are coded and paid in accordance with the state reimbursement methodology by the Third Party Administrator. Numerator = number of waiver encounter claims coded and paid for in accordance with reimbursement methodology.**

**Denominator = all claims reviewed in the sample.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**CLTS Data Warehouse – encounter paid claims**

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>

	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

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

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

**Performance Measure:**

**Claims are paid in accordance with the state rate methodology. Numerator = Claims reviewed that were paid in accordance with the state rate methodology. Denominator = Paid claims in the sample.**

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**CLTS encounter claim data**

<b>Responsible Party for data collection/generation (check each that applies):</b>	<b>Frequency of data collection/generation (check each that applies):</b>	<b>Sampling Approach (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <input type="text" value="+/- 5%"/>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

**b. Methods for Remediation/Fixing Individual Problems**

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

DMS uses several methods to monitor operational functions delegated to the CWAs to ensure service plans are being met, to ensure equitable access to services for participants, and to evaluate purchase of goods and services. These include the third party administrator (TPA), manual review, the annual Single State Audit process, record reviews conducted by the contracted external quality review organization (EQRO), and regionally assigned staff.

The TPA is responsible for ensuring CLTS Waiver Program services claims are preauthorized, billed, adjudicated and paid appropriately. On a quarterly basis, DMS identifies CLTS claims that were paid for dates of service overlapping with a participant's institutional stay. Waiver services provided while a participant is in an institution are disallowed. DMS compiles the claims and sends each affected county waiver agency a report and notes that the CLTS expenses will be disallowed during the reconciliation process, unless the claim was erroneous and is corrected before the annual reconciliation process. DMS is responsible for the annual fiscal reconciliation of waiver agencies. The DHS (OIG oversees the audit process and tracks financial findings in the audits. DMS pursues and ensures remediation of audit findings. The CWAs must reimburse the State and Federal government for errors found during the financial audit. On a monthly basis, DMS sends claims information to the expenditure tracking system for county waiver agencies to facilitate their review of the data. In addition, DMS monitors claims errors quarterly and annually and continues to follow up on errors using MMIS data until they are resolved. All adjustments are available through business intelligence reports. On a daily basis, the TPA vendor and fiscal agent, obtains from the enrollment system a listing of participants enrolled in the CLTS Waiver Program, which includes the participant's enrollment start date (and end date when applicable), their target group, and the responsible county waiver agency. The TPA will reject service authorizations and claims for any person not included on the enrollment list.

The TPA rejects claims for any service that is not prior authorized by the CWA. The Department uses the record review and the annual Single State Audit processes as means of discovery to ensure delivered services were included on the individualized service plan. Where the statewide rate-methodology dictates adherence to specific features of the methodology, DMS provides technical assistance, review and final approval.

**ii. Remediation Data Aggregation**

**Remediation-related Data Aggregation and Analysis (including trend identification)**

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:  <input type="text"/>

**c. Timelines**

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

**Yes**

*Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.*

## ***Appendix I: Financial Accountability***

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### ***I-2: Rates, Billing and Claims (1 of 3)***

**a. Rate Determination Methods.** *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The rate schedule is published on the DHS website: <https://www.dhs.wisconsin.gov/hcbs/ratestructure.htm>. 1. Rates for waiver services similar to state plan services are identical to the Medicaid state plan rate, including: supportive home care-personal care services; transportation services; nursing services; counseling and therapeutic services-Occupational, Physical and Speech Language Therapy. 2. All other rate methods: rate methods share similar values, calculations and expense categories with some variations. Rates factor both the individual care need and professional experience required and have common calculations and factors. Individual service planning is where participant information informs care and support needs. Rates are applied once care needs and individual outcomes are identified. Rates are published in the DHS fee schedule and used with the DHS code and unit crosswalk and service definitions. CWAs review requirements to determine appropriate rates, codes and units as part of the person-centered planning process, and in the ISP. The rate and service information in the ISP is the basis for authorizing waiver services delivered by operational agencies and providers paid via TPA claims payment. For most rates, direct staffing wage costs are the main driver. A base wage uses matching job categories similar to waiver service job descriptions and standard occupational classification codes from the Bureau of Labor Statistics. Average wages adjust to differentiate between level of service professional needed and whether the provider is a self-employed individual or an agency that employs direct caregivers. Agencies incur the higher overhead and fringe costs of being an employer. DHS accounted for higher overhead and fringe costs for agency (employer) versus individual providers by analyzing a variety of data sources. During the initial stages of the initiative the DHS subcontracted analyst, the University of Wisconsin Center for Health Systems Research and Analysis developed some preliminary models of overhead and fringe, which were later tested with input from provider surveys, DHS obtained ongoing county and provider feedback during rate development. For service rates with a provider type component (individual or agency), these costs were added to base BLS job category wage rates. Provider related overhead and fringe expenses built into rates include direct service wages, supervision (when applicable), employee-related cost factors (required tax and benefit obligations), and client and program overhead factors (expense related to indirect support and service delivery). When an individual requires an exception to the state rate in order to meet their unique needs, CWAs may submit an outlier request to increase a service rate based on either the individual's need or service availability. Outlier requests are available for all services subject to the rate schedule. Requests are reviewed and approved or denied by the state.

#### *Methodology by Service Category*

Adult family home-rate is the average amount paid by Family Care PIHPs, per most recent available encounter data. Child care rate is based on child care market data that DHS obtained from the Wisconsin Department of Children and Families. DCF conducts a market rate survey to determine the prices of regulated child care in the private market. Child care rates are set according to the maximum average market rates. To maximize community integration and access, the CLTS rate for this service is intended to approximate the average child care market rates throughout the state in inclusive childcare settings. Every time DCF conducts a new market rate survey, DHS will obtain and analyze the results, as well as assess CLTS child care service utilization. DHS will determine through these analyses whether child care rates should be adjusted.

Community integration services-the CLTS rate method includes two tiers based on the provider education level. The rate values were calculated using historical rate data from existing bundled CIS programs, excluding any services not covered by the CLTS Waiver. DHS obtained 2018 rate information from Community Integration Services (CIS) providers to determine an average rate. After publishing the average rate in the rate schedule, DHS received additional feedback from counties and CIS providers that the rate was too low and should be tiered to reflect the education level of the provider. DHS developed Tier 1 rates for providers with a bachelor's level degree and Tier 2 rates for providers with a master's level degree. The skill level required to meet the participant's needs and outcomes is determined through the individual service planning process.

Counseling and therapeutic services-for occupational therapy, physical therapy, and speech language therapy, the rates are set identical to State Plan fee for service rates. This service category also includes alternative therapies that Pay 85% of provider market rates for each alternative therapy (music, dance, art, etc), up to \$170/session.

Daily living skills training-rates based on individual and agency providers, but not differentiated by care level. Rates use the BLS job classification category that aligns with required staff skill level. The professional category needed is higher than the rates for respite and supportive home care.

Day services-rate calculation mirrors child care service rates due to service similarities, are based on child care market data collected by DCF, and is set according to the maximum average market rates. It pays a single full rate for all age groups.

Financial management services-the rate methodology creates a standardized list of services with two tiers: basic and enhanced. The enhanced tier of Financial Management Services (FMS) is comparable to that provided to adult participants under the Include, Respect, I Self Direct (IRIS) waiver program. Thus, the enhanced FMS rate is set equal to the IRIS rate. County and provider input and feedback have been instrumental in the development of the enhanced rate. During the rate development period, a work group of counties and providers helped develop and confirm the types of

activities that should be provided at the basic and enhanced tiers. After DHS released the draft rates in July 2018, county and provider feedback helped DHS determine that the initial enhanced rate was too low to sustain the required activities. The feedback led DHS to further review the IRIS service rate and determine it appropriately aligned with the CLTS enhanced FMS activities.

*Mentoring*-the rates are informed by the BLS job classification category that aligns with non-professionals with lived experience providing the service. The schedule sets both individual and agency provider rates assuming a low-to-medium care level.

*Respite* rates are based off of weighted average federal Bureau of Labor Statistics wage survey data for related job categories. These base rates were then adjusted for both care level and provider type components and require a care level classification.

*Support and service coordination*-the existing methodology is maintained for determining SSC rates for county waiver agency providers. Rates are set for each county using a weighted average hourly rate. The rate includes allowable administration costs supported as outlined in the DHS Allowable Cost Policy Manual, and can be specifically attributed to the provision of support and service coordination.

*Supported employment*-the rates are informed by the BLS job classification category and selected to align with the rates paid by the Wisconsin Department of Vocational Rehabilitation for job development staff. The rate methodology incentivizes individual supported employment with higher hourly rates. There is also a rate option that increases pay for providers with the number of weekly hours the participant works.

*Supportive home care*-the rates mirror respite rates methodology described above.

*Transportation-mileage* rates mirror the federal mileage reimbursement rate and will reflect annual federal updates. The trip rates align with per member per month costs to transport children through the Medicaid State Plan.

*Methodology Key Components*-DHS developed a unique methodology for several services that include at least one of the following components: child's care level classification and provider type

*Care Level Classifications*-Respite and Supportive home care services have three care level classifications: low, medium, and high. The progressively higher rate for each care level is informed by BLS job classification categories for caregiver levels to align with increased need for employee skill, training, experience.

*Support and service coordinators(SSC)*determine care levels with the family and apply their expertise to assess the child and family's level (or intensity) of support need with respect to these two service categories. SSCs consider information from formal sources and input from the participant. Several factors are considered, including:

- Information from the functional screen and assessment processes
- Child and family's situation or circumstances
- Intensity, type of support, or degree of professional experience required
- Extent of training/experience a provider must have in order to safely/effectively work with the individual

See Care Level Guidelines document for further details.

*Outlier Rate Request*-CWAs may request an exception to the CLTS rate schedule when either or both of the following criteria are present:

- The complexity or intensity of the individual's care needs (acuity) exceeds what is common among CLTS participants.
- No caregiver is located within a reasonable distance of the participant, or no caregiver within a reasonable distance will accept the rate (access).

CWAs submit outlier requests to DHS for review and final approval.

DHS has not established outlier rate maximums, but rather has published a draft Outlier Rate Guidelines document (<https://www.dhs.wisconsin.gov/publications/p02274.pdf>) to help CWAs determine whether an outlier rate is warranted. Up to 5% of participants are anticipated to meet the outlier criteria. Outlier requests are subject to DHS review and final approval.

*Individual Care Needs*-consider whether the participant:

- Exhibits significant behaviors that require frequent intervention or near-constant supervision.
- Has physical or mental health diagnoses that require intensive intervention or care.
- Has ongoing involvement with multiple systems (e.g.juvenile justice,substance abuse treatment,hospitals/institutions, etc.)

See outlier rate request document for further details

*Service Availability*-request an outlier rate when access to a service is limited, when no caregiver is located within a reasonable distance of the participant or is within a reasonable distance and will not accept the rate. See Outlier Rate Request Guidelines document.

*Provider Type*-some rates differ between individual and agency providers. Rates include employee wages and withholdings(e.g.federal and state taxes, workers compensation, etc., with higher non-salary costs for the agency provider type (e.g., overhead,supervision,training, fringe/benefit costs). Services may be paid at rates lower than the state based rate, in circumstances where a service provider's usual and customary service rate is lower than the state based



rate for a particular service. Market rates are used when certain goods or services under a service category are purchased at the price set by the market:

Supportive home care-caregiver living expenses, chore services; counseling and therapeutic services-therapeutic equipment, supplies and camps; respite camps; transportation–ancillary costs (parking fees,tolls,etc); mentoring–ancillary costs associated with the service.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

DMS contracts with a Third Party Administrator (TPA) responsible for paying CLTS service claims submitted by providers. County waiver agencies (CWAs) authorize services based on the participant's individualized service plan (ISP). The CWAs issue a prior authorization to both the service provider and to the TPA. The TPA receives a list of CLTS waiver enrollees, as well as a monthly file of Medicaid eligible participants with private health insurance to assist with coordination of benefits (COB). Waiver providers submit their service claims directly to the TPA. The TPA is responsible for ensuring COB compliance, and then pays claims that conform to the waiver agency's authorization and either the statewide rate-methodology or market rates. The TPA pays providers by check or EFT from a bank account held by the Wisconsin Department of Administration. DMS reviews a daily invoice and, once approved, submits it for processing through the Department's Bureau of Fiscal Services and the Wisconsin Department of Administration. The State pays contractually approved administrative expenses billed by the TPA. If the CWA is responsible for the non-federal share of the expense, the State makes cash-back adjustments to the waiver agency's expenditures in the Community Aids Reporting System (CARS) to ensure the appropriate funding sources are applied. The federal portion of the claims is reported to CMS quarterly.

The flow of billing for self-directed services is the same as other services, with the exception that some of these services are paid for through a fiscal agent. The fiscal agent submits claims to the Department's TPA vendor on the providers' behalf as the billing provider, and receives payment for those claims, then issues payment to the rendering providers.

## Appendix I: Financial Accountability

### I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures** (select one):

**No. state or local government agencies do not certify expenditures for waiver services.**

**Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

**Select at least one:**

**Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

DHS, the State Medicaid Agency, and CWAs share the certification of public expenditures validation process. This includes the contracted Third Party Administrator (TPA) receiving data from the DHS system on a daily basis to confirm CLTS Waiver Program current participant enrollment, as well as the enrolled providers eligible to be paid for the delivered services. CWAs submit prior authorizations for all CLTS waiver services to the TPA. The TPA is contractually required to ensure that all payments, adjustments, and other financial transactions made through the TPA must be made on behalf of clients enrolled in the HCBS waiver program, to enrolled providers, for approved services, and in accordance with the payment rules and other policies of the Department.

Using the daily invoices from the TPA, DHS staff verifies the amount paid from the bank account matches the claims submitted and that the bank account contains sufficient funds to cover the service claim payments. Any variances must be clarified with the TPA and if a payment was not appropriate, the Department must request a refund from or through the TPA. DHS reconciliation is completed monthly when bank statements arrive. Finally, DMS conducts a final fiscal reconciliation process, which is used to ensure that participants were eligible for CLTS Waiver Program services when they received them and that the appropriate funding source is applied to the appropriate services. DMS's fiscal reconciliation process occurs annually, after the end of the calendar year. Waiver agencies are responsible for verifying that DMS reconciliation is correct.

**Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

**Appendix I: Financial Accountability**

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**I-2: Rates, Billing and Claims (3 of 3)**

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

*The CWA conducts internal reviews to verify that each claim is reimbursable under the CLTS Waiver Program by determining that: the participant was eligible for services, the authorized services only include those listed on the child's approved individualized service plan (ISP), and the provider actually delivered the service to the participant.*

*The CLTS Waiver Program's TPA only pays claims for individuals enrolled in the CLTS Waiver Program. On a daily basis, the TPA receives a file of enrolled CLTS Waiver Program participants, which includes the participant's program start date and end date (when applicable), their target group and the applicable responsible county waiver agency. The TPA will reject service authorizations and claims for any person not included on the enrollment list. The county waiver agencies submit applicant ISPs to DMS, when applicable. A review of the claims data is completed during the annual site visit review and Single State Audit to ensure only the services on the ISP were paid.*

*DHS has established multilayered quality assurance processes to ensure CLTS billed services have been rendered to the participant.*

- *The DHS contracted TPA vendor requires attestations from providers to ensure services have been delivered as part of their claims processing and adjudication protocol (for both electronic and paper claims).*
- *During the annual CLTS record review process, the DHS contracted external quality review organization receives a list of all service claims for the selected participant. These service claims are compared to the participant's Individual Service Plan (ISP) for accuracy in ensuring the child's needs have been fully met.*
- *Annual surveys are also conducted with the participants and families to ensure services have been appropriately delivered.*

*The contracted TPA vendor has developed a CLTS service recovery protocol when CLTS service overpayments have been identified. Overpayments may be identified by the following entities:*

1. *DHS*
2. *Contracted TPA vendor*
3. *County waiver agencies*
4. *Providers*

*When DHS identifies inappropriate service payments during the annual CLTS fiscal reconciliation process, recoupments are processed through the TPA claims correction process when possible. Recoupments processed through the TPA claims corrections are recovered directly from the service provider.*

*DHS also has a process to recoup inappropriate payments directly from CWAs through the Community Aids Reporting System (CARS), which is described in Section I-1 of the waiver amendment. DHS ensures that CARS adjustments for inappropriate payments are reflected in the federal Medicaid reporting.*

*When the TPA claims department identifies or is notified by DHS, a CWA or provider about an overpayment:*

- *TPA collections department creates a record in the database.*
  - *TPA collections department issues a notice to the provider requesting return of the overpayment:*
    - o *Day 1 - initial letter*
    - o *Day 45 - second letter*
    - o *Day 60 - final letter*
    - o *TPA turns collection duties to DHS for any collections beyond 90 days*
    - o *Overpayment recovery amounts are processed, adjudicated, and the encounter data is updated in the data warehouse.*
- Beginning in 2019, if the provider does not return the overpayment amount voluntarily; the TPA will recoup it directly from the provider's future claims.*

*The state-established rate methodology will be validated using several approaches. The TPA will be updated to validate authorizations and claims payments in alignment with the policies and procedures governing the state established rate schedule. Each CWA will use the system updates for in scope services for each child. Initially the system will accommodate a transition for CWAs to the TPA system updates. During the initial period, the TPA will notify providers/CWAs if they did not utilize the rate validation system updates for an in scope service, but will allow claims to be paid against it to avoid service disruption. The initial phase is targeted to begin in July 2018, pending amendment approval and system readiness. Following the initial period, all authorizations and service claims must adhere to the system updates implementing the rate schedule by January 2020.*

*The TPA will develop a comprehensive training, technical assistance, and testing plan for DHS approval that ensures all*

CWAs and providers are fully compliant with the rate schedule by January 2020.

Following the system updates, DHS will monitor authorizations and claims data to understand how the rate schedule is impacting service utilization and access. This includes analysis of how care levels and outlier rates are being applied. DHS will also utilize the existing review process to validate proper county application of the rate schedule while the TPA system transitions. DHS monitoring will also inform ongoing rate schedule maintenance and help determine if rates need to be adjusted to address participant access or budget issues.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## Appendix I: Financial Accountability

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### I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

**Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

## Appendix I: Financial Accountability

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### I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a**

*managed care entity or entities.*

*The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.*

*The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.*

*Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:*

*The CLTS Waiver Provider Medicaid Agreement includes a provision detailing payment processes through the DHS contracted third-party administrator (TPA). The State-held bank account and the payment file from the TPA, based upon encounter entry of approved claims, avoids a conflict of interest as it is independent of the entities/persons delivering services or goods. Based on the participant's authorized ISP, which was developed jointly by the parent/guardian and the county waiver agency, the fiscal agent processes claims for expenditures that meet all required authorizations, answers inquiries from waiver agencies and providers, solves related problems, and provides the Department with a weekly certification of expenditures through the State's encounter reporting system.*

*DHS contracts with the TPA to perform all of the functions identified above. When deficiencies are identified, DHS works with the contractor to achieve remediation. If necessary, a corrective action plan is implemented followed by a re-review. The TPA submits paid claims through the DHS encounter reporting system and certifies that the submitted claims are true and accurate. To ensure financial integrity and accountability, DHS performs claims data quality checks related to the encounter reporting and certified paid claims against participants' authorized individualized budgets, and to determine if there is documentation that the services for paid claims were included in the ISP and were rendered. Where deficiencies are identified, remediation is required, according to the terms of the contract.*

*In addition, TPA conducts its own internal quality check to ensure that payments were made correctly. These include:*

- Assuring prior authorization for every claim paid under the CLTS Waiver Program. This assurance is met by the TPA requiring that claims data submitted from the provider is exact and within the code parameters on the authorization in order for a payment to be made (service code/modifiers, provider number, dates of service, participant ID, units of service allowed). Any data element that does not match will cause the claim to be denied.*
- Assuring that high dollar claims get additional review. This assurance is met by a code modifier that will force a claim to pend when billed charges are over \$15,000 for professional services and \$30,000 for institutional services. The TPA will review the claim to ensure the billed charges were submitted as intended. This edit prevents inappropriate escalated charges and/or entry errors.*
- Assuring that the correct rate is applied. This assurance is met by using pricing logic to pay the authorized rate regardless of charge amount or pay the lower of rate or billed charges.*
- Assuring there are not duplicate payments. This assurance is met using duplicate logic editing that compares new claims against pended and previous paid claims. Any new claim that matches a pended or paid claim will either auto reject or pend for desk level review.*
- Assuring that retroactive changes are enforced. This assurance is met through retro code change protocols. If a retro change to a record causes a previous processed claim to overpay, the TPA reviews claim history and requests refunds. These retro changes can include enrollment, COB indicator, rate changes, provider ID change, or participant ID number change.*
- Assure basic claim validation. This assurance is met by using a variety of other claim validation edits to ensure claims are processed accurately. These include assuring participant eligibility, COB, provider eligibility, proper HIPAA coding, disallowing claims for future dates, etc.*

#### *Provider Payment – Banking Process:*

*The TPA makes payments for provider claims directly from a State-controlled bank account. The TPA transmits a daily invoice to DMS for approval to fund the State-controlled bank account for the daily invoice dollar amount. The approved invoices are submitted through the Bureau of Fiscal Services to the Department of Administration, which administers the account. The payment account is a zero-balance account funded by the State and cannot receive external deposits. A separate receivables account was established for deposits and this account cannot be drawn upon.*

#### *Money Refunds:*

*The receivables account cannot be used to make payments. When the TPA makes a payment or collects a receivable, the TPA records the process in their system, which is certified and reported monthly to the State encounter-data system. The monies put back into the bank account are transactions processed through MMIS.*

#### *Payments:*

*When a provider fails to cash a check, the TPA returns the funds to the State after 180 days and the State is responsible for maintaining those funds. A provider has six years under State law to claim the payment and would claim the payment from the State Agency directly.*

*Billing Process:*

*Providers are informed about the billing process through TPA training materials and forms from DHS and the TPA, as well as the county waiver agencies. These materials will be updated to reflect the implementation of the statewide rate methodology.*

**Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

*Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.*

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**Appendix I: Financial Accountability**

**I-3: Payment (3 of 7)**

**c. Supplemental or Enhanced Payments.** *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

**No. The state does not make supplemental or enhanced payments for waiver services.**

**Yes. The state makes supplemental or enhanced payments for waiver services.**

*Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.*

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**Appendix I: Financial Accountability**

**I-3: Payment (4 of 7)**

**d. Payments to state or Local Government Providers.** *Specify whether state or local government providers receive payment for the provision of waiver services.*

**No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**

**Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

*Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:*

The Department has submitted a Section 1915(b)4 Waiver Fee-for Service Selective Contracting program application to the Centers for Medicare and Medicaid Services, designating county social/human/community services as the sole provider for the delivery of their Support and Service Coordination and foster care services, as well as reimbursement for covered goods and equipment costs for CLTS Waiver participants. County waiver agencies receive payment for delivered waiver services through the TPA claims process.

## Appendix I: Financial Accountability

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### I-3: Payment (5 of 7)

#### e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

*The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.*

*The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.*

*The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.*

Describe the recoupment process:

## Appendix I: Financial Accountability

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### I-3: Payment (6 of 7)

#### f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

*Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.*

*Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.*

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

## Appendix I: Financial Accountability

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### I-3: Payment (7 of 7)

#### g. Additional Payment Arrangements

##### i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:



**No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**

**Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System. Select one:**

**No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**

**Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

**iii. Contracts with MCOs, PIHPs or PAHPs.**

**The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

**The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

**This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

**This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these**

plans are made.

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (1 of 3)

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

**Appropriation of State Tax Revenues to the State Medicaid agency**

**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

## Appendix I: Financial Accountability

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### I-4: Non-Federal Matching Funds (2 of 3)

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

**Not Applicable.** There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

Check each that applies:

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

The CLTS Waiver Program is operated by county waiver agencies, which are county government agencies that have the ability to levy taxes through both property and county sales tax processes. These funds, if utilized through the waivers, are transferred through intergovernmental transfer and tracked through the Data Warehouse and CARS (State of Wisconsin – Department of Health Services reporting system) and a county waiver agency must show adequate non-federal match in order to claim the FFP. Wis. Stat. 46.22 gives counties authority to levy taxes for social service expenditures.

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Appendix I: Financial Accountability**

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**I-4: Non-Federal Matching Funds (3 of 3)**

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

*None of the specified sources of funds contribute to the non-federal share of computable waiver costs*

**The following source(s) are used**

Check each that applies:

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

**Appendix I: Financial Accountability**

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**I-5: Exclusion of Medicaid Payment for Room and Board**

**a. Services Furnished in Residential Settings.** Select one:

*No services under this waiver are furnished in residential settings other than the private residence of the individual.*

*As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.*

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

County waiver agencies must demonstrate that the CLTS waiver costs incurred for those participants residing in substitute care do not include room or board expenses. Because the use of Medicaid waiver funds is prohibited, the waiver participant pays some or all of the room and board costs. When the room and board costs exceed the participant's available resources, another source of funding, other than Medicaid waiver dollars, must be used.

The substitute care provider is responsible for the determination of the rate for their facility and for providing a breakdown to the waiver agency that identifies facility-specific costs attributed to room and board. The county waiver agency is responsible for assuring that such methodology is in place when contracting with a substitute care provider. Documentation identifying the facility costs for room and board must be kept on file at the waiver agency and should be updated at least annually to assure the facility costs are accurate and allowable. Items and cost specifically related to room and board costs include the following: rent, or depreciation and mortgage interest; insurance such as title, mortgage, property and casualty; building or grounds maintenance costs; resident food; household supplies necessary for the resident room; furnishings used by the resident; utilities such as electricity, water and sewer, heating fuel, resident telephone, and resident cable television. Facility specific documentation is maintained at the waiver agency and must be updated at least annually. Participant-specific documentation of substitute care room and board costs should be maintained in the participant record.

## Appendix I: Financial Accountability

### I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.** Select one:

**No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

**Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

## Appendix I: Financial Accountability

### I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

**a. Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

**No. The state does not impose a co-payment or similar charge upon participants for waiver services.**

**Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.**

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

**Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii)**

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through I-7-a-iv):

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*Nominal deductible*

*Coinsurance*

*Co-Payment*

*Other charge*

*Specify:*

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**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

**b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

**No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

**Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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**Appendix J: Cost Neutrality Demonstration**

**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Hospital, Nursing Facility, ICF/IID**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	8796.39	13686.91	22483.30	208736.24	17100.68	225836.92	203353.62
2	8977.37	13900.77	22878.14	212564.44	17544.07	230108.51	207230.37
3	9601.38	14840.39	24441.77	226579.34	18842.55	245421.89	220980.12
4	10136.94	15787.34	25924.28	239756.46	20107.23	259863.69	233939.41
5	10328.89	16240.28	26569.17	243761.55	20623.31	264384.86	237815.69

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

**Table: J-2-a: Unduplicated Participants**

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)		
		Level of Care:	Level of Care:	Level of Care:
		Hospital	Nursing Facility	ICF/IID
Year 1	7972	1487	556	5929
Year 2	10881	2193	739	7949
Year 3	13015	2699	877	9439
Year 4	13654	2814	926	9914
Year 5	14209	2903	971	10335

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 9)**

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

*Average Length of Stay is calculated by dividing the total number of projected enrollment days for the year by the number of projected unduplicated participants served during the year.*

*The total number of enrollment days for the year is calculated by summing the product of each month's projected enrollment multiplied by the number of calendar days in each month. Monthly projected enrollment is generally based on historical enrollment experience in waivers WI.0413, WI.0414, and WI.0415. Children on the waitlist are assumed to enroll October 2017 through July 2019. Additional capacity is added to ensure Factor C is not exceeded in the event of unforeseen enrollment spikes. After all members on the waitlist are enrolled, enrollment growth is assumed to slow to 4% per year based on post-waitlist growth experienced in the State's other waivers with similar levels of care.*

*The number of unduplicated participants served during the year is calculated by adding the number of members expected to disenroll during the year to the projected participant count at the end of the year. A churn factor based on the waiver's historical monthly disenrollment rate is applied to the projected monthly member count to calculate the number of members projected to disenroll each month. The sum of the monthly disenrollments is then added to the projected member count at year end to arrive at the total number of unduplicated participants served during the year.*

## **Appendix J: Cost Neutrality Demonstration**

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### **J-2: Derivation of Estimates (3 of 9)**

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

*The Factor D estimate is generally based on actual CY2014 waiver service costs in the CMS 372 reports. This is the most recent reporting year available. Alternate data sources were used for the following services:*

*Transition of Early Intensive Behavior Intervention and Consultative Behavior Intervention to benefits under Wisconsin's Medicaid State Plan is assumed to be completed by December 31, 2016. Much of the cost of these services is transitioned to State plan service costs; however, some existing waiver services are increased anticipating increased demand due to the transition.*

*Services in the current waivers shifting to EPSDT services in the State plan are assumed to changeover throughout CY2017 and be completely transitioned by December 31, 2017. Nursing Services are moved entirely to the State plan. A portion of Adaptive Aids and Specialized Medical and Therapeutic Services are assumed to be covered by the State plan and are transitioned accordingly. Encounter data indicates no EPSDT services reported for Community Integration Services, Counseling and Therapeutic Services, and Supportive Home Care-Personal Care; therefore no adjustments are necessary for these services.*

*Child Care Services, Relocation Services, and Training for Parents/Guardians & Families of Children with Disabilities have been added as new services. Cost and utilization are based on similar services in the existing children's waivers. Adjustments were made assuming Child Care will reduce Respite utilization and Relocation will replace Housing Start-up.*

*Supported Employment is split between Individuals and Small Groups based on membership in each employment situation assumed in other waivers. This change was made based on the September 16, 2011 CMS Informational Bulletin updating the 1915(c) Waiver Instructions and Technical Guide regarding employment and employment related services. In this guidance, supported employment was changed into two separate 1915(c) waiver services, Supported Employment-Individual and Supported Employment-Small Group.*

*Consumer and Family Directed Supports has been eliminated as a separately reported service. Members are still self-directing services, but the services are being reported in the category of the service received.*

*Costs are trended forward using the Consumer Price Index for All Items. A trend of 0.1% is applied in CY2015 and a trend 2.0% is applied in all other years.*

*The unduplicated participant count in the derivation is projected using the same method to derive Average Length of Stay as described above.*

**ii. Factor D' Derivation.** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

***Factor D' is based on actual CY2014 service costs paid by the State Medicaid plan for waiver members and estimated EPSDT services provided as waiver services under the current approved waivers. The portion of Factor D' related to self-directed personal care services is from certified encounter data. All other State plan service costs in Factor D' are pulled from the same Medicaid fee-for-service paid claims data in the State's MMIS used as for CY2014 CMS 372 reporting.***

***Costs are trended forward using the Consumer Price Index for Medical Care. A trend of 2.6% is applied in CY2015 and a trend of 2.8% is applied in all other years.***

***The unduplicated participant count used in the derivation is projected using the same method to derive Average Length of Stay as described above.***

**iii. Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*



Factor G is based on a blend of CY2014 Medicaid institutional costs for children residing in State Centers, Institutes for Mental Disease(IMDs), and Nursing Facilities as well as inpatient hospital stays to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State’s MMIS. Costs are trended forward using the Consumer Price Index for All Items. A trend of 0.1% is applied in CY2015 and a trend 2.0% is applied in all other years.

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay (ALOS) between the institutional populations and the waiver population. With the institutional population having a lower ALOS than the waiver participants, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional populations are adjusted by the ratio of the institutional ALOS to the wavier ALOS, which increases Factors G and G' for the waiver population relative to the institutional population.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on a blend of CY2014 Medicaid non-institutional costs for children residing in State Centers, Institutes for Mental Disease(IMDs), and Nursing Facilities as well as inpatient hospital stays to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State’s MMIS. Costs are trended forward using the Consumer Price Index for Medical Care. A trend of 2.6% is applied in CY2015 and a trend of 2.8% is applied in all other years.

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay (ALOS) between the institutional populations and the waiver population. With the institutional population having a lower ALOS than the waiver participants, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional populations are adjusted by the ratio of the institutional ALOS to the wavier ALOS, which increases Factors G and G' for the waiver population relative to the institutional population.

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Consumer Education and Training	
Day Services	
Respite	
Support and Service Coordination	
Supported Employment – Individual	
Supportive Home Care	
Financial Management Services	
Adaptive Aids	
Adult Family Home	
Child Care Services	
Children's Foster Care	
Communication Aids/Assistive Technology/Interpreter Services	
Community Integration Services	
Counseling and Therapeutic Services	
Daily Living Skills Training	

Waiver Services	
Home Modification	
Housing Counseling	
Mentoring	
Nursing Services	
Personal Emergency Response System (PERS)	
Relocation Services	
Specialized Medical and Therapeutic Supplies	
Supported Employment - Small Group	
Training for Parents/Guardians & Families of Children with Disabilities	
Transportation	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937).** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Consumer Education and Training Total:</b>							208610.89
Consumer Education and Training	<input type="checkbox"/>	Hours	327	18.47	34.54	208610.89	
<b>Day Services Total:</b>							284363.81
Day Services	<input type="checkbox"/>	Hours	102	208.83	13.35	284363.81	
<b>Respite Total:</b>							14599961.52
Respite	<input type="checkbox"/>	Hours	3614	224.56	17.99	14599961.52	
<b>Support and Service Coordination Total:</b>							16533438.50
Support and Service Coordination	<input type="checkbox"/>	25.94	7862	25.94	81.07	16533438.50	
<b>Supported Employment – Individual Total:</b>							28085.59
Supported Employment – Individual	<input type="checkbox"/>	Hours	6	287.35	16.29	28085.59	
<b>GRAND TOTAL:</b>							70124785.29
Total: Services included in capitation:							
Total: Services not included in capitation:							7972
Total Estimated Unduplicated Participants:							8796.39
Factor D (Divide total by number of participants):							8796.39
Services included in capitation:							8796.39
Services not included in capitation:							
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Supportive Home Care Total:</b>							5567658.89
Supportive Home Care - Days		Days	28	153.59	138.63	596181.09	
Supportive Home Care - Hours		Hours	809	304.52	20.18	4971477.80	
<b>Financial Management Services Total:</b>							833361.42
Financial Management Services		Hours	2694	7.42	41.69	833361.42	
<b>Adaptive Aids Total:</b>							1652793.08
Other		Items	1025	7.96	75.23	613801.57	
Vehicle Modifications		Items	107	2.71	3583.10	1038991.51	
<b>Adult Family Home Total:</b>							1501869.13
Adult Family Home		Days	43	241.46	144.65	1501869.13	
<b>Child Care Services Total:</b>							3433859.24
Child Care Services		Hours	850	224.56	17.99	3433859.24	
<b>Children's Foster Care Total:</b>							5450419.72
Children's Foster Care		Days	222	197.82	124.11	5450419.72	
<b>Communication Aids/Assistive Technology/Interpreter Services Total:</b>							75203.28
Communication Aids/Assistive Technology/Interpreter Services		Items	130	11.08	52.21	75203.28	
<b>Community Integration Services Total:</b>							540000.73
Community Integration Services		Days	31	158.43	109.95	540000.73	
<b>Counseling and Therapeutic Services Total:</b>							6327885.47
Counseling and Therapeutic Services - Hours		Hours	1414	81.16	54.41	6244104.66	
Counseling and Therapeutic Services - Items		Items	97	1.99	434.03	83780.81	
<b>Daily Living Skills</b>							8949927.57
<b>GRAND TOTAL:</b>							70124785.29
Total: Services included in capitation:							
Total: Services not included in capitation:							70124785.29
Total Estimated Unduplicated Participants:							7972
Factor D (Divide total by number of participants):							8796.39
Services included in capitation:							
Services not included in capitation:							8796.39
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Training Total:</b>							
Daily Living Skills Training		Hours	1902	221.75	21.22	8949927.57	
<b>Home Modification Total:</b>							
Home Modification		Projects	294	2.52	2122.98	1572873.42	
<b>Housing Counseling Total:</b>							
Housing Counseling		Hours	4	19.05	30.65	2335.53	
<b>Mentoring Total:</b>							
Mentoring		Hours	423	103.58	33.78	1480048.41	
<b>Nursing Services Total:</b>							
Nursing Services		Hours	3	170.04	27.84	14201.74	
<b>Personal Emergency Response System (PERS) Total:</b>							
Personal Emergency Response System (PERS)		Each	129	7.05	29.96	27247.12	
<b>Relocation Services Total:</b>							
Relocation Services		Projects	6	1.00	7058.90	42353.40	
<b>Specialized Medical and Therapeutic Supplies Total:</b>							
Specialized Medical and Therapeutic Supplies		Items	887	29.40	23.16	603961.85	
<b>Supported Employment - Small Group Total:</b>							
Supported Employment - Small Group		Hours	2	287.35	11.50	6609.05	
<b>Training for Parents/Guardians &amp; Families of Children with Disabilities Total:</b>							
Training for Parents/Guardians & Families of Children with Disabilities		Hours	327	4.00	54.41	71168.28	
<b>Transportation Total:</b>							
Specialized Transportation - Miles		Miles	310	787.22	0.52	126899.86	
<b>GRAND TOTAL:</b>							70124785.29
Total: Services included in capitation:							70124785.29
Total: Services not included in capitation:							7972
Total Estimated Unduplicated Participants:							8796.39
Factor D (Divide total by number of participants):							8796.39
Services included in capitation:							8796.39
Services not included in capitation:							8796.39
Average Length of Stay on the Waiver:							285

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Transportation - Trips		Trips	175	64.66	16.76	189647.78	
<b>GRAND TOTAL:</b>							70124785.29
Total: Services included in capitation:							
Total: Services not included in capitation:							70124785.29
Total Estimated Unduplicated Participants:							7972
Factor D (Divide total by number of participants):							8796.39
Services included in capitation:							
Services not included in capitation:							8796.39
Average Length of Stay on the Waiver:							285

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Consumer Education and Training Total:</b>							285898.70
Consumer Education and Training		Hours	444	18.20	35.38	285898.70	
<b>Day Services Total:</b>							387958.56
Day Services		Hours	139	206.44	13.52	387958.56	
<b>Respite Total:</b>							20235509.99
Respite		Hours	4922	222.59	18.47	20235509.99	
<b>Support and Service Coordination Total:</b>							23047891.81
Support and Service Coordination		Hours	10723	25.94	82.86	23047891.81	
<b>Supported Employment – Individual Total:</b>							43706.17
Supported Employment – Individual		Hours	9	288.89	16.81	43706.17	
<b>Supportive Home Care Total:</b>							7801575.30
<b>GRAND TOTAL:</b>							97682794.80
Total: Services included in capitation:							
Total: Services not included in capitation:							97682794.80
Total Estimated Unduplicated Participants:							10881
Factor D (Divide total by number of participants):							8977.37
Services included in capitation:							
Services not included in capitation:							8977.37
Average Length of Stay on the Waiver:							284

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Home Care - Days		Days	38	154.36	149.67	877916.33	
Supportive Home Care - Hours		Hours	1101	303.94	20.69	6923658.98	
<b>Financial Management Services Total:</b>							1142466.15
Financial Management Services		Hours	3644	7.37	42.54	1142466.15	
<b>Adaptive Aids Total:</b>							1955687.49
Other		Items	693	10.44	76.78	555497.16	
Vehicle Modifications		Items	143	2.68	3653.56	1400190.33	
<b>Adult Family Home Total:</b>							2213578.43
Adult Family Home		Days	59	243.12	154.32	2213578.43	
<b>Child Care Services Total:</b>							4756701.56
Child Care Services		Hours	1157	222.59	18.47	4756701.56	
<b>Children's Foster Care Total:</b>							7737559.38
Children's Foster Care		Days	313	195.05	126.74	7737559.38	
<b>Communication Aids/Assistive Technology/Interpreter Services Total:</b>							105581.52
Communication Aids/Assistive Technology/Interpreter Services		Items	175	10.91	55.30	105581.52	
<b>Community Integration Services Total:</b>							818115.31
Community Integration Services		Days	44	162.73	114.26	818115.31	
<b>Counseling and Therapeutic Services Total:</b>							8979023.81
Counseling and Therapeutic Services - Hours		Hours	1941	81.57	55.98	8863166.17	
Counseling and Therapeutic Services - Items		Items	132	1.99	441.06	115857.64	
<b>Daily Living Skills Training Total:</b>							12421204.29
<b>GRAND TOTAL:</b>							97682794.80
Total: Services included in capitation:							
Total: Services not included in capitation:							97682794.80
Total Estimated Unduplicated Participants:							10881
Factor D (Divide total by number of participants):							8977.37
Services included in capitation:							
Services not included in capitation:							8977.37
Average Length of Stay on the Waiver:							284

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Daily Living Skills Training		Hours	2597	219.50	21.79	12421204.28	
<b>Home Modification Total:</b>							2138241.60
Home Modification		Projects	396	2.50	2159.84	2138241.60	
<b>Housing Counseling Total:</b>							2949.38
Housing Counseling		Hours	5	18.87	31.26	2949.38	
<b>Mentoring Total:</b>							2148694.73
Mentoring		Hours	596	104.65	34.45	2148694.73	
<b>Nursing Services Total:</b>							0.00
Nursing Services		Hours	0	0.00	0.01	0.00	
<b>Personal Emergency Response System (PERS) Total:</b>							37609.23
Personal Emergency Response System (PERS)		Each	176	7.02	30.44	37609.23	
<b>Relocation Services Total:</b>							68526.81
Relocation Services		Projects	9	1.00	7614.09	68526.81	
<b>Specialized Medical and Therapeutic Supplies Total:</b>							811526.13
Specialized Medical and Therapeutic Supplies		Items	1164	29.38	23.73	811526.13	
<b>Supported Employment - Small Group Total:</b>							6858.25
Supported Employment - Small Group		Hours	2	288.89	11.87	6858.25	
<b>Training for Parents/Guardians &amp; Families of Children with Disabilities Total:</b>							98499.19
Training for Parents/Guardians & Families of Children with Disabilities		Hours	446	3.98	55.49	98499.19	
<b>Transportation Total:</b>							437430.99
Specialized Transportation - Miles		Miles	425	782.10	0.53	176168.02	
<b>GRAND TOTAL:</b>							97682794.80
Total: Services included in capitation:							97682794.80
Total: Services not included in capitation:							10881
Total Estimated Unduplicated Participants:							8977.37
Factor D (Divide total by number of participants):							8977.37
Services included in capitation:							8977.37
Services not included in capitation:							284
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Transportation - Trips		Trips	237	63.98	17.23	261262.97	
<b>GRAND TOTAL:</b>							97682794.80
Total: Services included in capitation:							
Total: Services not included in capitation:							97682794.80
Total Estimated Unduplicated Participants:							10881
Factor D (Divide total by number of participants):							8977.37
Services included in capitation:							
Services not included in capitation:							8977.37
Average Length of Stay on the Waiver:							284

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 3

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Consumer Education and Training Total:</b>							362123.19
Consumer Education and Training		Hours	530	18.89	36.17	362123.19	
<b>Day Services Total:</b>							489613.45
Day Services		Hours	166	214.82	13.73	489613.45	
<b>Respite Total:</b>							25786064.98
Respite		Hours	5883	231.79	18.91	25786064.98	
<b>Support and Service Coordination Total:</b>							29442172.21
Support and Service Coordination		Hours	12823	27.14	84.60	29442172.21	
<b>Supported Employment – Individual Total:</b>							57771.93
Supported Employment – Individual		Hours	11	304.64	17.24	57771.93	
<b>Supportive Home Care Total:</b>							9985474.10
<b>GRAND TOTAL:</b>							124961949.96
Total: Services included in capitation:							
Total: Services not included in capitation:							124961949.96
Total Estimated Unduplicated Participants:							13015
Factor D (Divide total by number of participants):							9601.38
Services included in capitation:							
Services not included in capitation:							9601.38
Average Length of Stay on the Waiver:							296



Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Home Care - Days		Days	45	161.92	156.84	1142798.98	
Supportive Home Care - Hours		Hours	1316	317.55	21.16	8842675.13	
<b>Financial Management Services Total:</b>							1445689.15
Financial Management Services		Hours	4343	7.67	43.40	1445689.15	
<b>Adaptive Aids Total:</b>							2468163.20
Other		Items	827	10.82	78.34	700997.29	
Vehicle Modifications		Items	170	2.79	3725.84	1767165.91	
<b>Adult Family Home Total:</b>							2916562.33
Adult Family Home		Days	71	255.51	160.77	2916562.33	
<b>Child Care Services Total:</b>							6057511.78
Child Care Services		Hours	1382	231.79	18.91	6057511.78	
<b>Children's Foster Care Total:</b>							9970920.17
Children's Foster Care		Days	379	203.39	129.35	9970920.17	
<b>Communication Aids/Assistive Technology/Interpreter Services Total:</b>							135894.29
Communication Aids/Assistive Technology/Interpreter Services		Items	209	11.31	57.49	135894.29	
<b>Community Integration Services Total:</b>							1099301.35
Community Integration Services		Days	54	173.24	117.51	1099301.35	
<b>Counseling and Therapeutic Services Total:</b>							11573901.70
Counseling and Therapeutic Services - Hours		Hours	2327	85.63	57.34	11425626.31	
Counseling and Therapeutic Services - Items		Items	158	2.09	449.02	148275.38	
<b>Daily Living Skills Training Total:</b>							15823632.66
<b>GRAND TOTAL:</b>							124961949.96
Total: Services included in capitation:							
Total: Services not included in capitation:							124961949.96
Total Estimated Unduplicated Participants:							13015
Factor D (Divide total by number of participants):							9601.38
Services included in capitation:							
Services not included in capitation:							9601.38
Average Length of Stay on the Waiver:							296

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Daily Living Skills Training		Hours	3108	228.41	22.29	15823632.66	
<b>Home Modification Total:</b>							2694364.92
Home Modification		Projects	471	2.60	2200.20	2694364.92	
<b>Housing Counseling Total:</b>							3743.35
Housing Counseling		Hours	6	19.57	31.88	3743.35	
<b>Mentoring Total:</b>							2799880.19
Mentoring		Hours	722	110.42	35.12	2799880.19	
<b>Nursing Services Total:</b>							0.00
Nursing Services		Hours	0	0.00	0.01	0.00	
<b>Personal Emergency Response System (PERS) Total:</b>							47622.46
Personal Emergency Response System (PERS)		Each	210	7.32	30.98	47622.46	
<b>Relocation Services Total:</b>							92099.04
Relocation Services		Projects	11	1.00	8372.64	92099.04	
<b>Specialized Medical and Therapeutic Supplies Total:</b>							1023727.36
Specialized Medical and Therapeutic Supplies		Items	1384	30.49	24.26	1023727.36	
<b>Supported Employment - Small Group Total:</b>							11122.41
Supported Employment - Small Group		Hours	3	304.64	12.17	11122.41	
<b>Training for Parents/Guardians &amp; Families of Children with Disabilities Total:</b>							118794.07
Training for Parents/Guardians & Families of Children with Disabilities		Hours	535	3.93	56.50	118794.08	
<b>Transportation Total:</b>							555799.67
Specialized Transportation - Miles		Miles	510	816.12	0.54	224759.45	
<b>GRAND TOTAL:</b>							124961949.96
Total: Services included in capitation:							124961949.96
Total: Services not included in capitation:							13015
Total Estimated Unduplicated Participants:							9601.38
Factor D (Divide total by number of participants):							9601.38
Services included in capitation:							9601.38
Services not included in capitation:							296
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Transportation - Trips		Trips	282	66.51	17.65	331040.22	
<b>GRAND TOTAL:</b>							124961949.96
Total: Services included in capitation:							
Total: Services not included in capitation:							124961949.96
Total Estimated Unduplicated Participants:							13015
Factor D (Divide total by number of participants):							9601.38
Services included in capitation:							
Services not included in capitation:							9601.38
Average Length of Stay on the Waiver:							296

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Consumer Education and Training Total:</b>							400986.92
Consumer Education and Training		Hours	556	19.55	36.89	400986.92	
<b>Day Services Total:</b>							545419.00
Day Services		Hours	175	222.62	14.00	545419.00	
<b>Respite Total:</b>							28558810.02
Respite		Hours	6174	239.92	19.28	28558810.02	
<b>Support and Service Coordination Total:</b>							32616368.00
Support and Service Coordination		Hours	13453	28.10	86.28	32616368.00	
<b>Supported Employment – Individual Total:</b>							61303.44
Supported Employment – Individual		Hours	11	316.83	17.59	61303.44	
<b>Supportive Home Care Total:</b>							11061103.80
<b>GRAND TOTAL:</b>							138409757.19
Total: Services included in capitation:							
Total: Services not included in capitation:							138409757.19
Total Estimated Unduplicated Participants:							13654
Factor D (Divide total by number of participants):							10136.94
Services included in capitation:							
Services not included in capitation:							10136.94
Average Length of Stay on the Waiver:							307

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Home Care - Days		Days	47	167.62	159.96	1260187.27	
Supportive Home Care - Hours		Hours	1382	328.63	21.58	9800916.52	
<b>Financial Management Services Total:</b>							1600838.62
Financial Management Services		Hours	4560	7.93	44.27	1600838.62	
<b>Adaptive Aids Total:</b>							2724800.12
Other		Items	868	11.19	79.96	776645.08	
Vehicle Modifications		Items	178	2.88	3800.24	1948155.03	
<b>Adult Family Home Total:</b>							3213370.08
Adult Family Home		Days	74	264.78	164.00	3213370.08	
<b>Child Care Services Total:</b>							6707203.52
Child Care Services		Hours	1450	239.92	19.28	6707203.52	
<b>Children's Foster Care Total:</b>							11060284.27
Children's Foster Care		Days	397	211.17	131.93	11060284.27	
<b>Communication Aids/Assistive Technology/Interpreter Services Total:</b>							150201.65
Communication Aids/Assistive Technology/Interpreter Services		Items	219	11.69	58.67	150201.65	
<b>Community Integration Services Total:</b>							1209061.38
Community Integration Services		Days	56	180.13	119.86	1209061.38	
<b>Counseling and Therapeutic Services Total:</b>							12817916.89
Counseling and Therapeutic Services - Hours		Hours	2439	88.70	58.49	12653685.66	
Counseling and Therapeutic Services - Items		Items	166	2.16	458.03	164231.24	
<b>Daily Living Skills Training Total:</b>							17529533.54
<b>GRAND TOTAL:</b>							138409757.19
Total: Services included in capitation:							
Total: Services not included in capitation:							138409757.19
Total Estimated Unduplicated Participants:							13654
Factor D (Divide total by number of participants):							10136.94
Services included in capitation:							
Services not included in capitation:							10136.94
Average Length of Stay on the Waiver:							307

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Daily Living Skills Training		Hours	3261	236.39	22.74	17529533.54	
<b>Home Modification Total:</b>							2995488.88
Home Modification		Projects	496	2.69	2245.09	2995488.88	
<b>Housing Counseling Total:</b>							3943.38
Housing Counseling		Hours	6	20.21	32.52	3943.38	
<b>Mentoring Total:</b>							3100606.06
Mentoring		Hours	755	114.65	35.82	3100606.06	
<b>Nursing Services Total:</b>							0.00
Nursing Services		Hours	0	0.00	0.01	0.00	
<b>Personal Emergency Response System (PERS) Total:</b>							52696.16
Personal Emergency Response System (PERS)		Each	220	7.58	31.60	52696.16	
<b>Relocation Services Total:</b>							106543.56
Relocation Services		Projects	12	1.00	8878.63	106543.56	
<b>Specialized Medical and Therapeutic Supplies Total:</b>							1135074.60
Specialized Medical and Therapeutic Supplies		Items	1455	31.52	24.75	1135074.60	
<b>Supported Employment - Small Group Total:</b>							11795.58
Supported Employment - Small Group		Hours	3	316.83	12.41	11795.58	
<b>Training for Parents/Guardians &amp; Families of Children with Disabilities Total:</b>							131562.02
Training for Parents/Guardians & Families of Children with Disabilities		Hours	561	4.07	57.62	131562.02	
<b>Transportation Total:</b>							614845.70
Specialized Transportation - Miles		Miles	534	845.35	0.55	248279.30	
<b>GRAND TOTAL:</b>							138409757.19
Total: Services included in capitation:							138409757.19
Total: Services not included in capitation:							13654
Total Estimated Unduplicated Participants:							10136.94
Factor D (Divide total by number of participants):							10136.94
Services included in capitation:							10136.94
Services not included in capitation:							307
Average Length of Stay on the Waiver:							

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Transportation - Trips		Trips	296	68.80	18.00	366566.40	
<b>GRAND TOTAL:</b>							138409757.19
Total: Services included in capitation:							
Total: Services not included in capitation:							138409757.19
Total Estimated Unduplicated Participants:							13654
Factor D (Divide total by number of participants):							10136.94
Services included in capitation:							
Services not included in capitation:							10136.94
Average Length of Stay on the Waiver:							307

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 5

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Consumer Education and Training Total:</b>							426264.43
Consumer Education and Training		Hours	579	19.58	37.60	426264.43	
<b>Day Services Total:</b>							579698.03
Day Services		Hours	182	223.05	14.28	579698.03	
<b>Respite Total:</b>							30312592.25
Respite		Hours	6426	240.06	19.65	30312592.25	
<b>Support and Service Coordination Total:</b>							34601486.16
Support and Service Coordination		Hours	14001	28.09	87.98	34601486.16	
<b>Supported Employment – Individual Total:</b>							68103.17
Supported Employment – Individual		Hours	12	316.70	17.92	68103.17	
<b>Supportive Home Care Total:</b>							11725326.28
<b>GRAND TOTAL:</b>							146763172.19
Total: Services included in capitation:							
Total: Services not included in capitation:							146763172.19
Total Estimated Unduplicated Participants:							14209
Factor D (Divide total by number of participants):							10328.89
Services included in capitation:							
Services not included in capitation:							10328.89
Average Length of Stay on the Waiver:							306

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supportive Home Care - Days		Days	49	167.44	162.15	1330369.40	
Supportive Home Care - Hours		Hours	1438	328.58	22.00	10394956.88	
<b>Financial Management Services Total:</b>							1702832.25
Financial Management Services		Hours	4750	7.94	45.15	1702832.25	
<b>Adaptive Aids Total:</b>							2903644.63
Other		Items	905	11.20	81.61	827198.96	
Vehicle Modifications		Items	186	2.88	3876.28	2076445.67	
<b>Adult Family Home Total:</b>							3391225.92
Adult Family Home		Days	77	264.50	166.51	3391225.92	
<b>Child Care Services Total:</b>							7122940.29
Child Care Services		Hours	1510	240.06	19.65	7122940.29	
<b>Children's Foster Care Total:</b>							11692879.47
Children's Foster Care		Days	411	211.46	134.54	11692879.47	
<b>Communication Aids/Assistive Technology/Interpreter Services Total:</b>							159766.66
Communication Aids/Assistive Technology/Interpreter Services		Items	229	11.70	59.63	159766.66	
<b>Community Integration Services Total:</b>							1271799.10
Community Integration Services		Days	58	179.69	122.03	1271799.10	
<b>Counseling and Therapeutic Services Total:</b>							13569192.31
Counseling and Therapeutic Services - Hours		Hours	2536	88.62	59.60	13394523.07	
Counseling and Therapeutic Services - Items		Items	173	2.16	467.43	174669.24	
<b>Daily Living Skills Training Total:</b>							18589517.14
<b>GRAND TOTAL:</b>							146763172.19
Total: Services included in capitation:							
Total: Services not included in capitation:							146763172.19
Total Estimated Unduplicated Participants:							14209
Factor D (Divide total by number of participants):							10328.89
Services included in capitation:							
Services not included in capitation:							10328.89
Average Length of Stay on the Waiver:							306

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Daily Living Skills Training		Hours	3392	236.53	23.17	18589517.14	
<b>Home Modification Total:</b>							3187163.76
Home Modification		Projects	517	2.69	2291.72	3187163.76	
<b>Housing Counseling Total:</b>							4026.95
Housing Counseling		Hours	6	20.24	33.16	4026.95	
<b>Mentoring Total:</b>							3276511.11
Mentoring		Hours	783	114.52	36.54	3276511.11	
<b>Nursing Services Total:</b>							0.00
Nursing Services		Hours	0	0.00	0.01	0.00	
<b>Personal Emergency Response System (PERS) Total:</b>							55962.84
Personal Emergency Response System (PERS)		Each	229	7.58	32.24	55962.84	
<b>Relocation Services Total:</b>							108101.52
Relocation Services		Projects	12	1.00	9008.46	108101.52	
<b>Specialized Medical and Therapeutic Supplies Total:</b>							120882.13
Specialized Medical and Therapeutic Supplies		Items	1517	31.56	25.25	120882.13	
<b>Supported Employment - Small Group Total:</b>							12018.76
Supported Employment - Small Group		Hours	3	316.70	12.65	12018.76	
<b>Training for Parents/Guardians &amp; Families of Children with Disabilities Total:</b>							139689.24
Training for Parents/Guardians & Families of Children with Disabilities		Hours	584	4.07	58.77	139689.24	
<b>Transportation Total:</b>							653547.79
Specialized Transportation - Miles		Miles	556	845.69	0.56	263314.04	
<b>GRAND TOTAL:</b>							146763172.19
Total: Services included in capitation:							146763172.19
Total: Services not included in capitation:							14209
Total Estimated Unduplicated Participants:							10328.89
Factor D (Divide total by number of participants):							10328.89
Services included in capitation:							10328.89
Services not included in capitation:							306
Average Length of Stay on the Waiver:							



Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Transportation - Trips		Trips	309	68.86	18.34	390233.75	
<b>GRAND TOTAL:</b>							146763172.19
<i>Total: Services included in capitation:</i>							
<i>Total: Services not included in capitation:</i>							146763172.19
<b>Total Estimated Unduplicated Participants:</b>							14209
<b>Factor D (Divide total by number of participants):</b>							10328.89
<i>Services included in capitation:</i>							
<i>Services not included in capitation:</i>							10328.89
<b>Average Length of Stay on the Waiver:</b>							306