1915(i) State plan Home and Community-Based Services Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. Services. *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

Housing Consultation
Housing Transition
Housing Sustaining
Relocation Supports

2. Concurrent Operation with Other Programs. (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

◉	**Not applicable**
○	**Applicable**

Check the applicable authority or authorities:

☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** 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 1915(i) State plan HCBS. 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. *Specify:* *(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 specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**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:*

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

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§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 §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

◉	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	◉	The Medical Assistance Unit *(name of unit)*:	Division of Medicaid Services
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☒ *(By checking this box the state assures that):* When the Medicaid agency does not directly conduct an administrative 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. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☐	☐
3 Review of participant service plans	☑	☐	☒	☐
4 Prior authorization of State plan HCBS	☑	☐	☐	☐
5 Utilization management	☑	☐	☐	☐
6 Qualified provider enrollment	☑	☐	☒	☐
7 Execution of Medicaid provider agreement	☑	☐	☒	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐	☒	☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

Function 3: Review of participant service plans – The contracted entity is the State Medicaid Agency's External Quality Review Organization (EQRO), MetaStar

Function 6: Qualified provider enrollment – The contracted entity is the State Medicaid Agency's (SMA's) fiscal agency , Gainwell Technologies

Function 7: Execution of Medicaid Provider Agreement – The contracted entity is the SMA's fiscal agency, Gainwell Technologies

Function 10: Quality Assurance and quality improvement activities – The contracted Entity is the SMA's EQRO, MetaStar

(By checking the following boxes the State assures that):

5. ☒ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

The state opts to allow certain providers (i.e. supportive housing agencies) of state plan HCBS to perform the individual assessment and develop care plans for the same recipients to whom they are also providing state plan HCBS in the following situations:

1) such providers are the only willing and qualified entities in certain geographic areas who can perform the individual assessments and develop the individual service plans. The Department will evaluate gaps in capacity and provider shortages and establish steps to address these barriers to access for recipients of these services. Once a provider shortage no longer exists in a given area, the Department will prohibit 1915(i) state plan HCBS direct service providers from conducting assessments and care plan development. The Department believes provider shortages will initially exist in all areas of the state outside of the city of Milwaukee.
2) such providers are the only willing and qualified providers with experience and knowledge to provide services to individuals who share a common language or cultural background.

In order to ensure conflict of interest standards are met, the Department will put these safeguards in place:

- The Department will prohibit the same professional within the same supportive housing agency from conducting both the plan of care and providing state plan HCBS to the same recipient.
- Supportive housing agencies that provide both care plan development, and state plan HCBS must document the use of different professionals.
- The supportive housing agency that develops the person-centered service plan must administratively separate the plan development function from the direct service provider functions.
- Recipients who receive state plan HCBS from the same agency that provided the care plan development, are protected by fair hearing rights and the ability to change providers. Provider entities must receive prior authorization from the Department before providing services to recipients when the entity also created a care plan.
- Recipients who receive state plan HCBS from the same agency that provided the care plan development will be provided full disclosure of the conflict of interest.
- The care plan must indicate that recipients were notified of the conflicts and the dispute resolution process, and that the client has exercised their right in free choice of provider after notification of the conflict.
- Recipients will be supported in exercising their right to free choice of providers and will be provided information about the full range of services available, not just the services furnished by the entity that is responsible for the person-centered service plan development;
- Recipients may file a grievance to dispute that there is not another entity who is not the individual's service provider to develop their person-centered service plan.
- The Department will provide direct oversight and periodic evaluation of safeguards.

6. ☒ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☒ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☒ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual

an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. Projected Number of Unduplicated Individuals To Be Served Annually.

(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/1/25	1 /1/26	390
Year 2			
Year 3			
Year 4			
Year 5			

2. ☒ **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☒ **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☐ The State does not provide State plan HCBS to the medically needy.

☒ The State provides State plan HCBS to the medically needy. (*Select one*):

☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.

☒ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. Responsibility for Performing Evaluations / Reevaluations. Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

◉ Directly by the Medicaid agency

○	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

Individuals at the state that review the evaluation and verify eligibility will be required to hold Bachelor's degrees from an accredited four-year college or university.

To ensure integrity of the process, staff evaluating eligibility for Housing Support Services complete initial and ongoing training conducted by the State Medicaid Agency. Training provides guidance on the requirements and responsibilities of 1915(i) evaluation/ reevaluation.

3. Process for Performing Evaluation/Reevaluation. Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

The supportive housing agency completes the assessment of need developed by the State Medicaid Agency with the potential member. Supportive housing agencies will be instructed on how to assess the individual's needs for 1915(i) housing support services. The State Medicaid Agency receives the assessment of need from the supportive housing agency and will review the results, verify eligibility requirements, and determine 1915(i) eligibility.

This same process is used for both evaluation and reevaluation.

4. ☒ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☒ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

The needs-based criteria an individual must meet to be deemed eligible for 1915i Housing Support Services are as follows:
-Due to homelessness or due to symptoms of a substance use condition and/or a mental health condition, the individual must require assistance with at least two of the following:

- Managing finances
- Maintaining housing stability
- Managing Behavioral health symptoms
- Managing Medication
- Managing Substance use related needs
- Making Decisions
- Coordinating Healthcare needs or services
- Coordinating Transportation

And the individual must be experiencing housing instability, which is evidenced by meeting one of the following risk factors –

- The individual lacks a fixed, regular, and adequate nighttime residence, (HUD Category 1 Homeless)
- The individual will imminently lose their primary nighttime residence, provided that: (1) Residence will be lost within 14 days; (2) No subsequent residence has been identified; *and* (3) The individual lacks the resources or support networks needed to obtain other permanent housing. (HUD Category 2 Homeless)
- The individual is defined as homeless under the other listed federal statutes, provided that: (1) the individual has not had a lease, ownership interest in permanent housing during the 60 days prior to application; (2) has experienced persistent instability as measured by two moves or more during in the preceding 60 days; and (3) can be expected to continue in such status for an extended period of time due to special needs or barriers. (HUD Category 3 Homeless)
- The individual is fleeing/attempting to flee domestic violence ("Domestic Violence" includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual that either takes place in, or makes the individual afraid to return to, their primary nighttime residence, including human trafficking). (HUD Category 4 Homeless.)

6. ☒ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart*

below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
The needs-based criteria an individual must meet to be deemed eligible for 1915i Housing Support Services are as follows: -Due to homelessness or due to symptoms of a substance use condition and/or a mental health condition, the individual must require assistance with at least two of the following: • Managing finances • Maintaining housing stability • Managing Behavioral health symptoms • Managing Medication • Managing Substance use related needs. • Making Decisions • Coordinating Healthcare needs or services • Coordinating Transportation	The person must have a long-term care condition or have a condition that is expected to result in death within one year. The person's condition must meet one or more of the target group definitions that are eligible for publicly funded long-term care programs in Wisconsin. These eligible target groups are: i) Frail elder: An individual aged 65 or older who has a physical disability, or an irreversible dementia, that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently. Wisconsin Admin. Code § DHS 10.13(25m) ii) Physical disability: A physical condition, including an anatomical loss, or musculoskeletal, neurological,	The person must have a long-term care condition or have a condition that is expected to result in death within one year. The person must meet the federal definition of intellectual disability, defined as having: (i) A level of intellectual disability described in the American Association of Intellectual and Developmental Disabilities' Manual on Classification in Intellectual Disability, or (ii) A related condition as defined by 42 C.F.R. § 435.1010 which states, "Person with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions: (a) It is attributable to: 1. Cerebral palsy or epilepsy or 2. Any other condition, other than mental illness, found to be closely related to intellectual disability because this condition	For inpatient hospital psychiatric emergency detention or involuntary commitment, state statutes require that: i) The individual is mentally ill, drug dependent, or developmentally disabled; ii) The individual presents an immediate danger of harm to self or others based on a recent act or omission; and iii) Inpatient hospitalization is the least restrictive placement consistent with the requirements of the individual (i.e. the individual's needs can only be met on an inpatient basis). IMD hospital admissions nearly always occur on emergency detention or involuntary commitment basis. For a voluntary admission (to a psychiatric unit of a general hospital), the inpatient services must: i) Directed by a physician or dentist; and ii) Be medically necessary as certified by a physician or dentist. Among the

And the individual must be experiencing housing instability, which is evidenced by meeting one of the following risk factors – • The individual lacks a fixed, regular, and adequate nighttime residence, (HUD Category 1 Homeless) •The individual will imminently lose their primary nighttime residence, provided that: (1) Residence will be lost within 14 days; (2) No subsequent residence has been identified; and (3) The individual lacks the resources or support networks needed to obtain other permanent housing. (HUD Category 2 Homeless) •The individual is defined as homeless under the other listed federal statutes, provided that: (1) the individual has not had a lease, ownership interest in permanent housing during the 60 days prior to application. (2) has experienced persistent instability as measured by two moves or more during in the preceding 60 days; and	respiratory, or cardiovascular impairment, which results from injury, disease, or congenital disorder and which significantly interferes with or significantly limits at least one major life activity of a person." Wisconsin Stat. § 15.197(4)(a)2. iii) Alzheimer's disease or other irreversible dementia (onset any age): A degenerative disease of the central nervous system characterized especially by premature senile mental deterioration and also includes any other irreversible deterioration of intellectual faculties with concomitant emotional disturbance resulting from organic brain disorder. Per Wisconsin Stat. § 46.87(1)(a) iv) A terminal condition with death expected within one year from the date of screening for long term care needs.	results in impairment of general intellectual functioning or adaptive behavior similar to that of intellectually disabled persons, and requires treatment or services similar to those required for these persons. (b) It is manifested before the person reaches age 22. (c) It is likely to continue indefinitely. (d) It results in substantial functional limitations in three or more of the following areas of major life activity: self-care; understanding and use of language; learning; mobility; self-direction; or capacity for independent living. If a person with an intellectual/developmental disability (I/DD) has no other health condition, he or she must meet the intellectual/developmental disability per FEDERAL definition target group in order to be eligible for IRIS. If the person does not meet the federal definition of intellectual disability, then they may meet the state definition of developmental disability, as defined as	criteria in the state definition of "medical necessity" is the requirement that the service (e.g., inpatient hospitalization) is the most appropriate level of service that can safely and effectively be provided to the recipient/individual.

(3) can be expected to continue in such status for an extended period of time due to special needs or barriers. (HUD Category 3 Homeless) •The individual is fleeing/attempting to flee domestic violence ("Domestic Violence" includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual that either takes place in, or makes the individual afraid to return to, their primary nighttime residence, including human trafficking). (HUD Category 4 Homeless.)		meaning: • A disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, intellectual disability, or another neurological condition closely related to an intellectual disability or requiring treatment similar to that required for individuals with an intellectual disability, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual. • 'Developmental disability' does not include senility which is primarily caused by the process of aging or the infirmities of aging. Wisconsin Stat. § 51.01(5)(a). The person whose condition meets one of the disability definitions must have a need for assistance from another person to complete activity of daily living/instrumental	

		activity of daily living (ADL/IADL) or health-related services (HRS) tasks that are directly related to the conditions(s) that qualified the person for a target group.	

*Long Term Care/Chronic Care Hospital
**LOC= level of care

7. ☒ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Housing Support Services are targeted to individuals who must meet all of the following criteria:
1) age 18 and older and
2) have a mental health condition, and/or substance use condition

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box the State assures that):

8. ☒ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) 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 person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* **one**

ii.	**Frequency of services**. The state requires (select one):	
	◉	**The provision of 1915(i) 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 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☒ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

   (Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Housing Sustaining Services are provided to members living in housing that complies with Federal home and community-based settings requirements at 42 CFR 441.710. The housing will be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community. No individuals will be housed in non-compliant settings as detailed in § 441.710(a)(2). Under this initiative, members will be housed in apartments/homes in residential settings. The individual will be able to choose the apartment/home that he or she would like to reside in where they hold a lease with a landlord or housing/property management agency and will receive the housing sustaining services. No individuals will be placed in settings that are provider controlled.

If the housing was built before 1978 and the home has original doors or windows or there is visible interior and exterior areas with chipping or peeling paint, then agencies will refer members and landlords to Wisconsin's Lead-Safe Homes Program. The Lead Safe Homes Program provides repairs to owner-occupied and rental properties to make them lead-safe. Lead-safe repairs provided through the program include new windows, doors, painting, and other household repairs for individuals living in housing built before 1978.Housing will adhere to federal nondiscrimination laws that require providers to grant requests for reasonable accommodations and modifications in housing. These laws prohibit agencies from refusing services to persons with disabilities, or placing conditions on their residency, because they require reasonable accommodations or modifications.

Housing Transition and Housing Consultation services may be provided in settings such as the street, in a shelter, in a hotel/motel or other settings in the community in which the person dwells or receives services. They may also be provided to members doubled up with family/friends in the community. Individuals will transition from these settings to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Housing Relocation services are provided to individuals exiting from an institutional setting or another provider operated living arrangement to a living arrangement in a private residential setting in the community where the member is directly responsible for his/her own living expenses. Relocation services may be provided to members who have exited from the following provider operated/controlled settings:

- An overnight or a day homeless shelter per Wis. Admin. Code § 86.02
- Medically monitored residential SUD treatment and transitional treatment facilities certified in Wisconsin under Wis. Admin. Code § DHS 75
- Recovery residence per Wis. Stat. § 46.234
- In-Patient Hospital per DHS 124
- A warming shelter or extreme heat cooling center
- A domestic violence shelter per Wis. Admin. Code 49.165d

The State Medicaid Agency assures that this state plan amendment will be subject to applicable provisions and requirements. The SMA determined that the following settings would typically meet the compliance requirements of 42 C.F.R. § 441.301(c)(4):

- The participant's private residence whether owned or rented
- Community sites predominantly used by the general public for typical community activities, including but not limited to: retail establishments; schools; recreational and entertainment facilities; libraries; places of religious worship; public and private transportation settings such as buses, trains, and private vehicles; restaurants;

community centers; professional offices; non-disability related service establishments; streets; and other public accommodations
- Family's private residence, whether owned or rented

While these settings are viewed as integrated in the community, the SMA will not assume that in each instance they meet the HCBS settings rule requirements. As part of ongoing monitoring for HCBS settings compliance for the 1915(i) State Plan Amendment, settings in which services are delivered will be assessed by the supportive housing agency to ensure that the setting is not designed in such a way that it isolates the individual from the greater community. This assessment will occur at the time of development of the person-centered housing support plan and at reviews of that plan on at least an annual basis. The person-centered housing support plan will document the settings where services are received. The State's External Quality Review Organization will verify that settings meet HCBS compliance during the annual Quality Improvement Strategy review.

Person-Centered Planning & Service Delivery

(By checking the following boxes the state assures that):

1. ☒ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☒ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☒ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The independent assessment is completed by supportive housing agency staff that are either behavioral health professionals or a social services worker who is a graduate of an accredited four-year college or university.

Individuals performing this function have the following minimum qualifications:

- Demonstrates an understanding of how behavioral health issues can affect housing;
- Demonstrate an understanding of how housing instability can affect the health of people with behavioral health conditions and
- Experienced in conducting social and health assessments.

All supportive housing agency staff must complete the following training provided by the Institute for Community Alliances:

Homeless Management Information System Security and Privacy Training 2022
Data Standards Changes Training
Homeless History Tracking Form
Chronic Homeless Definition
HMIS Data Standards Manual
Definition of Homeless

The Department will review the results of the independent assessment conducted by the supportive housing agency and will verify requirements.

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The Medicaid provider conducting the housing consultation will act as a Case Manager and assist participants in gaining access to needed services (medical, social, educational and other needs). The housing consultation provider will also be responsible for the development of the person-centered housing supports plan, which identifies a member's needs and presents options. The qualifications for the housing consultation provider includes the following:

- Bachelor's Degree from an accredited college or university or equivalent related experience or training
- Competency to assess the needs of persons served and knowledge of the resources available to meet those needs.
- Trained in HMIS data entry processes or HMIS-comparable database
- Trained in evidence-based model of care for interviewing and engagement (ex: Motivational Interviewing, Cultural Competency, and Trauma Informed Care)

Appropriate knowledge and experience with local community resources

Further information on Housing Consultation services is in the Services section of this attachment.

6. **Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

Person-centered planning principles are used in the development of the housing support plan, which creates a process that incorporates the foundational components of partnerships, evocation, support autonomy, and empathy. Person-centered planning includes engaging participants and their representatives, as appropriate and determined by the participant, in the person planning process and supporting participants in directing the process to the extent that they choose. Participants have full authority to determine who is included in the person- centered planning process. Additionally, the development of the person-centered plan will occur in the location of the participants' choice.

The Department's web site offers a considerable amount of information and training for Medicaid recipients, family/peer supports and providers regarding person-centered service delivery. This includes an online training certificate that is free and open to all. The training provides an extensive overview of the core components and elements of Person-Centered Planning practice. Information on the training is available at: PCP: Training | Wisconsin Department of Health Services.

The Department's website also includes a person-centered planning toolkit, a person-centered planning practice profile, and resources on Wisconsin's person-centered planning model. Person-centered planning resources can be found at: Person-Centered Planning | Wisconsin Department of Health Services.

The materials on the website will also be provided in print form for program participants.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

Upon completion of the assessment of need and consenting the member's participation for services, supportive housing agency staff will inform the eligible members of which housing consultation

providers are in their region and allow the member to select a provider. If a member does not have a preference, it is current practice for agencies to know which housing consultation providers have the capacity to serve new members. If the member has no preference, this will be documented in the person-centered plan.

Once a housing consultant has developed the person-centered housing support plan in partnership with the member, the consultant will then inform the member of the supportive housing agencies available to deliver the housing transition services. Once the member chooses their supportive housing provider they will begin receiving housing transition services. Once a member is housed, the supportive housing provider will follow the same process to transition the member to housing sustaining services.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The State Medicaid Agency will review a sample of approved service plans to: assess whether the needs of the participants are being addressed, identify best practices and quality improvement opportunities, and identify areas of technical assistance. Annual samples will be generated for each agency operating the program. Samples will be representative of the population enrolled. All participants enrolled at least 60 days with the agency will be included in the sampling pool. The sample size will have a 95% confidence interval and 5% margin of error. The State Medicaid Agency's external quality review organization, MetaStar will conduct the reviews. The SMA will complete remediation activities. The SMA will work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results.

Assessment information will be entered into the SMA's ForwardHealth portal for SMA review.

9. **Maintenance of Person-Centered 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 §74.53. Service plans are maintained by the following *(check each that applies):*

☐	Medicaid agency	☐	Operating agency	☒	Case manager
☐	Other (*specify):*				

Services

1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Housing Consultation
Service Definition (Scope)*:*	
Housing consultation assists participants in gaining access to needed state plan and waiver services as well as to needed medical, social, educational, and other needed services, regardless of the funding source for the services to which access is gained. Housing consultation providers are responsible for the development of person-centered housing support service plans. Housing consultation identifies	

and evaluates a member's needs to present options through the person-centered service plan. This will include:

- Conducting an individualized screening that identifies the member's preferences for, and barriers to, housing –including factors such as accessibility and affordability;
- Identifying other needs related to accessing non-Medicaid services and Medicaid services including referrals to these other needed services and supports; and
- Collaboratively developing a person-centered housing support plan based on the identified needs.

Housing consultants are responsible for the ongoing monitoring of the provision of services included in the participant's service plan, Housing consultants annually re-evaluate the individual's level of care and modify service plans as needed.

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*

	Housing consultation services may only be billed after completion of the person-centered housing support plan**.** Housing consultation services are available one time, annually unless the member becomes homeless or experiences a significant change in a condition that impacts their housing, or when a person requests an update or change to their plan. To avoid conflict of interest, an individual cannot receive housing consultation services and housing transition or housing sustaining services from the same employee at a given provider organization. Services may not be duplicated by any other services provided through a Home & Community Based Services 1915(c) waiver. Housing Consultation services may be provided to individuals who are transitioning or exiting from -provider-operated living arrangements to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Housing Consultation services may also be provided to individuals residing in settings such as the street or doubled up with family/friends and are transitioning to living arrangements in a private residence where the person is directly responsible for his or her own living expenses. The state will not allow housing consultation services to be provided prior to 1915i enrollment. Individuals may select a different provider for each of the services: (1) the housing consultation service, (2) housing transition service, (3) housing sustaining service, and (4) relocation supports.
☒	Medically needy *(specify limits):*
	Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Supportive Housing Agency	none	none	Agencies are limited to those agencies who are enrolled as Supportive Housing Providers under the Wisconsin Medicaid Provider process and agreement.
Individual	none	none	Be employed by an enrolled billing/rendering group provider; and meet the following criteria: - Bachelor's Degree from an accredited college or university or equivalent related experience or training - Appropriate knowledge and experience with local community resources - Competency to assess the needs of persons served and knowledge of the resources available to meet those needs. - Trained HMIS data entry processes or HMIS-comparable databases used by

			service victim survivors - Trained in evidence based model of care for interviewing and engagement (ex: Motivational Interviewing, Cultural Competency, and Trauma Informed Care)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Supportive Housing Agency	Wisconsin Department of Health Services SMA's fiscal agent, Gainwell Technologies	Every three (3) years
Individual hired by supportive housing agency	Wisconsin Department of Health Services SMA's fiscal agent, Gainwell Technologies	Every three (3) years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Housing Transition

Service Definition (Scope)*:*

Assist members to prepare for and transition to housing. These supports include:

- Assisting the individual with and providing education on the housing search, including assisting the individual with the following activities: searching for available housing; identifying the adequacy and availability of transportation in areas under consideration; completing the application for housing assistance and an application for the residence itself; and gathering documentation for rental applications;
- Coaching the member on landlord outreach and lease/rental agreement review;
- Ensuring that housing units are safe and ready for move-in that meet Housing Quality Standards under 24 CFR 567.403; assessing potential health risks to ensure living environment is not adversely affecting occupants' health; and confirming that units meet the Federal HCBS requirements per 42 CFR 441.710(a)(a)1-2);
- Connecting the member to community-based resources that provide assistance with activities through securing required documents and fees needed to apply for housing and making any reasonable accommodation request(s) related to disability to a housing provider.

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope

than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits):*

Housing Transition services are limited to 150 hours annually. Additional hours beyond this threshold may be authorized by the Department.

Housing Transition services are not covered when a recipient is concurrently receiving housing sustaining services.

To avoid conflict of interest, an individual cannot receive housing consultation services and Housing Transition services from the same employee at a given provider organization.

Housing Transition Services may not be duplicated by any other services provided through a Home & Community Based Services 1915(c) waiver.

Housing Transition services may be provided to individuals who are transitioning or exiting from provider-operated living arrangements to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Housing Transition services may also be provided to individuals residing in settings such as the street or doubled up with family/friends and are transitioning to living arrangements in a private residence where the person is directly responsible for his or her own living expenses.

The state will not allow housing transition services to be provided prior to 1915i enrollment.

Individuals may select a different provider for each of the services: (1) the housing consultation service, (2) housing transition service, (3) housing sustaining service, and (4) relocation supports.

Housing Transition services **do not** cover :

- Deposits
- Food
- Furnishings
- Rent
- Utilities
- Room and board
- Moving expenses

☒ Medically needy *(specify limits):*

Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Supportive Housing Agency	none	none	Agencies are limited to those agencies who are enrolled as Supportive Housing

			Providers under the Wisconsin Medicaid Provider process and agreement.
Individual	none	none	Be employed by an enrolled billing/rendering group provider; and meet the following criteria: - Bachelor's Degree from an accredited college or university or equivalent related experience or training - Appropriate knowledge and experience with local community resources - Competency to assess the needs of persons served and knowledge of the resources available to meet those needs. - Trained HMIS data entry processes or HMIS-comparable databases used by service victim survivors - Trained in evidence based model of care for interviewing and engagement (ex: Motivational Interviewing, Cultural Competency, and Trauma Informed Care)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Supportive Housing Agency	Wisconsin Department of Health Services SMA's fiscal agent, Gainwell Technologies	Every three (3) years
Individual hired by supportive housing agency	Wisconsin Department of Health Services SMA's fiscal agent, Gainwell Technologies	Every three (3) years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title:	Housing Sustaining

Service Definition (Scope)*:*

Provided once a member is housed to help them achieve and maintain housing stability and achieve the goals identified in the housing support plan. These supports include:

- Developing a plan, which must identify early prevention and intervention for behaviors or occurrences that may jeopardize housing (ex. Lease violation or hospitalization) and providing those interventions if housing is jeopardized. Interventions include assisting in reducing risk of eviction by providing services that help the member improve his or her

conflict resolution skills including coaching, role-playing and communication strategies targeted towards resolving disputes with landlords and neighbors; and coaching to develop and maintain key relationships with landlord/property manager and neighbors; communicating with landlords and neighbors to reduce the risk of eviction; addressing biopsychosocial behaviors that put housing at risk. The biopsychosocial approach systematically considers biological, psychological, and social factors and their complex interactions in understanding health and service delivery. All relevant biological, psychological, and social factors that might contribute to housing instability will be examined and referred to professionals for treatment, if needed. and providing support with activities related to household management; related activities could include helping to create a system for chores, financial organizing and assisting with schedules for meal preparation and pet care.

- Education on the role, rights, and responsibilities of the tenant and landlord;
- Connecting the member to community resources to maintain housing stability;
- Supporting individuals in the development of independent living skills, skills coaching and financial counseling; and
- Providing individualized coordination efforts connecting members with needed resources in accordance with the housing support plan.

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

None.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒	Categorically needy *(specify limits):*

	Housing Sustaining services are limited to 150 hours annually. Additional hours beyond this threshold may be authorized by the Department. To avoid conflict of interest, an individual cannot receive housing consultation services and Housing–Sustaining services from the same employee at a given provider organization. Housing Sustaining services will be provided in private units/apartments/homes in residential settings. The housing will be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community. Services may not be duplicated by any other services provided through a Home & Community Based Services 1915(c) waiver. The state will not allow housing sustaining services to be provided prior to 1915i enrollment. Individuals may select a different provider for each of the services: (1) the housing consultation service, (2) housing transition service, (3) housing sustaining service, and (4) relocation supports.
☒	Medically needy *(specify limits):*
	Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Supportive Housing Agency	none	none	Agencies are limited to those agencies who are enrolled as Supportive Housing Providers under the Wisconsin Medicaid Provider process and agreement.
Individual	none	none	Be employed by an enrolled billing/rendering group provider; and meet the following criteria: - Bachelor's Degree from an accredited college or university or equivalent related experience or training - Appropriate knowledge and experience with local community resources - Competency to assess the needs of persons served and knowledge of the resources available to meet those needs. - Trained HMIS data entry processes or HMIS-comparable databases used by service victim survivors - Trained in evidence based model of care for interviewing and engagement (ex: Motivational Interviewing, Cultural Competency, and Trauma Informed Care)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Supportive Housing Agency	Wisconsin Department of Health Services SMA's fiscal agent, Gainwell Technologies	Every three (3) years
Individual hired by supportive housing agency	Wisconsin Department of Health Services SMA's fiscal agent, Gainwell Technologies	Every three (3) years

Service Delivery Method. *(Check each that applies)*:			
☐	Participant-directed	☒	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	Relocation Supports

Service Definition (Scope)*:*

Non-recurring set-up expenses for members who are transitioning from a Medicaid-funded institution or another provider operated or controlled living arrangement to a living arrangement in a private residence where the member is directly responsible for his/her own living expenses. Approved payments are the following expenses to establish basic living arrangements:

- Security Deposits;
- Utility activation fees for electric, gas, internet, sewage, and telephone;
- Essential household furnishings - furniture, window coverings, food preparation items and bed/bath linens
  Health and Safety services: Services necessary for the member's health and safety including pest eradication and a one-time cleaning prior to occupancy.

Relocation Supports include assisting the member with moving into stable housing and providing assistance in obtaining furniture, commodities, or utilities set up.

The services under this 1915(i) benefit are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with SPA objectives of avoiding institutionalization.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

In addition to meeting the target group criteria previously stated, members must be transitioning from a Medicaid-funded institution or another provider-operated/controlled living arrangement to a living arrangement in a private residence where the member is directly responsible for his or her own living expenses.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any

individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☒ Categorically needy *(specify limits):*

Relocation Supports can only be used if no other resources have been identified. Security deposits cannot exceed one month's rent at Fair Market Rate (FMR) within the selected agencies region served as defined each Fiscal Year (FY) by the Department of Housing and Urban Development (HUD) Office of Policy Development and Research.

Relocation supports can be utilized once per relocation event/occurrence. The total provided to the member will not exceed a cap of $2,000 per relocation event/occurrence.

Relocation Supports are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense, or when the services cannot be obtained from other sources.

Relocation Supports will only be provided to individuals transitioning to a less restrictive setting, and for individuals transitioning from a Medicaid-funded institution or from provider-operated or controlled settings. The service is only provided to those transitioning to a private residence where the individual will be directly responsible for his or her own living expense.

Relocation Supports **do not** cover :

- Food
- Rent
- Room and board
- Moving expenses

Relocation Supports do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Services may not be duplicated by any other relocation services provided through a Home & Community Based Services 1915(c) waiver.

The state will not allow relocation supports to be provided prior to 1915i enrollment.

Relocation Supports may not be used to pay for furnishing living arrangements that are owned or leased by a HCBS provider where the provision of these items and services are inherent to the service they are already providing.

☒ Medically needy *(specify limits):*

Same limits as those for categorically needy.

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Other Standard *(Specify):*
Supportive Housing Agency	none	none	Agencies are limited to those agencies who are enrolled as Supportive Housing

			Providers under the Wisconsin Medicaid Provider process and agreement.
Individual	none	none	Be employed by an enrolled billing/rendering group provider; and meet the following criteria: - Bachelor's Degree from an accredited college or university or equivalent related experience or training - Appropriate knowledge and experience with local community resources - Competency to assess the needs of persons served and knowledge of the resources available to meet those needs. - Trained HMIS data entry processes or HMIS-comparable databases used by service victim survivors - Trained in evidence based model of care for interviewing and engagement (ex: Motivational Interviewing, Cultural Competency, and Trauma Informed Care)

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Supportive Housing Agency	Wisconsin Department of Health Services SMA's fiscal agent, Gainwell Technologies	Every three (3) years
Individual hired by supportive housing agency	Wisconsin Department of Health Services SMA's fiscal agent, Gainwell Technologies	Every three (3) years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☒	Provider managed

2. ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (S*elect one):*

◉	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (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 approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option)*:

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. Voluntary and Involuntary Termination of Participant-Direction. *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

◉	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**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.
	☐	**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.

b. Participant–Budget Authority (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

◉	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	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.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. **Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.**

2. **Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.**

3. **Providers meet required qualifications.**

4. **Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**

5. **The SMA retains authority and responsibility for program operations and oversight.**

6. **The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**

7. **The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.**

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	1a. Service plans address assessed needs of 1915(i) participants;
Discovery	
Discovery Evidence *(Performance Measure)*	Number of Service plans reviewed that address the assessed needs of the participants. Numerator: Number of service plans reviewed that addressed all assessed needs of the participant. Denominator: Number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95%

		Margin of Error +/- 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO ensures needed remediation is completed. EQRO and State Medicaid Agency: – Aggregate and analyze service-plan audit data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agency performance until the issue(s) is resolved. – Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and describes how service plans will be corrected.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		1b. Service plans are updated annually
Discovery		
	Discovery Evidence *(Performance Measure)*	Number of service plans reviewed that are updated annually. Numerator: Number of service plans reviewed that were updated at least annually. Denominator: Number of service plans reviewed.
	Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95% Margin of Error +/- 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO

Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO ensures needed remediation is completed. EQRO and State Medicaid Agency: – Aggregate and analyze service-plan audit data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agency performance until the issue(s) is resolved. – Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and describes how service plans will be corrected.
Frequency *(of Analysis and Aggregation)*	Annually

Requirement	1c. Service plans document choice of services and providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Number of service plans reviewed with documentation that participants were given choice of services and providers. Numerator: Number of service plans reviewed with documentation that participants were given choice of services and providers. Denominator: Number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95% Margin of Error +/- 5%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO
Frequency	Annually
Remediation	
Remediation Responsibilities	EQRO ensures needed remediation is completed.

	(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	EQRO and State Medicaid Agency: – Aggregate and analyze service-plan audit data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agency performance until the issue(s) is resolved. – Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and describes how service plans will be corrected.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		2a. An evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future
Discovery		
	Discovery Evidence *(Performance Measure)*	Number of applicants that received an independent evaluation to determine eligibility. Numerator: Number of applicants that received an independent evaluation. Denominator: All applicants for whom there is reasonable indication of need in the quarter under review.
	Discovery Activity *(Source of Data & sample size)*	100% review of applicants
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	EQRO and State Medicaid Agency - Aggregate and analyze applicant and assessment data. - Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. - Continuously monitor CE agencies' performance until the issue(s) is resolved.

	timeframes for remediation)	- Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.
	Frequency *(of Analysis and Aggregation)*	Ongoing

Requirement		2b. The processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately
Discovery		
	Discovery Evidence *(Performance Measure)*	Number of participants with a determination of 1915(i) eligibility using appropriate processes and instruments (the 1915i state developed eligibility evaluation). Numerator: Number of participants with a determination of 1915(i) eligibility using appropriate processes and instruments (the 1915i state developed eligibility evaluation). Denominator: Number of participant records reviewed
	Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95% Margin of Error +/- 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
	Frequency	Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO and State Medicaid Agency – Aggregate and analyze applicant and assessment data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor CE agencies' performance until the issue(s) is resolved. – Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.

Frequency *(of Analysis and Aggregation)*	Ongoing

Requirement	2c. The 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.
Discovery	
Discovery Evidence *(Performance Measure)*	Number of participants that received an annual reevaluation for eligibility. Numerator: Number of participant records reviewed that had an annual reevaluation for eligibility. Denominator: Number of participant records reviewed
Discovery Activity *(Source of Data & sample size)*	100% review of applicants
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency
Frequency	Quarterly
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO and State Medicaid Agency – Aggregate and analyze applicant and reevaluation data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor CE agencies' performance until the issue(s) is resolved. – Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.
Frequency *(of Analysis and Aggregation)*	Ongoing

Requirement	3. Providers meet required qualifications.
Discovery	
Discovery Evidence	Number of service providers (new and ongoing) that meet the required

	(Performance Measure)	qualifications prior to furnishing services. Numerator: Number of service plans that contained service providers who meet the required qualifications prior to furnishing services. Denominator: Total number of service plans reviewed.
	Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95% Margin of Error +/- 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO ensures needed remediation is completed. EQRO and State Medicaid Agency: – Aggregate and analyze service-plan audit data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agency performance until the issue(s) is resolved. – Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).
Discovery	
Discovery Evidence *(Performance Measure)*	Number of participant service plans that indicate a setting for service delivery that meets the home and community-based settings requirements as specified by this SPA and in accordance with 42 CFR 441.710(a)(1) and (2)

		Numerator: The number of participant records reviewed whose service plan indicate a setting for service delivery that meets the home and community-based settings requirements as specified by this SPA and in accordance with 42 CFR 441.710(a)(1) and (2) Denominator: Total number of participant records reviewed
	Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95% Margin of Error +/- 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO ensures needed remediation is completed. EQRO and State Medicaid Agency: – Aggregate and analyze service-plan audit data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agency performance until the issue(s) is resolved. – Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	5.1. The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	**(1)** Supportive housing agencies complete all required remediation activities. – Numerator: Number of participant records that have remediation completed. – Denominator: Number of participants reviewed.

	Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95% Margin of Error +/- 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO and State Medicaid Agency
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO ensures needed remediation is completed. EQRO and State Medicaid Agency: – Aggregate and analyze service-plan audit data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agencies' performance until the issue(s) is resolved. Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	5.2 The SMA retains authority and responsibility for program operations and oversight.
Discovery	
Discovery Evidence *(Performance Measure)*	2. Participants report satisfaction with services and supports provided through the program on satisfaction survey. - Numerator: Number of participants who report satisfaction with services and supports provided through the program. - Denominator: Number of participants who provided response to satisfaction surveys.
Discovery Activity *(Source of Data & sample size)*	Annual Satisfaction Survey Results
Monitoring	EQRO and State Medicaid Agency

	Responsibilities *(Agency or entity that conducts discovery activities)*	
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO and State Medicaid Agency: – Aggregate and analyze data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agencies' performance until the issue(s) is resolved. Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.
Discovery	
Discovery Evidence *(Performance Measure)*	Number of services authorized on the service plan for participants that are paid in accordance with the reimbursement methodology as specified in the SPA. Numerator: Number of service plans reviewed that demonstrate authorized services were paid. Denominator: Number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95% Margin of Error +/- 5%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO
Frequency	Annually

Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO ensures needed remediation is completed. EQRO and State Medicaid Agency: – Aggregate and analyze data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agencies' performance until the issue(s) is resolved. – Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	7.1. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery	
Discovery Evidence *(Performance Measure)*	1.Number of incidents of abuse, neglect, and exploitation that are appropriately and timely addressed by the supportive housing agency. Numerator: Number of case records that indicate a provider took appropriate and timely action when they suspect incidences of abuse, neglect and exploitation. Denominator: Number of case records reviewed that indicate an incidence of abuse, neglect or exploitation may have occurred
Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95% Margin of Error +/- 5%
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO
Frequency	Annually
Remediation	

	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	EQRO and State Medicaid Agency: – Aggregate and analyze data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agencies' performance until the issue(s) is resolved. Address a pattern of substandard performance through the provision of technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		7.2 The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.
Discovery		
	Discovery Evidence *(Performance Measure)*	2. 2. Number and percent of participants who receive information about how to report abuse, neglect, and exploitation. Numerator: Number of participants with signed acknowledgement affirming receipt of information. Denominator: Total number of participants
	Discovery Activity *(Source of Data & sample size)*	Record Review Representative Sample of eligible population: Confidence Interval = 95% Margin of Error +/- 5%
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	EQRO
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required*	EQRO and State Medicaid Agency: – Aggregate and analyze data. – Work with supportive housing agencies to achieve remediation of substandard performance within 60 days of receiving results. – Continuously monitor supportive housing agencies' performance until the issue(s) is resolved. – Address a pattern of substandard performance through the provision of

	timeframes for remediation)	technical assistance, which may include a corrective action plan. The corrective action plan includes a timeline and details steps necessary to improve performance.
	Frequency *(of Analysis and Aggregation)*	Annually

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. Methods for Analyzing Data and Prioritizing Need for System Improvement

Discovery and remediation information comes from the continuous evaluation of the data collected for the performance measurements identified for each sub-assurance. Each performance measure is stated as a metric, and specifies a numerator and dominator, ensuring the performance measure is concise, answerable and measurable. When applicable, sample sizes and methods are based on a representative sample of the population (95% confidence level with a +/-5 percent margin of error.

The SMA routinely analyzes performance measure data for trends and opportunities for improvement. Improvement opportunities and intervention strategies will be prioritized, with priority given to participant health, welfare, and safety.

2. Roles and Responsibilities

The EQRO will conduct review activities and collect data for the applicable performance measures. The EQRO will monitor and ensure the completion of any needed remediation for the applicable performance measures.

DHS program and policy staff will review and analyze program operations, performance measures, and remediation data. The team will identify opportunities for system improvements (e.g., improved training, provider standards, etc.) Policy staff will review emerging issues that comprises participant, provider and community representatives.

3. Frequency

The EQRO will provide results to the Department of Health Services (DHS) on an ongoing basis DHS will review and analyze program process and outcome data on an ongoing basis.

4. Method for Evaluating Effectiveness of System Changes

For performance measures trending near or below 85%, DHS will discuss and plan quality improvement strategies. After the strategies has been implemented, performance measure data will be reviewed quarterly to ensure data is trending toward desired outcomes. Participant health, welfare, and safety will be prioritized above all else. DHS will routinely monitor improvement initiatives and conduct targeted/evaluative assessment to gauge the effectiveness of the interventions it implements.

Methods and Standards for Establishing Payment Rates

1. Services Provided Under Section 1915(i) of the Social Security Act. For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care
For Individuals with Chronic Mental Illness, the following services:	
☐	HCBS Day Treatment or Other Partial Hospitalization Services
☐	HCBS Psychosocial Rehabilitation
☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)
☒	Other Services (specify below)
☒	Housing Consultation - Housing Consultation is paid at $84.36 per consultation, based on an average time estimate of 1.5 hours per consultation provided by supportive housing agencies. Medicaid will pay the lower of billed charges or the max fee schedule rate set by the state agency. Housing Consultation is reimbursed at a per 15-minute rate. The rate was validated against a number of unit-based case management rates for programs in Wisconsin Medicaid.
☒	Housing transition services are reimbursed at $14.06 per 15 minutes of service. Medicaid will pay the lower of billed charges or the max fee schedule rate set by the state agency. The rate was calculated using averages of the following information provided by supportive housing agencies: • Staff hourly salary and benefits • Administrative costs • Average time spent providing the following categories of service: Direct - Direct time includes any time spent administering housing transition services with

	the member (individual receiving transition) present, whether that is face-to-face, over the phone, or via video conference, etc. Member Specific Indirect - This includes any time spent providing housing transition services that can be attributed to a specific member, but where said member is not present. Travel - This includes time spent traveling to and from in-person meetings with a member or a collateral contact such as a landlord. Other - This includes all time spent working on housing transition services that is not member specific. For example, trainings on how to deliver housing transition services and team meetings that are not about a specific member. Providers cannot bill for travel time or time not specific to a given member. The rate was designed to cover this time.
☒	Housing sustaining services are reimbursed at $14.06 per 15 minutes of service. Medicaid will pay the lower of billed charges or the max fee schedule rate set by the state agency. This rate was calculated using averages of the following information provided by supportive housing agencies: • Staff hourly salary and benefits • Administrative costs • Average time spent providing the following categories of service: Direct - Direct time includes any time spent administering housing sustaining services with the member (individual receiving housing sustaining services) present, whether that is face-to-face, over the phone, or via video conference, etc. Member Specific Indirect - This includes any time spent providing housing sustaining services that can be attributed to a specific member, but where said member is not present. Travel - This includes time spent traveling to and from in-person meetings with a member or a collateral contact such as a landlord. Other - This includes all time spent working on housing sustaining services that is not member specific. For example, trainings on how to deliver housing sustaining services and team meetings that are not about a specific member. Providers cannot bill for travel time or time not specific to a given member. The rate was designed to cover this time.
☒	Relocation Supports- Relocation supports are reimbursed at cost up to a $2,000 limit set by the state agency. The $2,000 relocation supports service was established based upon the estimated costs of security deposits, utilities activations and essential home furnishings and health and safety services The $2,000 is the maximum for this service.