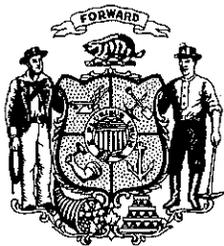


# State of Wisconsin

SENATE CHAIR  
**Alberta Darling**

317 East, State Capitol  
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Phone: (608) 266-5830



ASSEMBLY CHAIR  
**John Nygren**

308 East, State Capitol  
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Phone: (608) 266-2343

## Joint Committee on Finance

### MEMORANDUM

To: Members  
Joint Committee on Finance

From: Senator Alberta Darling  
Representative John Nygren

Date: May 10, 2019

Re: 14-Day Passive Review Approval – DHS

Pursuant to s. 20.940(4), Stats., attached is a 14-day passive review request from the Department of Health Services, received on May 10, 2019.

Please review the material and notify **Senator Darling** or **Representative Nygren** no later than **Thursday, May 30, 2019**, if you have any concerns about the request or if you would like the Committee to meet formally to consider it.

Also, please contact us if you need further information.

Attachments

AD:JN:jm



State of Wisconsin  
Department of Health Services

Tony Evers, Governor  
Andrea Palm, Secretary

MAY 10 2019  
St. Finance

May 9, 2019

The Honorable Alberta Darling, Senate Co-Chair  
Joint Committee on Finance  
Room 317 East  
State Capitol  
P.O. Box 7882  
Madison, WI 53707

The Honorable John Nygren, Assembly Co-Chair  
Joint Committee on Finance  
Room 309 East  
State Capitol  
P.O. Box 8953  
Madison, WI 53708

Dear Senator Darling and Representative Nygren:

Per s. 20.940(4), created by 2017 Act 370, I am submitting the proposed federal waiver renewal requests for the Family Care 1915(b) managed care waiver and the concurrent Family Care/Family Care Partnership 1915(c) community-based services waiver.

The expiration date of the current waivers for both programs is December 31, 2019. Prior to submission of the renewal requests to the Centers for Medicare and Medicaid Services (CMS), DHS must also provide public notice, offer a period for public comment on the proposed renewal, and engage in tribal consultation. It will take a period of up to three months to receive and evaluate these comments.

DHS must submit the renewal request to CMS no later than 90 days prior to expiration, or October 1, 2019. However, CMS recommends submission of the renewal request 120 days prior to expiration to allow sufficient time for CMS to complete its review. It is our goal to follow this recommendation and submit the waiver to CMS on September 2, 2019.

The Family Care and Family Care Partnership programs provide long-term care services and support to over 52,300 of Wisconsin's most vulnerable adults with physical and developmental disabilities and our frail elders. The daily supports provided through these programs are critical to allowing enrollees to continue living independently in their homes and communities. Given

Senator Alberta Darling  
Representative John Nygren  
May 9, 2019  
Page 2.

the crucial role of these programs, it is very important to receive federal approval prior to the current waivers' expiration date.

The 1915(b) waiver renewal request includes the following changes to the existing waiver:

- As required by federal regulations, requires MCOs to complete two performance improvement projects, one clinical and one non-clinical, per each two-year contract cycle.

The 1915(c) waiver renewal includes the following changes to the existing waiver:

- Requires all providers who have regular direct contact with a member to be subject to caregiver and criminal background checks. Previously, providers who were serving self-directing members were excluded from this requirement.
- Expands existing supportive home care service to add bug inspection and/or extermination services.
- Updates qualifications for individuals who perform the initial member level of care determinations.
- Per federal requirements, requires MCOs to obtain provider signatures on the member-centered plan (MCP) and to distribute the MCP to the member's essential providers.
- Removes MCP documentation requirements for members who have complex medication regimens, as the requirement duplicates documentation requirements in the member assessment.
- Defines one consistent methodology to determine member room and board financial obligation to be used by all MCOs.
- Changes the requirement for written notice of member incident investigation results to allow for verbal notice.
- Allows United Community Center to provide both case management and other waiver services to Hispanic members in Milwaukee County.

In addition, both the 1915(b) and 1915(c) renewal applications include updates to clarify language and realign the waivers with current practice.

Please contact me if you have any questions about these submissions.

Sincerely,



Andrea Palm  
Secretary-designee

## Facesheet: 1. Request Information (1 of 2)

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**A. The State of Wisconsin** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

**B. Name of Waiver Program(s):** Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program	
Family Care	Family Care	PIHP;	

**Waiver Application Title** (*optional - this title will be used to locate this waiver in the finder*):

B Waiver Renewal - Family Care 2020

**C. Type of Request.** This is an:

**Renewal request.**

**The State has used this waiver format for its previous waiver period.**

The renewal modifies (Sect/Part):

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

1 year

2 years

3 years

4 years

5 years

**Draft ID: WI.048.07.00**

**D. Effective Dates:** This renewal is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

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

01/01/20

**Proposed End Date:** 12/31/24

*Calculated as "Proposed Effective Date" (above) plus "Requested Approval Period" (above) minus one day.*

## Facesheet: 2. State Contact(s) (2 of 2)

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**E. State Contact:** The state contact person for this waiver is below:

**Name:**

Diane Poole

**Phone:**

(608) 267-4896

**Ext:**

**TTY**

**Fax:**

**E-mail:**

diane.poole@dhs.wisconsin.gov

**If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.**

**The State contact information is different for the following programs:**

### **Family Care**

*Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the*

## **Section A: Program Description**

### **Part I: Program Overview**

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#### **Tribal consultation.**

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

In September 2018, the SMA extended an invitation to all of its stakeholders (contracted PIHPs, tribes, members of the long-term care community, advocates, providers, etc.) to provide any ideas they would like the SMA to consider in preparing this waiver renewal. The SMA received numerous submissions and conducted extensive review of the submissions.

Major Wisconsin newspapers contained public notices on 5/31/2019 that the draft Family Care 1915(c) and (b) waiver renewal applications were available on the SMA's website for a 30-day public input period. The draft Family Care 1915(c) and (b) waiver renewal applications were posted for a 30-day public input period.

Wisconsin tribes received written notice that the draft Family Care waiver renewal applications were available on the SMA's website for a 30-day tribal input period on 5/31/19. The SMA also provided in person tribal consultation on 5/7/19 at the Mid-Year Tribal Consultation Meeting and on 5/8/19 at the Tribal Health Directors Meeting. The written notice, agendas, and meeting notes are included with this waiver renewal submission.

#### **Program History.**

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

Implementation of the Family Care program began in 1998 to reform the existing fragmented long-term care system in Wisconsin. The first members were enrolled in the managed long-term services and supports program in February of 2000. For several years, Family Care operated as a pilot program in five counties serving frail elders and adults with physical and intellectual and/or developmental disabilities.

With the assistance of a Real Choice Systems Change grant awarded in September 2004, Wisconsin began to expand Family Care geographically beyond the five pilot counties. In early 2007, the first expansion counties began operating. By February 2014, Family Care had expanded to 57 of Wisconsin's 72 counties and waitlists were eliminated in these counties. Family Care was expanded to the remaining Wisconsin counties as follows: Brown (7/1/15); Door (8/1/15); Kewaunee (6/1/15); Marinette (10/1/15); Menominee (11/1/15); Oconto (6/1/15); Shawano (9/1/15); Rock (7/1/16); Florence (7/1/17); Forest (7/1/17); Oneida (7/1/17); Taylor (7/1/17); Vilas (7/1/17); Dane (2/1/18); and Adams (7/1/18). Family Care became statewide with expansion to Adams county.

On 7/1/18, enrollment in a PIHP (aka Family Care MCO) became mandatory for the Family Care program. This was a technical change that did not, in reality, change anything for existing or prospective members. Enrollment in a PIHP has always been a requirement in Family Care. The SMA has always contracted with PIHPs to administer the program. These PIHPs are certified by the SMA and monitored under a comprehensive SMA-PIHP contract. All individuals are able to opt out of the Family Care program at any time.

On 7/1/18, the SMA established non-risk payments to PIHPs for Indian members receiving care management services from Indian Health Care Providers (IHCPs).

The Family Care target populations and program design have remained constant.

## Section A: Program Description

### Part I: Program Overview

#### A. Statutory Authority (1 of 3)

**1. Waiver Authority.** The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

- a. **1915(b)(1)** - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.  
*-- Specify Program Instance(s) applicable to this authority*

##### Family Care

- b. **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.  
*-- Specify Program Instance(s) applicable to this authority*

##### Family Care

- c. **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.  
*-- Specify Program Instance(s) applicable to this authority*

##### Family Care

- d. **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).  
*-- Specify Program Instance(s) applicable to this authority*

**Family Care**

The 1915(b)(4) waiver applies to the following programs

**MCO**

**PIHP**

**PAHP**

**PCCM** (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)

**FFS Selective Contracting program**

Please describe:

## Section A: Program Description

### Part I: Program Overview

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#### A. Statutory Authority (2 of 3)

**2. Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

- a. **Section 1902(a)(1) - Statewideness**--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.  
*-- Specify Program Instance(s) applicable to this statute*  

**Family Care**
- b. **Section 1902(a)(10)(B) - Comparability of Services**--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.  
*-- Specify Program Instance(s) applicable to this statute*  

**Family Care**
- c. **Section 1902(a)(23) - Freedom of Choice**--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.  
*-- Specify Program Instance(s) applicable to this statute*  

**Family Care**
- d. **Section 1902(a)(4) - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them.** (If state seeks waivers of additional managed care provisions, please list here).

In certain counties, dependent on RFP results, successful certification and contracting with PIHPs, Family Care members may only have one PIHP option.

*-- Specify Program Instance(s) applicable to this statute*

**Family Care**

- e. **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

-- Specify Program Instance(s) applicable to this statute

**Family Care**

**Section A: Program Description**

**Part I: Program Overview**

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**A. Statutory Authority (3 of 3)**

**Additional Information.** Please enter any additional information not included in previous pages:

**Section A: Program Description**

**Part I: Program Overview**

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**B. Delivery Systems (1 of 3)**

**1. Delivery Systems.** The State will be using the following systems to deliver services:

- a. **MCO:** Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
  
- b. **PIHP:** Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.
  - The PIHP is paid on a risk basis**
  - The PIHP is paid on a non-risk basis**
  
- c. **PAHP:** Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.
  - The PAHP is paid on a risk basis**
  - The PAHP is paid on a non-risk basis**
  
- d. **PCCM:** A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.
  
- e. **Fee-for-service (FFS) selective contracting:** State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.
  - the same as stipulated in the state plan**

**different than stipulated in the state plan**

Please describe:

**f. Other:** (Please provide a brief narrative description of the model.)

The PIHPs will not be at financial risk for Indian members choosing to receive care management from an Indian Health Care Provider (IHCP). The SMA will pay the PIHPs an interim monthly payment. The SMA will reconcile the interim payment so that the PIHP receives the difference between the total non-administrative portion of the interim payments the SMA paid the PIHP before the member's cost share was deducted and the full cost of services the PIHP paid for Indian members receiving care management from an IHCP. The SMA will determine the full cost of services to be reconciled by totaling all encounters the PIHP submitted to the SMA for Indian members receiving care management from the IHCP. The reconciliation will take place annually within eighteen months of the calendar year in which the Indian member received services. The reconciliation could include recoupments from the PIHPs if actual service costs are less than the payments they received from the SMA.

The administrative portion of the interim payments the SMA pays to the PIHP will be developed in accordance with the administrative rate methodology the SMA uses to develop the PIHP's capitation payment for other populations.

The SMA will submit claims for 100% federal financial participation for payments to PIHPs only for Indian members receiving care management through the IHCP and only for those services provided by an IHCP.

The SMA may choose to pay the PIHPs an interim payment equal to the PIHP's capitation payment for other populations. The SMA acknowledges that the cost data from the non-risk contract must be excluded from the data used to develop the capitation rates for the at-risk contracts.

The SMA will not need to establish a rate schedule for the 1915(c) waiver services within the PIHP contract. PIHPs and IHCPs can negotiate the rates the PIHP will pay as the interim payment to the IHCPs.

## Section A: Program Description

### Part I: Program Overview

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#### B. Delivery Systems (2 of 3)

**2. Procurement.** The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

**Procurement for MCO**

**Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

**Open** cooperative procurement process (in which any qualifying contractor may participate)

**Sole source** procurement

**Other** (please describe)

**Procurement for PIHP**

**Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

**Open** cooperative procurement process (in which any qualifying contractor may participate)

**Sole source** procurement

**Other** (please describe)

**Procurement for PAHP**

**Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

**Open** cooperative procurement process (in which any qualifying contractor may participate)

**Sole source** procurement

**Other** (please describe)

**Procurement for PCCM**

**Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

**Open** cooperative procurement process (in which any qualifying contractor may participate)

**Sole source** procurement

**Other** (please describe)

**Procurement for FFS**

**Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)

**Open** cooperative procurement process (in which any qualifying contractor may participate)

**Sole source** procurement

**Other** (please describe)

**Section A: Program Description**

**Part I: Program Overview**

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**B. Delivery Systems (3 of 3)**

**Additional Information.** Please enter any additional information not included in previous pages:

**Section A: Program Description**

**Part I: Program Overview**

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**C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)**

**1. Assurances.**

The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries ability to access services.

PIHP provider networks are robust enough to ensure access to all needed services and a choice of providers within the PIHP. PIHPs are also required to honor member's requests to enroll a provider in a PIHP's provider network to the extent appropriate and possible. If a PIHP does not have the capacity to meet the needs of the member, the PIHP is required to adequately and timely authorize and arrange for services with non-network providers.

**2. Details.** The State will provide enrollees with the following choices (please replicate for each program in waiver):

*Program: " Family Care. "*

**Two or more MCOs**

**Two or more primary care providers within one PCCM system.**

**A PCCM or one or more MCOs**

**Two or more PIHPs.**

**Two or more PAHPs.**

**Other:**

please describe

In most counties, members will have the choice of more than one PIHP. In all counties, the PIHP provider networks are robust enough to ensure access to all needed services.

**Section A: Program Description**

**Part I: Program Overview**

**C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)**

**3. Rural Exception.**

The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the following areas ( "rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

**4. 1915(b)(4) Selective Contracting.**

**Beneficiaries will be limited to a single provider in their service area**

Please define service area.

**Beneficiaries will be given a choice of providers in their service area**

**Section A: Program Description**

**Part I: Program Overview**

### C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

**Additional Information.** Please enter any additional information not included in previous pages:

Members eligible only for State Plan services, because they do not meet the level of care requirements for 1915 (c) waiver services, have the choice of receiving those Medicaid State Plan services through the PIHP or disenrolling and receiving state plan services through regular Medicaid if they financially qualify.

## Section A: Program Description

### Part I: Program Overview

#### D. Geographic Areas Served by the Waiver (1 of 2)

**1. General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

- **Statewide** -- all counties, zip codes, or regions of the State  
-- *Specify Program Instance(s) for Statewide*

Family Care

- **Less than Statewide**  
-- *Specify Program Instance(s) for Less than Statewide*

Family Care

**2. Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Menominee County	PIHP	Lakeland Care; Care Wisconsin
Rusk County	PIHP	Inclusa
Crawford County	PIHP	Inclusa; Care Wisconsin; My Choice Family Care
Juneau County	PIHP	Inclusa; Care Wisconsin; My Choice Family Care
Calumet County	PIHP	Community Care, Inc.; Lakeland Care
Chippewa County	PIHP	Inclusa; Care Wisconsin
Price County	PIHP	Inclusa
Manitowoc County	PIHP	Community Care, Inc.; Lakeland Care
Dodge County	PIHP	Care Wisconsin; Inclusa
Rock County	PIHP	My Choice Family Care; Inclusa
Kewaunee County	PIHP	Lakeland Care; Care Wisconsin
Waushara County	PIHP	Care Wisconsin; Inclusa
Taylor County	PIHP	Inclusa; Care Wisconsin
Kenosha County	PIHP	Community Care, Inc.; My Choice Family Care; Care Wisconsin
Oneida County	PIHP	Inclusa; Lakeland Care
Green County	PIHP	Inclusa; Care Wisconsin; My Choice Family Care
LaFayette County	PIHP	Inclusa; Care Wisconsin; My Choice Family

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
		Care
Fond du Lac County	PIHP	Community Care, Inc.; Lakeland Care
Marquette County	PIHP	Care Wisconsin; Inlusa
Outagamie County	PIHP	Community Care, Inc.; Lakeland Care
Waupaca County	PIHP	Community Care, Inc.; Lakeland Care
Burnett County	PIHP	Inlusa
Winnebago County	PIHP	Community Care, Inc.; Lakeland Care
Dunn County	PIHP	Inlusa; Care Wisconsin
Marinette County	PIHP	Lakeland Care; Care Wisconsin
Washburn County	PIHP	Inlusa
Dane County	PIHP	Care Wisconsin; My Choice Family Care
Racine County	PIHP	Community Care, Inc.; My Choice Family Care; Care Wisconsin
Jackson County	PIHP	Inlusa; Care Wisconsin; My Choice Family Care
St. Croix County	PIHP	Inlusa; Care Wisconsin
Trempealeau County	PIHP	Inlusa; Care Wisconsin; My Choice Family Care
Marathon County	PIHP	Inlusa; Lakeland Care
Waukesha County	PIHP	Care Wisconsin; Inlusa; Community Care, Inc.; My Choice Family Care
Ashland County	PIHP	Inlusa
Oconto County	PIHP	Lakeland Care; Care Wisconsin
Door County	PIHP	Lakeland Care; Care Wisconsin
Eau Claire County	PIHP	Inlusa; Care Wisconsin
Portage County	PIHP	Inlusa; Lakeland Care
Columbia County	PIHP	Care Wisconsin; Inlusa
Vernon County	PIHP	Inlusa; Care Wisconsin; My Choice Family Care
Richland County	PIHP	Inlusa; Care Wisconsin; My Choice Family Care
Shawano County	PIHP	Lakeland Care; Care Wisconsin
Brown County	PIHP	Lakeland Care; Care Wisconsin
Buffalo County	PIHP	Inlusa; Care Wisconsin; My Choice Family Care
Langlade County	PIHP	Inlusa; Lakeland Care
Milwaukee County	PIHP	Community Care, Inc.; My Choice Family Care; iCare
Pierce County	PIHP	Inlusa; Care Wisconsin
Wood County	PIHP	Inlusa; Lakeland Care
Florence County	PIHP	Inlusa; Lakeland Care
Iron County	PIHP	Inlusa
Pepin County	PIHP	Inlusa; Care Wisconsin; My Choice Family

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
		Care
Sauk County	PIHP	Inclusa; Care Wisconsin; My Choice Family Care
Washington County	PIHP	Care Wisconsin; Inclusa; Community Care, Inc.; My Choice Family Care
Polk County	PIHP	Inclusa
Iowa County	PIHP	Inclusa; Care Wisconsin; My Choice Family Care
Lincoln County	PIHP	Inclusa; Lakeland Care
Douglas County	PIHP	Inclusa
Vilas County	PIHP	Inclusa; Lakeland Care
Sawyer County	PIHP	Inclusa
Grant County	PIHP	Inclusa; Care Wisconsin; My Choice Family Care
Sheboygan County	PIHP	Care Wisconsin; Community Care, Inc.; My Choice Family Care; Inclusa
Jefferson County	PIHP	Care Wisconsin; Inclusa
Forest County	PIHP	Inclusa; Lakeland Care
LaCrosse County	PIHP	Inclusa; Care Wisconsin; My Choice Family Care
Clark County	PIHP	Inclusa; Care Wisconsin; My Choice Family Care
Walworth County	PIHP	Care Wisconsin; Community Care, Inc.; My Choice Family Care; Inclusa
Adams County	PIHP	Inclusa; Care Wisconsin
Monroe County	PIHP	Inclusa; Care Wisconsin; My Choice Family Care
Green Lake County	PIHP	Care Wisconsin; Inclusa
Barron County	PIHP	Inclusa
Bayfield County	PIHP	Inclusa
Ozaukee County	PIHP	Care Wisconsin; Community Care, Inc.; My Choice Family Care; Inclusa

## Section A: Program Description

### Part I: Program Overview

#### D. Geographic Areas Served by the Waiver (2 of 2)

**Additional Information.** Please enter any additional information not included in previous pages:

## Section A: Program Description

### Part I: Program Overview

## E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the States specific circumstances.

**1. Included Populations.** The following populations are included in the Waiver Program:

**Section 1931 Children and Related Populations** are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

**Mandatory enrollment**

**Voluntary enrollment**

**Section 1931 Adults and Related Populations** are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

**Mandatory enrollment**

**Voluntary enrollment**

**Blind/Disabled Adults and Related Populations** are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

**Mandatory enrollment**

**Voluntary enrollment**

**Blind/Disabled Children and Related Populations** are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

**Mandatory enrollment**

**Voluntary enrollment**

**Aged and Related Populations** are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

**Mandatory enrollment**

**Voluntary enrollment**

**Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

**Mandatory enrollment**

**Voluntary enrollment**

**TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Childrens Health Insurance Program (SCHIP) through the Medicaid program.

**Mandatory enrollment**

**Voluntary enrollment**

**Other** (Please define):

## Section A: Program Description

### Part I: Program Overview

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## E. Populations Included in Waiver (2 of 3)

**2. Excluded Populations.** Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the Aged population may be required to enroll into the program, but Dual Eligibles within that population may not be allowed to participate. In addition, Section 1931 Children may be able to enroll voluntarily in a managed care program, but Foster Care Children within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

**Medicare Dual Eligible** --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

**Poverty Level Pregnant Women** -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

**Other Insurance** --Medicaid beneficiaries who have other health insurance.

**Reside in Nursing Facility or ICF/IID** --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

**Enrolled in Another Managed Care Program** --Medicaid beneficiaries who are enrolled in another Medicaid managed care program

**Eligibility Less Than 3 Months** --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

**Participate in HCBS Waiver** --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

**American Indian/Alaskan Native** --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

**Special Needs Children (State Defined)** --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

**SCHIP Title XXI Children** Medicaid beneficiaries who receive services through the SCHIP program.

**Retroactive Eligibility** Medicaid beneficiaries for the period of retroactive eligibility.

**Other** (Please define):

## Section A: Program Description

### Part I: Program Overview

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## E. Populations Included in Waiver (3 of 3)

**Additional Information.** Please enter any additional information not included in previous pages:

1) Included Populations: Section 1931 Adults and Related Populations -

Only the subset of adults in this population with disabilities who are determined through functional screening to require a nursing home or non-nursing level of care are included.

2) Excluded Populations: Participate in HCBS Waiver -

Medicaid beneficiaries who participate in a different Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver) are excluded, except for the 1915(c) HCBS waiver (CMS control number WI.0367) that runs concurrently with this 1915(b) waiver.

## Section A: Program Description

### Part I: Program Overview

#### F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

##### 1. Assurances.

The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

## Section A: Program Description

### Part I: Program Overview

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#### F. Services (2 of 5)

- 2. Emergency Services.** In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

Emergency Services Category General Comments (optional):

Inpatient and outpatient services needed to evaluate or stabilize an emergency condition are not a covered benefit in Family Care PIHPs. PIHPs are responsible to instruct all members on where and how to obtain emergency services not covered in the PIHP benefit package. In addition, PIHP interdisciplinary care management teams are responsible to monitor the health conditions of members and to coordinate PIHP services with primary and acute health care services members receive from other sources. This includes responsibility for referring to, or arranging for, emergency services when necessary and ensuring the availability of transportation needed to access primary and acute health care services. PIHP member handbooks are required to explain that members should access emergency medical care as they would in any case, such as by calling 911.

- 3. Family Planning Services.** In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

The State will pay for all family planning services, whether provided by network or out-of-network providers.

Other (please explain):

Family planning services are not included under the waiver.

Family Planning Services Category General Comments (optional):

Family planning and emergency services are covered by the Medicaid State Plan available FFS.

## Section A: Program Description

### Part I: Program Overview

---

#### F. Services (3 of 5)

- 4. FQHC Services.** In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services.

The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period. The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:

The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

FQHC Services Category General Comments (optional):

FQHC services are not included in the Family Care benefit. A member may obtain FQHC services through the regular Medicaid Program while enrolled in this waiver program.

For Indians choosing to receive services from an Indian Health Care Provider (FQHC) under ARRA, those services, per CMS, are considered long-term care services and not FQHC services.

#### 5. EPSDT Requirements.

The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

EPSDT Requirements Category General Comments (optional):

EPSDT services are not included under the waiver.

## Section A: Program Description

### Part I: Program Overview

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#### F. Services (4 of 5)

##### 6. 1915(b)(3) Services.

This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

1915(b)(3) Services Requirements Category General Comments:

##### 7. Self-referrals.

The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the

MCO/PIHP/PAHP/PCCM contract:

Self-referrals Requirements Category General Comments:

**8. Other.**

Other (Please describe)

**Section A: Program Description**

**Part I: Program Overview**

---

**F. Services (5 of 5)**

**Additional Information.** Please enter any additional information not included in previous pages:

Family planning and emergency services are covered by the Medicaid State Plan available FFS.

Prescription drugs are carved out of the Family Care benefit.

**Section A: Program Description**

**Part II: Access**

---

**A. Timely Access Standards (1 of 7)**

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries access to emergency services and family planning services.

**1. Assurances for MCO, PIHP, or PAHP programs**

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS

Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

## Section A: Program Description

### Part II: Access

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#### A. Timely Access Standards (2 of 7)

**2. Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

- a. Availability Standards.** The States PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees access to the following providers. For each provider type checked, please describe the standard.

**1. PCPs**

*Please describe:*

**2. Specialists**

*Please describe:*

**3. Ancillary providers**

*Please describe:*

**4. Dental**

*Please describe:*

**5. Hospitals**

*Please describe:*

**6. Mental Health**

*Please describe:*

7. Pharmacies

*Please describe:*

8. Substance Abuse Treatment Providers

*Please describe:*

9. Other providers

*Please describe:*

## Section A: Program Description

### Part II: Access

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#### A. Timely Access Standards (3 of 7)

##### 2. Details for PCCM program. (Continued)

- b. **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The States PCCM Program includes established standards for appointment scheduling for waiver enrollees access to the following providers.

1. PCPs

*Please describe:*

2. Specialists

*Please describe:*

3. Ancillary providers

*Please describe:*

**4. Dental**

*Please describe:*

**5. Mental Health**

*Please describe:*

**6. Substance Abuse Treatment Providers**

*Please describe:*

**7. Urgent care**

*Please describe:*

**8. Other providers**

*Please describe:*

**Section A: Program Description**

**Part II: Access**

---

**A. Timely Access Standards (4 of 7)**

**2. Details for PCCM program. (Continued)**

**c. In-Office Waiting Times:** The States PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

**1. PCPs**

*Please describe:*

2. Specialists

*Please describe:*

3. Ancillary providers

*Please describe:*

4. Dental

*Please describe:*

5. Mental Health

*Please describe:*

6. Substance Abuse Treatment Providers

*Please describe:*

7. Other providers

*Please describe:*

## Section A: Program Description

### Part II: Access

#### A. Timely Access Standards (5 of 7)

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##### 2. Details for PCCM program. (Continued)

##### d. Other Access Standards

**Section A: Program Description**

**Part II: Access**

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**A. Timely Access Standards (6 of 7)**

**3. Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures timely access to the services covered under the selective contracting program.

**Section A: Program Description**

**Part II: Access**

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**A. Timely Access Standards (7 of 7)**

**Additional Information.** Please enter any additional information not included in previous pages:

**Section A: Program Description**

**Part II: Access**

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**B. Capacity Standards (1 of 6)**

**1. Assurances for MCO, PIHP, or PAHP programs**

The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

*If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.*

**Section A: Program Description**

**Part II: Access**

---

## B. Capacity Standards (2 of 6)

**2. Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a. The State has set **enrollment limits** for each PCCM primary care provider.

*Please describe the enrollment limits and how each is determined:*

- b. The State ensures that there are adequate number of PCCM PCPs with **open panels**.

*Please describe the States standard:*

- c. The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

*Please describe the States standard for adequate PCP capacity:*

## Section A: Program Description

### Part II: Access

---

## B. Capacity Standards (3 of 6)

**2. Details for PCCM program.** (Continued)

- d. The State compares **numbers of providers** before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal
---------------	-----------------	---------------------	-----------------------

*Please note any limitations to the data in the chart above:*

- e. The State ensures adequate **geographic distribution** of PCCMs.

*Please describe the States standard:*

## Section A: Program Description

### Part II: Access

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## B. Capacity Standards (4 of 6)

**2. Details for PCCM program.** (Continued)

- f. **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio
---------------------------	------------------------

*Please note any changes that will occur due to the use of physician extenders.:*

- g. **Other capacity standards.**

*Please describe:*

**Section A: Program Description**

**Part II: Access**

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**B. Capacity Standards (5 of 6)**

- 3. Details for 1915(b)(4)FFS selective contracting programs:** Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) for facility programs, or vehicles (by type, per contractor) for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

**Section A: Program Description**

**Part II: Access**

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**B. Capacity Standards (6 of 6)**

**Additional Information.** Please enter any additional information not included in previous pages:

**Section A: Program Description**

**Part II: Access**

---

**C. Coordination and Continuity of Care Standards (1 of 5)**

**1. Assurances for MCO, PIHP, or PAHP programs**

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

## Section A: Program Description

### Part II: Access

#### C. Coordination and Continuity of Care Standards (2 of 5)

---

##### 2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

- a. The plan is a PIHP/PAHP, and the State has determined that based on the plans scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208.

*Please provide justification for this determination:*

The SMA defines “persons with special health care needs” to mean any individual who is a frail elder or an adult with an intellectual disability or physical disability. Since all persons enrolled in a Family Care PIHP are “persons with special health care needs,” there is no need for the PIHP to implement a process to identify “persons with special health care needs.” In addition, since primary and acute health care services are carved out of the Family Care PIHP contract, there is no need for the PIHP to implement a process to assure that it effectively provides those services to “persons with special health care needs.” The PIHP is required by contract to coordinate with providers that deliver primary and acute health care services to its members.

- b. **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

*Please describe:*

- c. **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

*Please describe the enrollment limits and how each is determined:*

- d. **Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. Developed by enrollees primary care provider with enrollee participation, and in consultation

with any specialists care for the enrollee.

2. Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. In accord with any applicable State quality assurance and utilization review standards.

*Please describe:*

- e. **Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollees condition and identified needs.

*Please describe:*

## Section A: Program Description

### Part II: Access

---

#### C. Coordination and Continuity of Care Standards (3 of 5)

3. **Details for PCCM program.** The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a. Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollees needs.
- b. Each enrollee selects or is assigned to a designated **designated health care practitioner** who is primarily responsible for coordinating the enrollees overall health care.
- c. Each enrollee is receives **health education/promotion** information.

*Please explain:*

- d. Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. There is appropriate and confidential **exchange of information** among providers.
- f. Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. Primary care case managers **address barriers** that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- h. **Additional case management** is provided.

*Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.*

- i. **Referrals.**

*Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers files.*

## Section A: Program Description

### Part II: Access

---

#### C. Coordination and Continuity of Care Standards (4 of 5)

**4. Details for 1915(b)(4) only programs:** If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

## Section A: Program Description

### Part II: Access

---

#### C. Coordination and Continuity of Care Standards (5 of 5)

**Additional Information.** Please enter any additional information not included in previous pages:

## Section A: Program Description

### Part III: Quality

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#### 1. Assurances for MCO or PIHP programs

The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of

managed care services offered by all MCOs and PIHPs.

The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on:

(mm/dd/yy)

The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.

*Please provide the information below (modify chart as necessary):*

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PIHP	MetaStar, Inc.	X	X	X

## Section A: Program Description

### Part III: Quality

#### 2. Assurances For PAHP program

The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

## Section A: Program Description

### Part III: Quality

**3. Details for PCCM program.** The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

- a. The State has developed a set of overall quality **improvement guidelines** for its PCCM program.

*Please describe:*

## Section A: Program Description

### Part III: Quality

---

#### 3. Details for PCCM program. (Continued)

- b. **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below.

1. Provide education and informal mailings to beneficiaries and PCCMs
2. Initiate telephone and/or mail inquiries and follow-up
3. Request PCCMs response to identified problems
4. Refer to program staff for further investigation
5. Send warning letters to PCCMs
6. Refer to States medical staff for investigation
7. Institute corrective action plans and follow-up
8. Change an enrollees PCCM
9. Institute a restriction on the types of enrollees
10. Further limit the number of assignments
11. Ban new assignments
12. Transfer some or all assignments to different PCCMs
13. Suspend or terminate PCCM agreement
14. Suspend or terminate as Medicaid providers
15. Other

*Please explain:*

## Section A: Program Description

### Part III: Quality

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#### 3. Details for PCCM program. (Continued)

- c. **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
3. Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

- A. Initial credentialing
- B. Performance measures, including those obtained through the following (check all that apply):
  - The utilization management system.
  - The complaint and appeals system.
  - Enrollee surveys.
  - Other.

*Please describe:*

- 4. Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
- 5. Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
- 6. Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
- 7. Other

*Please explain:*

## Section A: Program Description

### Part III: Quality

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#### 3. Details for PCCM program. (Continued)

- d. Other quality standards (please describe):

## Section A: Program Description

### Part III: Quality

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- 4. **Details for 1915(b)(4) only programs:** Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

## Section A: Program Description

### Part IV: Program Operations

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#### A. Marketing (1 of 4)

##### 1. Assurances

The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

## Section A: Program Description

### Part IV: Program Operations

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#### A. Marketing (2 of 4)

##### 2. Details

###### a. Scope of Marketing

1. The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

*Please list types of indirect marketing permitted:*

Indirect marketing materials include internet, brochures and leaflets, radio, television and print media presentations and materials in all mediums to individuals who are not currently enrolled in any of Wisconsin's long-term support programs. Pursuant to the SMA-PIHP Contract, all marketing/outreach materials must be approved by the SMA prior to distribution. The Contract also prohibits direct and indirect cold calls. Direct and indirect cold calls include door-to-door, email, telephone, text or other cold call marketing activity.

3. The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

*Please list types of direct marketing permitted:*

## Section A: Program Description

### Part IV: Program Operations

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#### A. Marketing (3 of 4)

##### 2. Details (Continued)

**b. Description.** Please describe the States procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

*Please explain any limitation or prohibition and how the State monitors this:*

Enrollment is conducted by Aging and Disability Resource Centers (ADRCs), which are independent from the PIHPs. ADRCs monitor for any potential gifts or incentives by the PIHPs. The SMA requires ADRCs to use SMA-approved materials in the enrollment process and choice counseling.

The SMA-PIHP contract also prohibits PIHPs from offering potential members any material or financial gain as an enrollment incentive and requires that all PIHP marketing/ outreach activities and materials be approved by the SMA.

2. The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

*Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:*

3. The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

*Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):*

The list of languages is updated every five years – see methodology below. The current languages are Arabic, Chinese (Mandarin), Hmong, Laotian, Serbo-Croatian, Somali, and Spanish.

The State has chosen these languages because (check any that apply):

- a. The languages comprise all prevalent languages in the service area.

*Please describe the methodology for determining prevalent languages:*

Using United States Census Bureau survey data and member eligibility data, the SMA determines which non-English languages are considered prevalent in each service area. For each service area, prevalent languages are any non-English languages spoken by 1% or more of the population or the three most commonly spoken non-English languages, whichever is greater.

- b.

The languages comprise all languages in the service area spoken by approximately  percent or more of the population.

c. Other

*Please explain:*

## Section A: Program Description

### Part IV: Program Operations

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#### A. Marketing (4 of 4)

**Additional Information.** Please enter any additional information not included in previous pages:

PIHPs' marketing plans must be submitted for initial certification and during annual certification if there has been a material change since last approved by the SMA. The standards for certification are described by Wis. Admin. Code. § DHS 10.43.

The SMA-PIHP contract requires that all PIHP marketing/outreach plans and materials be approved by the SMA prior to distribution.

Written materials sent to potential members, including marketing materials, include, in the non-English languages prevalent in the particular service area, two taglines indicating (1) the availability of written and oral translation of the materials and (2) the availability of auxiliary aids and services, including the provision of the materials in alternate formats.

## Section A: Program Description

### Part IV: Program Operations

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#### B. Information to Potential Enrollees and Enrollees (1 of 5)

##### 1. Assurances

The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

## Section A: Program Description

### Part IV: Program Operations

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## B. Information to Potential Enrollees and Enrollees (2 of 5)

### 2. Details

#### a. Non-English Languages

1. Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

*Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):*

Every five years, the SMA determines the non-English languages prevalent in each service area using the methodology described below. The current list of non-English prevalent languages is Arabic, Chinese (Mandarin), Hmong, Laotian, Serbo-Croatian, Somali, and Spanish.

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

- a. The languages spoken by significant number of potential enrollees and enrollees.

*Please explain how the State defines significant.:*

- b. The languages spoken by approximately  percent or more of the potential enrollee/enrollee population.

- c. Other

*Please explain:*

Using United States Census Bureau survey data and member eligibility data, the SMA determines which non-English languages are considered prevalent in each service area. For each service area, prevalent languages are any non-English languages spoken by 1% or more of the population or the three most commonly spoken non-English languages, whichever is greater.

2. Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

Live oral translators are contracted for by the PIHPs and Aging and Disability Resource Centers (ADRCs) for prevalent languages. A telephonic translation service is available for other non-prevalent languages. These services are available to all PIHP staff and ADRC staff as well as potential members and members.

3. The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

*Please describe:*

As part of options counseling, the Aging and Disability Resource Center (ADRC) helps members and potential members understand managed care, in general, and the Family Care program, in particular. Enrollment counseling provided by the ADRC provides information for prospective members to choose among the available managed long-term care options.

## Section A: Program Description

### Part IV: Program Operations

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#### B. Information to Potential Enrollees and Enrollees (3 of 5)

##### 2. Details (Continued)

##### b. Potential Enrollee Information

Information is distributed to potential enrollees by:

State

Contractor

*Please specify:*

The SMA contracts with an Aging and Disability Resource Center (ADRC) in each service area to provide information to potential members.

ADRCs meet state and federal requirements for organizational independence from any PIHP, as described by Wis. Admin. Code § DHS 10.22 and 42 CFR § 438.810(b)(1) and (2).

There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

## Section A: Program Description

### Part IV: Program Operations

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#### B. Information to Potential Enrollees and Enrollees (4 of 5)

##### 2. Details (Continued)

##### c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

the State

State contractor

*Please specify:*

The SMA contracts with an Aging and Disability Resource Center (ADRC) in each service area to provide information to potential members.

ADRCs meet state and federal requirements for organizational independence from any PIHP, as described by Wis. Admin. Code § DHS 10.22 and 42 CFR § 438.810(b)(1) and (2).

The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

## Section A: Program Description

### Part IV: Program Operations

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#### B. Information to Potential Enrollees and Enrollees (5 of 5)

**Additional Information.** Please enter any additional information not included in previous pages:

PIHPs are required by contract to provide information about member rights to members.

## Section A: Program Description

### Part IV: Program Operations

#### C. Enrollment and Disenrollment (1 of 6)

##### 1. Assurances

The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

## Section A: Program Description

### Part IV: Program Operations

#### C. Enrollment and Disenrollment (2 of 6)

##### 2. Details

Please describe the States enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

##### a. Outreach

The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

*Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:*

The SMA contracts with Aging and Disability Resource Centers (ADRCs) in each service area to serve as the single entry point for information and assistance on long-term care and other issues affecting older people, people with disabilities, or their families. ADRCs provide (1) information and education, (2) outreach, (3) assistance, (4) benefit specialist services, (5) long-term care options counseling and referral to appropriate LTC programs or providers, (6) Family Care functional eligibility determination and level of care assessments using the SMA-developed automated long-term care functional screening tool, and (7) coordination of the Family Care eligibility and enrollment processes. For Indians, the Tribal Aging and Disability Resource Specialist (TADRS) performs the functional screen when the individual's tribe has opted to provide this service to its members. The TADRS is certified to provide the screen, and the individual opts to have this service provided by the TADRS rather than the ADRC.

The functional screen process must include a face-to-face interview with the individual and/or his/her legal representative. The ADRC or TADRS is required by contract to inform the individual or her/his legal representative of available service and enrollment options, including but not limited to home care, community services, residential care, nursing home care, post hospital care, and case management services. The ADRC or TADRS is also required to document the options discussed, factors considered, results, and next steps.

If the individual is an Indian, the ADRC or TADRS informs the potential enrollee and/or her/his legal representative of 1) the option to choose between an Indian Health Care Provider (IHCP), if available, and the PIHP for care management services and 2) the option to choose to receive benefit package services from either the IHCP (if available) or PIHP network providers. The ADRC or TADRS also provides information about other options available to individuals, including the SSI Managed Care Program, where available.

If the individual chooses Family Care, the preferred enrollment date is identified. This information is documented on an enrollment form, which is signed by the member or his/her legal representative. The ADRC or TADRS facilitates enrollment and provides the member and the PIHP with copies of the signed enrollment form. The enrollment form is maintained by the ADRC or TADRS. .

In addition, once enrolled in managed long term care, the plan of care used by each PIHP includes a statement that informs the individual of the options for nursing facility services, self-directed supports waiver services, home and community-based waiver services, IHCP services available to Indians, and the availability of options counseling regarding these services at the ADRC or TADRS. An individual can request nursing facility services as part of the individualized member-centered care planning process in the PIHP, or the individual may disenroll at any time to seek admission and Medicaid reimbursement for nursing facility care or to seek self-directed supports program services.

## Section A: Program Description

### Part IV: Program Operations

#### C. Enrollment and Disenrollment (3 of 6)

##### 2. Details (Continued)

##### b. Administration of Enrollment Process

State staff conducts the enrollment process.

The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Aging and Disability Resource Centers

Please list the functions that the contractor will perform:

choice counseling

enrollment

other

*Please describe:*

Aging and Disability Resource Centers (ADRCs) provide choice counseling to those who are functionally eligible for or considering enrolling in long-term care. The counseling sessions help prospective members weigh their long-term care options and select a program. When a prospective member decides to enroll in long-term care, the ADRC obtains the required enrollment forms and processes the enrollment.

In addition to the functions listed above, ADRCs administer the long-term care functional screen to determine whether an individual is eligible for the program; provide options counseling to inform prospective members of the full range of care options available; and conduct disenrollment counseling to discuss the reasons for disenrollment, programs and services that maybe available to the member if he or she disenrolls, and the implications of disenrollment.

State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

*Please describe the process:*

## Section A: Program Description

### Part IV: Program Operations

#### C. Enrollment and Disenrollment (4 of 6)

##### 2. Details (Continued)

**c. Enrollment** . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

This is a **new** program.

Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

This is an **existing program** that will be expanded during the renewal period.

*Please describe:* Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

The program will not be expanded during the waiver period as expansion is already complete effective 7/1/2018.

If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

**i.**

Potential enrollees will have  **day(s) / month(s)** to choose a plan.

- ii. There is an auto-assignment process or algorithm.

*In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:*

The State automatically enrolls beneficiaries.

on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).

on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).

on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

*Please specify geographic areas where this occurs:*

The State provides **guaranteed eligibility** of  months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM.

*Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:*

The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

## Section A: Program Description

### Part IV: Program Operations

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#### C. Enrollment and Disenrollment (5 of 6)

##### 2. Details (Continued)

##### d. Disenrollment

The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- i. Enrollee submits request to State.

- ii. Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- iii. Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of  months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

*Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollees health care needs):*

The State does not have a **lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees.

- i. MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

*Please describe the reasons for which enrollees can request reassignment*

Enrollees are permitted to disenroll from the PIHP, or transfer to another PIHP, without cause at any time.

The PIHP can request enrollee reassignment for the following reasons:

If the member has committed acts or threatened to commit acts that pose a threat to PIHP staff, subcontractors, providers, or other members of the PIHP; the member refuses to participate in care planning or to allow care management contacts; the member is temporarily out of the PIHP's service area and the PIHP is unable to assure the member's health and safety during the period of absence; or the member is no longer accepting services, other than care management efforts to contact the member.

- ii. The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.
- iii. If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCMs caseload.
- iv. The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

## Section A: Program Description

### Part IV: Program Operations

#### C. Enrollment and Disenrollment (6 of 6)

**Additional Information.** Please enter any additional information not included in previous pages:

If a member speaks with his/her PIHP regarding disenrollment, the PIHP must direct the member to the ADRC. Once the member makes contact with the ADRC, the ADRC will provide options counseling. If the member wishes to disenroll, the member (or his/her legal decision-maker) will sign a disenrollment form and the ADRC will inform the PIHP of the disenrollment and enter the information into the SMA's enrollment system. If applicable, the ADRC will also notify the newly selected PIHP of the enrollment and enrollment date. A member may disenroll at any time. The disenrollment date is chosen by the member. The ADRC will inform the member of any other long term care options available to the member.

## Section A: Program Description

### Part IV: Program Operations

#### D. Enrollee Rights (1 of 2)

##### 1. Assurances

The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

## Section A: Program Description

### Part IV: Program Operations

#### D. Enrollee Rights (2 of 2)

**Additional Information.** Please enter any additional information not included in previous pages:

## Section A: Program Description

### Part IV: Program Operations

#### E. Grievance System (1 of 5)

**1. Assurances for All Programs** States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

**a.** informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an

- action,
- b.** ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
- c.** other requirements for fair hearings found in 42 CFR 431, Subpart E.

The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

## Section A: Program Description

### Part IV: Program Operations

#### E. Grievance System (2 of 5)

- 2. Assurances For MCO or PIHP programs.** MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

## Section A: Program Description

### Part IV: Program Operations

#### E. Grievance System (3 of 5)

- 3. Details for MCO or PIHP programs**

- a. Direct Access to Fair Hearing**

The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

- b. Timeframes**

The States timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is  60 days (between 20 and 90).

The States timeframe within which an enrollee must file a **grievance** is  days.

- c. Special Needs**

The State has special processes in place for persons with special needs.

*Please describe:*

## Section A: Program Description

### Part IV: Program Operations

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#### E. Grievance System (4 of 5)

**4. Optional grievance systems for PCCM and PAHP programs.** States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollees freedom to make a request for a fair hearing or a PCCM or PAHP enrollees direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

The State has a grievance procedure for its PCCM and/or PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):  
The grievance procedures are operated by:

the State

the States contractor.

Please identify:

the PCCM

the PAHP

Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

*Please describe:*

Has a committee or staff who review and resolve requests for review.

*Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:*

Specifies a time frame from the date of action for the enrollee to file a request for review.

*Please specify the time frame for each type of request for review:*

Has time frames for resolving requests for review.

*Specify the time period set for each type of request for review:*

Establishes and maintains an expedited review process.

*Please explain the reasons for the process and specify the time frame set by the State for this process:*

Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review. Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

Other.

*Please explain:*

## Section A: Program Description

### Part IV: Program Operations

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#### E. Grievance System (5 of 5)

**Additional Information.** Please enter any additional information not included in previous pages:

## Section A: Program Description

### Part IV: Program Operations

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#### F. Program Integrity (1 of 3)

##### 1. Assurances

The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCOs, PCCMs, PIHPs, or PAHPs equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCOs, PCCMs, PIHPs, or PAHPs obligations under its contract with the State.

The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. Employs or contracts directly or indirectly with an individual or entity that is
  - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
  - b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

## Section A: Program Description

### Part IV: Program Operations

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#### F. Program Integrity (2 of 3)

##### 2. Assurances For MCO or PIHP programs

The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

*Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:*

The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content, Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

## Section A: Program Description

### Part IV: Program Operations

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#### F. Program Integrity (3 of 3)

**Additional Information.** Please enter any additional information not included in previous pages:

## Section B: Monitoring Plan

### Part I: Summary Chart of Monitoring Activities

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#### Summary of Monitoring Activities (1 of 3)

**The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the**

**areas of the waiver that must be monitored.**

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

**Summary of Monitoring Activities: Evaluation of Program Impact**

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
<b>Accreditation for Non-duplication</b>	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
<b>Accreditation for Participation</b>	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
<b>Consumer Self-Report data</b>	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
<b>Data Analysis (non-claims)</b>	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
<b>Enrollee Hotlines</b>	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
<b>Focused Studies</b>	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM	PCCM	PCCM	PCCM
	FFS	FFS	FFS	FFS	FFS	FFS
<b>Geographic mapping</b>	MCO	MCO	MCO	MCO	MCO	MCO
	PIHP	PIHP	PIHP	PIHP	PIHP	PIHP

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	PAHP PCCM FFS	PAHP PCCM FFS	PAHP PCCM FFS	PAHP PCCM FFS	PAHP PCCM FFS	PAHP PCCM FFS
<b>Independent Assessment</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Measure any Disparities by Racial or Ethnic Groups</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Network Adequacy Assurance by Plan</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Ombudsman</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>On-Site Review</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Improvement Projects</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Measures</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Periodic Comparison of # of Providers</b>	MCO	MCO	MCO	MCO	MCO	MCO

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS
<b>Profile Utilization by Provider Caseload</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Provider Self-Report Data</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Test 24/7 PCP Availability</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Utilization Review</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Other</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

## Section B: Monitoring Plan

### Part I: Summary Chart of Monitoring Activities

#### Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:

- There must be at least one checkmark in each column under Evaluation of Program Impact.
- There must be at least one check mark in one of the three columns under Evaluation of Access.
- There must be at least one check mark in one of the three columns under Evaluation of Quality.

### Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Accreditation for Non-duplication	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Accreditation for Participation	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Consumer Self-Report data	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Data Analysis (non-claims)	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Enrollee Hotlines	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Focused Studies	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Geographic mapping	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Independent Assessment	MCO	MCO	MCO

<b>Evaluation of Access</b>			
<b>Monitoring Activity</b>	<b>Timely Access</b>	<b>PCP / Specialist Capacity</b>	<b>Coordination / Continuity</b>
	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS	PIHP PAHP PCCM FFS
<b>Measure any Disparities by Racial or Ethnic Groups</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Network Adequacy Assurance by Plan</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Ombudsman</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>On-Site Review</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Improvement Projects</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Measures</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Periodic Comparison of # of Providers</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Profile Utilization by Provider Caseload	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Provider Self-Report Data	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Test 24/7 PCP Availability	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Utilization Review	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS
Other	MCO	MCO	MCO
	PIHP	PIHP	PIHP
	PAHP	PAHP	PAHP
	PCCM	PCCM	PCCM
	FFS	FFS	FFS

## Section B: Monitoring Plan

### Part I: Summary Chart of Monitoring Activities

#### Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a big picture of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs:
  - There must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs:
  - There must be at least one checkmark in each column under Evaluation of Program Impact.
  - There must be at least one check mark in one of the three columns under Evaluation of Access.
  - There must be at least one check mark in one of the three columns under Evaluation of Quality.

#### Summary of Monitoring Activities: Evaluation of Quality

<b>Evaluation of Quality</b>			
<b>Monitoring Activity</b>	<b>Coverage / Authorization</b>	<b>Provider Selection</b>	<b>Quality of Care</b>
<b>Accreditation for Non-duplication</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Accreditation for Participation</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Consumer Self-Report data</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Data Analysis (non-claims)</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Enrollee Hotlines</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Focused Studies</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Geographic mapping</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Independent Assessment</b>	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM	MCO PIHP PAHP PCCM

<b>Evaluation of Quality</b>			
<b>Monitoring Activity</b>	<b>Coverage / Authorization</b>	<b>Provider Selection</b>	<b>Quality of Care</b>
	FFS	FFS	FFS
<b>Measure any Disparities by Racial or Ethnic Groups</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Network Adequacy Assurance by Plan</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Ombudsman</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>On-Site Review</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Improvement Projects</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Performance Measures</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Periodic Comparison of # of Providers</b>	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
<b>Profile Utilization by Provider Caseload</b>	MCO PIHP PAHP	MCO PIHP PAHP	MCO PIHP PAHP

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Quality of Care
	PCCM FFS	PCCM FFS	PCCM FFS
Provider Self-Report Data	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Test 24/7 PCP Availability	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Utilization Review	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS
Other	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS	MCO PIHP PAHP PCCM FFS

## Section B: Monitoring Plan

### Part II: Details of Monitoring Activities

#### Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

##### Programs Authorized by this Waiver:

Program	Type of Program
Family Care	PIHP;

*Note: If no programs appear in this list, please define the programs authorized by this waiver on the*

## Section B: Monitoring Plan

### Part II: Details of Monitoring Activities

#### Program Instance: Family Care

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a.

**Accreditation for Non-duplication** (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organizations standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

**Activity Details:**

**NCQA**

**JCAHO**

**AAAHC**

**Other**

Please describe:

b.

**Accreditation for Participation** (i.e. as prerequisite to be Medicaid plan)

**Activity Details:**

**NCQA**

**JCAHO**

**AAAHC**

**Other**

Please describe:

c.

**Consumer Self-Report data**

**Activity Details:**

Responsible entity: SMA  
 Activity: The SMA develops a member satisfaction survey tool and contracts with a third party vendor to administer the survey. The SMA collects and analyzes the data.  
 Frequency: Annual  
 Information: The tool is designed to solicit member feedback about each PIHP's performance in offering choice, coverage, authorization, provider selection, and quality of care.

**CAHPS**

Please identify which one(s):

**State-developed survey**

**Disenrollment survey**

**Consumer/beneficiary focus group**

d.

**Data Analysis (non-claims)**

**Activity Details:**

Responsible entity: SMA

Activity: PIHPs report local grievance and appeal data to the SMA. The SMA collects data related to State-level appeals directed to the SMA and to the State Division of Hearings and Appeals; data is analyzed by SMA oversight teams for each PIHP and by SMA contract compliance staff.

Frequency: Data for individual PIHPs is analyzed quarterly by SMA oversight teams; statewide data is reviewed quarterly by SMA contract compliance staff.

Information: Data provides information on trends in grievances and appeals on individual PIHPs and collectively.

**Denials of referral requests**

**Disenrollment requests by enrollee**

**From plan**

**From PCP within plan**

**Grievances and appeals data**

**Other**

Please describe:

e.

**Enrollee Hotlines**

**Activity Details:**

Responsible entity: SMA

Activity: The SMA provides a toll free number for members to report appeals or grievances to the SMA.

Frequency: Ongoing

Information: The entity contracted to monitor the hotline provides summary data to the SMA about appeals and grievances reported on the hotline.

f.

**Focused Studies** (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

**Activity Details:**

g.

**Geographic mapping**

**Activity Details:**

h.

**Independent Assessment** (Required for first two waiver periods)

**Activity Details:**

**i. Measure any Disparities by Racial or Ethnic Groups**

**Activity Details:**

**j. Network Adequacy Assurance by Plan [Required for MCO/PIHP/PAHP]**

**Activity Details:**

Responsible entity: SMA  
Activity: Certification of PIHP network adequacy  
Frequency: Annual  
Information: PIHPs submit their complete provider network to the SMA for review. SMA oversight teams review the adequacy of the network through a process that includes review of historical service utilization data, current and projected plan enrollment, as well as provider availability per each region served.

**k. Ombudsman**

**Activity Details:**

Responsible entity: SMA  
Activity: Monitor contracted ombudsman program's effectiveness in assisting members with grievances and appeals and identifying systemic grievance and appeal issues.  
Frequency: Ongoing  
Information: The contracted ombudsman program produces monthly, quarterly, and annual reports which are analyzed by the SMA. These reports provide data on appeal and grievance outcomes for members, the ombudsman's performance with respect to six key performance expectations, the results of an annual member satisfaction survey and any systemic grievance and appeal issues identified by the ombudsman.

**l. On-Site Review**

**Activity Details:**

Responsible entity: SMA and EQRO  
Activity: Quality reviews  
Frequency: Annual  
Information: The tools used in the reviews are designed to collect information about choice, marketing, enrollment/disenrollment, program integrity, information to members, grievances, timely access, coordination/continuity, coverage/authorization, quality of care, and provider selection.

**m. Performance Improvement Projects [Required for MCO/PIHP]**

**Activity Details:**

Responsible entity: PIHP  
Activity: PIHPs conduct two performance improvement projects (PIPs) per contract cycle. One PIP addresses clinical opportunities for improvement and the other addresses non-clinical opportunities for improvement. PIPs are reviewed by the SMA and validated by the EQRO annually.  
Frequency: Biannual  
Information: PIP activities and results are analyzed by the SMA and EQRO.

**Clinical**

**Non-clinical**

**n.**

**Performance Measures** [Required for MCO/PIHP]

**Activity Details:**

Responsible entity: SMA and EQRO

Activity: Care management review, quality compliance review, annual certification (please see <http://www.dhs.wisconsin.gov/lcicare/StateFedReqs/EQRO.htm>)

Frequency: Annual

Information: The tools used in the reviews are designed to collect information about choice, marketing, enrollment/disenrollment, program integrity, information to members, grievance, timely access, coordination/continuity, coverage/authorization, quality of care, and provider selection.

**Process**

**Health status/ outcomes**

**Access/ availability of care**

**Use of services/ utilization**

**Health plan stability/ financial/ cost of care**

**Health plan/ provider characteristics**

**Beneficiary characteristics**

**o.**

**Periodic Comparison of # of Providers**

**Activity Details:**

**p.**

**Profile Utilization by Provider Caseload** (looking for outliers)

**Activity Details:**

**q.**

**Provider Self-Report Data**

**Activity Details:**

Responsible entity: PIHP

Activity: PIHPs must verify their contracted providers are not excluded and must assure the SMA they do not knowingly employ or contract with excluded individuals or entities.

Frequency: Annual

Information: PIHPs must verify their contracted providers are not on the excluded provider registry.

**Survey of providers**

**Focus groups**

**r.**

**Test 24/7 PCP Availability**

**Activity Details:**

s. **Utilization Review** (e.g. ER, non-authorized specialist requests)

Activity Details:

t. **Other**

Activity Details:

## Section C: Monitoring Results

### Renewal Waiver Request

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Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the States Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

**This is a renewal request.**

**This is the first time the State is using this waiver format to renew an existing waiver.** The State provides below the results of the monitoring activities conducted during the previous waiver period.

**The State has used this format previously** The State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

**The Monitoring Activities were conducted as described:**

Yes    No

If No, please explain:

**Provide the results of the monitoring activities:**

Consumer Self-Report Data: In each of the 1st 3 waiver years, PIHPs administered a SMA designed survey. Results were positive. The survey used various response categories—yes/no, 4 point scale, 5 point scale and numerical ranking. For most questions, responses were more than 80% positive. Only one question fell below 80% -“In the last 12 months, were you offered the option to self-direct some or part of your services?” Over 80% of PIHPs were rated 8 or above on a scale of 0-10.

In 2018, the SMA and the UW Survey Research Center developed a survey that was administered by the Survey Center and sent to a sample of members with the goal of having responses at the 95% confidence level with a 5% margin by PIHP, program, and target group. The new survey tool includes similar questions to the earlier tool, but the Survey Center revised questions and response categories were revised to reflect best practice. The results of the new survey cannot be directly compared to the earlier surveys due to these design and methodology changes.

Data Analysis: Grievances and appeals are small at the local and State level. Member appeals to the SMA and the State Division of Hearings and Appeals averaged 7/1000 members/month. State level data does not show problematic trends and the SMA did not identify trends or issues with local grievances and appeals.

Enrollee Hotlines: The enrollee hotline is one way for members to report grievances and appeals. Members may choose one or more of the following options to exercise their rights: PIHP level; DHS review; or State Fair Hearing.

In 2017, .7% of total enrollment requested a review/hearing.

A contracted entity monitors the hotline and reports monthly to the SMA the number of appeals by program, PIHP, target group, and category of grievances and appeals. There are no problematic trends or issues.

Network Adequacy Assurance by Plan: The SMA annually reviews the adequacy of each PIHP's network. PIHPs must have an electronic version of its provider network directory on its website. Directories are updated within 30 calendar days after the PIHP receives updated provider information. PIHP networks are assessed through a process that reviews historical service utilization data, current and projected plan enrollment, and provider availability per each region served. No significant issues were identified between 2017 and 2018.

Ombudsman: The responsible entity and activity described under section B, Part II, item k. is the SMA's monitoring of the contracted ombudsman's effectiveness in assisting members with appeals and grievances. PIHP performance regarding grievances and appeals is monitored as explained in section B, Part II, item d.

The contracted ombudsman produces monthly, quarterly, and annual reports for the SMA. January 2015 through October 2018 results are:

Member satisfaction with resolution of their issue: 1,992 cases were closed. 36.3 % of members were “fully satisfied;” 15.7% were “partially satisfied;” 3.3% felt their issue was not resolved to their satisfaction; 17.2% had no resolution as member withdrew issue, passed away, or a timeline expired; 2% were not pursued as the ombudsman determined they lacked merit; 25.6% were referred to another individual or entity for assistance with outcomes unknown.

100% of all initial ombudsman contacts must receive an attempted follow up call within two business days. Results: Met.

95% of “brief cases” and 100% of “full cases” must receive an opening and closing letter. Results: Opening letter sent for 98.4% of full and 92.5% of brief cases. Closing letter sent for 98.6% of full and 93.5% of brief cases.

100% of ombudsman must meet the ombudsman entity's core competency expectations as measured in annual performance reviews. Results: Met.

Ombudsman must meet at least annually with the PIHP to discuss advocacy issues and promote collaboration on patterns of issues. Results: Met.

Ombudsman must resolve at least 75% of cases informally. Results: 84.4% resolved informally.

The ombudsman must distribute an annual survey to members it has assisted to measure satisfaction with its services. An average of 86.5% of members indicated that they were “very satisfied” with the ombudsman's skill level; 79.5% indicated that the ombudsman was “very important” in solving their problem; 80.75% were “very satisfied” with the results they received; 92% would call an ombudsman again; and 89.5% would recommend the ombudsman service to friends.

The SMA identified no problems in the ombudsman’s effectiveness in assisting members with appeals and grievances.

On-Site Review: The EQRO does an on-site Annual Quality Review (AQR) of each PIHP. The AQR assesses the following PIHP systems and processes: Care Management Review, Assessment, Planning, Service Coordination and Delivery, Participant Centered Focus, Validation of Performance Improvement Projects, Quality Compliance Review, Member Rights, Access to Services, Structure and Operations, Quality Measurement and Improvement, and Grievance Systems. The AQR results are submitted to the SMA and can be found at: <https://www.dhs.wisconsin.gov/non-dhs/dms/eqro2017-18.pdf>. Various issues were identified for each PIHP. The SMA required corrective actions, made improvement recommendations and monitored PIHP completion of requirements.

Performance Improvement Projects (PIPS)- See EQRO report at: <https://www.dhs.wisconsin.gov/non-dhs/dms/eqro2017-18.pdf>

Performance Measures: See Care Management Review and Quality Compliance Review in the EQRO report at: <https://www.dhs.wisconsin.gov/non-dhs/dms/eqro2017-18.pdf>.

Provider Self-Report Data: PIHPs annually submit assurances that they do not knowingly employ or contract with excluded individuals or entities and that they have written policies and procedures to guard against fraud and abuse. PIHPs check the excluded provider registry upon initial contract with a provider.

## Section D: Cost-Effectiveness

### Medical Eligibility Groups

Title	
Nursing Home Level of Care	
Non-Nursing Home Level of Care	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	01/01/2017	12/31/2017	01/01/2018	12/31/2018
Enrollment Projections for the Time Period*	01/01/2020	12/31/2020	01/01/2021	12/31/2021

\*\*Include actual data and dates used in conversion - no estimates  
 \*Projections start on Quarter and include data for requested waiver period

## Section D: Cost-Effectiveness

### Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Personal Emergency Response System Services				
Alcohol and Drug Abuse Day Treatment				
Financial Management Services				
Relocation Services				
Durable Medical Equipment (excluding hearing aids and prosthetics)				
Speech and Language Pathology Services (except in inpatient hospital settings)				

<b>Service Name</b>	<b>State Plan Service</b>	<b>1915(b)(3) Service</b>	<b>Included in Actual Waiver Cost</b>	
Specialized Medical Supplies				
Occupational Therapy				
Transportation - Community - Self-directed non-emergency medical				
Personal Care				
Nursing Home Stays (Nursing Home, Institution for Mental Disease (IMD) and ICF-I/ID Facility)				
Communication Aids/Assistive Technologies				
Adaptive Aids - Vehicles				
Supportive Home Care				
Transportation - Common Carrier				
Housing Counseling				
Home Modifications				
Day Habilitation Services				
Meals - Home Delivered				
Home Health Services				
Community Support Program				
Disposable Medical Supplies				
Supported Employment - Individual Employment Support				
Prevocational Services				
Consumer Education and Training				
Adaptive Aids - General				
Consultative Clinical and Therapeutic Services for Caregivers				
Respiratory Therapy by Independent Nurse or Therapist Employed by a Home Health Agency				
Case Management				
Consumer Directed Supports (Self Directed Supports) Support Broker				
Daily Living Skills Training				
Training Services for Unpaid Caregivers				
Skilled Nursing				
Counseling/Therapeutic Resources				
Transportation - Medical (including specialized medical vehicle)				
Transportation - Community - Non-				

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
medical				
Physical Therapy				
Mental Health Counseling/Therapy (except those provided by a physician or on an inpatient basis)				
Mental Health Day Treatment				
Adult Day Care				
Vocational Futures Planning and Support				
Respite Care				
Residential Services - RCAC, CBRF, Adult Family Home				
Supported Employment - Small Group Employment Support				
Self-Directed Personal Care				
AODA Treatment (excludes those provided by a physician or on an inpatient basis)				

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

**A. Assurances**

**a. [Required] Through the submission of this waiver, the State assures CMS:**

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the States waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the States submitted CMS-64 forms.

**Signature:**

State Medicaid Director or Designee

**Submission Date:**

**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

**b. Name of Medicaid Financial Officer making these assurances:**

**c. Telephone Number:**

**d. E-mail:**

**e. The State is choosing to report waiver expenditures based on**

**date of payment.**

**date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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**B. Expedited or Comprehensive Test**

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

- b.** The State provides additional services under 1915(b)(3) authority.
- c.** The State makes enhanced payments to contractors or providers.
- d.** The State uses a sole-source procurement process to procure State Plan services under this waiver.
- e.** The State uses a sole-source procurement process to procure State Plan services under this waiver. *Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.*

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete *Appendix D3*
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB.*

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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**C. Capitated portion of the waiver only: Type of Capitated Contract**

**The response to this question should be the same as in A.I.b.**

- a.** MCO
- b.** PIHP
- c.** PAHP
- d.** PCCM
- e.** Other

Please describe:

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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**D. PCCM portion of the waiver only: Reimbursement of PCCM Providers**

**Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):**

**a. Management fees are expected to be paid under this waiver.**

The management fees were calculated as follows.

- 1. Year 1: \$  per member per month fee.
- 2. Year 2: \$  per member per month fee.
- 3. Year 3: \$  per member per month fee.
- 4. Year 4: \$  per member per month fee.

**b. Enhanced fee for primary care services.**

Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

**c. Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization.** Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

**d. Other reimbursement method/amount.**

\$

Please explain the State's rationale for determining this method or amount.

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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**E. Member Months**

**Please mark all that apply.**

- a. [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

Program expansion occurred during R1 (CY2017) when Florence, Forest, Oneida, Taylor, and Vilas counties began operating the Family Care program. Dane and Adams counties began operating the Family Care program during R2 (CY2018). Members of federally recognized tribes receiving services under the legacy waivers were also enrolled during R2 (CY2018).

Member months are expected to increase throughout the proposed waiver period due to completing the enrollment of members on legacy waiver waitlists and growth that has historically been experienced in counties after Family Care becomes an entitlement.

The Family Care waiver is available statewide as of 7/1/2018; however, there are eight counties that have not yet reached entitlement with some having waitlists from the legacy waivers. Persons on a waitlist are assumed to be enrolled evenly over 36 months from the date Family Care begins operating in a county. Approximately 1,350 persons on waitlists for long-term care services are expected to gradually transition into Family Care by 7/1/2021. In counties with people on a waitlist, projected enrollment is based on the number of people remaining on the waitlist multiplied by the proportion of eligible individuals assumed to choose to enroll in the Family Care waiver. A county specific Family Care selection factor is used in counties with stable population. A statewide factor is used in counties with small populations or experiencing variability. On average, roughly 56% of new members are assumed to enroll in the Family Care program with the other 44% enrolling in the Self-Directed 1915(c) waiver option, PACE, or Partnership programs. When Family Care becomes an entitlement in a county beginning in the 37th month after program operations start, historical enrollment growth rates are used -- approximately 10% in a county's first year of entitlement, 6% in the second, 5% in the third, and 5% in the fourth.

A county specific historical growth rate is used for counties at entitlement with sufficiently stable experience.

Family Care member months are expected to increase by 5.1% from R1 (CY2017) to R2 (CY2018), 6.7% from R2 (CY2018) to P1 (CY2020), 3.2% from P1 (CY2020) to P2 (CY2021), 3.1% from P2 (CY2021) to P3 (CY2022), 2.9% from P3 (CY2022) to P4 (CY2023), and 2.8% from P4 (CY2023) to P5 (CY2024).

- d. [Required] Explain any other variance in eligible member months from BY/R1 to P2:

The majority the growth in member months in R1 (CY2017) and R2 (CY2018) is attributable to the gradual enrollment of persons on the waitlist and transitioning home and community based-waiver enrollees into Family Care as described above. There is a 12 month gap (1/1/2019 - 12/31/2019) from the end of R2 (CY2018) to the beginning of P1 (CY2020). Additional growth is expected in counties that have reached entitlement based on historical experience.

- e. [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

R1 is 1/1/2017 - 12/31/2017. R2 is 1/1/2018 – 12/31/2018.

## Appendix D1 Member Months

### Section D: Cost-Effectiveness

#### Part I: State Completion Section

#### F. Appendix D2.S - Services in Actual Waiver Cost

##### For Conversion or Renewal Waivers:

- a. [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.  
Explain the differences here and how the adjustments were made on Appendix D5:

No changes have been made. Services included in the actual waiver cost from the previous period in Appendix D3 are the same as the upcoming waiver period in Appendix D5.

- b. **[Required] Explain the exclusion of any services from the cost-effectiveness analysis.**  
 For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

Primary and acute health care are carved out of the Family Care benefit.

**Appendix D2.S: Services in Waiver Cost**

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Personal Emergency Response System Services							
Alcohol and Drug Abuse Day Treatment							
Financial Management Services							
Relocation Services							
Durable Medical Equipment (excluding hearing aids and prosthetics)							
Speech and Language Pathology Services (except in inpatient hospital settings)							
Specialized Medical Supplies							
Occupational Therapy							
Transportation - Community - Self-directed non-emergency medical							
Personal Care							
Nursing Home Stays (Nursing Home, Institution for Mental Disease (IMD) and ICF-I/ID Facility)							
Communication Aids/Assistive Technologies							
Adaptive Aids - Vehicles							
Supportive Home Care							
Transportation - Common Carrier							
Housing Counseling							

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Home Modifications							
Day Habilitation Services							
Meals - Home Delivered							
Home Health Services							
Community Support Program							
Disposable Medical Supplies							
Supported Employment - Individual Employment Support							
Prevocational Services							
Consumer Education and Training							
Adaptive Aids - General							
Consultative Clinical and Therapeutic Services for Caregivers							
Respiratory Therapy by Independent Nurse or Therapist Employed by a Home Health Agency							
Case Management							
Consumer Directed Supports (Self Directed Supports) Support Broker							
Daily Living Skills Training							
Training Services for Unpaid Caregivers							
Skilled Nursing							
Counseling/Therapeutic Resources							
Transportation - Medical (including specialized medical vehicle)							
Transportation - Community - Non- medical							
Physical Therapy							
Mental Health Counseling/Therapy (except those provided by a physician or on an							

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
inpatient basis)							
Mental Health Day Treatment							
Adult Day Care							
Vocational Futures Planning and Support							
Respite Care							
Residential Services - RCAC, CBRF, Adult Family Home							
Supported Employment - Small Group Employment Support							
Self-Directed Personal Care							
AODA Treatment (excludes those provided by a physician or on an inpatient basis)							

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

**G. Appendix D2.A - Administration in Actual Waiver Cost**

**[Required]** The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

The allocation method for either initial or renewal waivers is explained below:

- a. The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees *Note: this is appropriate for MCO/PCCM programs.*
- b. The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. **Other**  
Please explain:

**Appendix D2.A: Administration in Actual Waiver Cost**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

**H. Appendix D3 - Actual Waiver Cost**

- a. The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical

services. The State will be spending a portion of its waiver savings for additional services under the waiver.

**b. The State is including voluntary populations in the waiver.**

Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

The issue of selection bias is handled through the State's risk adjustment process. Risk adjustment has been a central component of Family Care rate setting from the program's inception. Historical costs of actual program enrollees are used as the base cost for the capitation rates. Functional status information obtained from the long-term care functional screen tool is then used to risk adjust the capitation rates. The PIHPs are paid a capitation that reflects case mix across 31 - 48 different measures of functional status. The detail behind this risk adjustment approach is contained in each year's rate report from the State's contracted actuary.

- c. Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage:** Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

**Basis and Method:**

1. **The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.**

2. **The State provides stop/loss protection**

Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

Stop loss is met by the State requiring working capital, restricted reserves, and pooled solvency fund contributions by each PIHP.

**d. Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:**

1. **[For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program.** The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

**Document**

- i. **Document the criteria for awarding the incentive payments.**
- ii. **Document the method for calculating incentives/bonuses, and**
- iii. **Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.**

i. The Department will provide an incentive payment to the PIHP of \$1,000 for each member of a PIHP who is relocated from an institution into a community setting consistent with federal Money Follows the Person (MFP) guidelines. The incentive is a one-time payment paid to the PIHP per relocated member. The incentive payments themselves are not incorporated into rate setting for future years, but the service costs for the member are included in the encounter data used for future year rate setting.

ii. The amount of payment provided to a PIHP will be determined after the end of the contract year. The PIHP will submit before December 31 of the contract year a list of members for whom the PIHP anticipates a receipt of an incentive payment. The Department will compare the PIHP's list of member's to the Department's list of Medicaid members for whom the Department is receiving an enhanced Medicaid match through the MFP program to determine the number of relocations to use for calculation the incentive payment to the PIHP. The Department will notify the PIHP of the estimated amount of the incentive payment and the list of PIHP members for whom an incentive payment is being made prior to issuing the incentive payment.

iii. The approximate amount of anticipated incentive payment will be known prior to the end of the contract year. As described in the method above, the PIHP will submit before December 31 of the contract year a list of members for whom the PIHP anticipates a receipt of an incentive payment. The Department will compare the PIHP's list of member's to the Department's list of Medicaid members for whom the Department is receiving an enhanced Medicaid match through the MFP program.

2. **For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).** For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

**Document:**

- i. Document the criteria for awarding the incentive payments.**
- ii. Document the method for calculating incentives/bonuses, and**
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.**

**Appendix D3 Actual Waiver Cost**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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**I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)**

**This section is only applicable to Initial waivers**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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**I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)**

**This section is only applicable to Initial waivers**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

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## I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

**This section is only applicable to Initial waivers**

### Section D: Cost-Effectiveness

#### Part I: State Completion Section

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## I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

**This section is only applicable to Initial waivers**

### Section D: Cost-Effectiveness

#### Part I: State Completion Section

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## I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

**This section is only applicable to Initial waivers**

### Section D: Cost-Effectiveness

#### Part I: State Completion Section

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## I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

**This section is only applicable to Initial waivers**

### Section D: Cost-Effectiveness

#### Part I: State Completion Section

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## I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

**This section is only applicable to Initial waivers**

### Section D: Cost-Effectiveness

#### Part I: State Completion Section

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## I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

**This section is only applicable to Initial waivers**

### Section D: Cost-Effectiveness

#### Part I: State Completion Section

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## J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

**a. State Plan Services Trend Adjustment** the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. .

**This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**

1. [Required, if the States BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).

The actual trend rate used is: 3.81

Please document how that trend was calculated:

Nursing Home Level of Care: 3.8%  
Non-Nursing Home Level of Care: 3.8%

Trends from R2 (CY2018) to P1 (CY2020) are two year adjustments. 1.8% from CY2018 to CY2019 and 2.0% from CY2019 to CY2020.

The trends from R2 (CY2018) to CY2019 are based on trends developed by the State's contracted actuaries for CY2019 capitation rates. Detail for the CY2019 capitation rates and trend development can be found in the annual Capitation Rate Development Report. The trend estimates are developed for Developmentally Disabled, Physically Disabled, and Frail Elder target groups for both Medicaid Eligibility Groups using standard actuarial practices based on actual CY2015 – CY2017 program service costs.

The individual target group trends from CY2019 to P1 (CY2020) are the same trend used for CY2019 capitation rates adjusted to reflect State budget assumptions. The proposed State budget assumes an aggregate cost increase of 2.0% for CY2020. Analyses suggest the service cost trends for the Family Care program as a whole have been held down in recent years due to an increasing proportion of new members enrolling at a lower acuity level relative to a decreasing proportion of existing higher cost members that enrolled from the legacy waivers. As these proportions stabilize, overall cost increases will no longer be diluted by an increasing proportion of lower cost members. The trend in the State budget is, therefore, adjusted to reflect trends more consistent with the Consumer Price Index. Trends are weighted by target group enrollment to arrive at the composite trend for each MEG for each year.

2. **[Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (i.e., trending from present into the future).**

**i. State historical cost increases.**

Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

Years on which the rates are based: CY2015 – CY 2017.

Trend rates are based primarily on the trends calculated by the State’s contracted actuaries for CY2019 capitation rate development. Detail for the CY2019 capitation rates and trend development can be found in the annual Capitation Rate Development Report. The trend estimates were developed for Developmentally Disabled, Physically Disabled, and Frail Elder target groups for both Medicaid Eligibility Groups using standard actuarial practices based on actual CY2015 – CY2017 program service costs.

The individual target group trends are adjusted to reflect State budget assumptions. The proposed State budget assumes an aggregate cost increase of 2.0% for both CY2020 and CY2021. The same trend is assumed for CY2022 – CY2024. Analyses suggest the service cost trends for the Family Care program as a whole have been held down in recent years due to an increasing proportion of new members enrolling at a lower acuity level relative to a decreasing proportion of existing higher cost members that enrolled from the legacy waivers. As these proportions stabilize, overall cost increases will no longer be diluted by an increasing proportion of lower cost members. The trend in the State budget is, therefore, adjusted to reflect trends more consistent with the Consumer Price Index. Trends are weighted by target group enrollment to arrive at the composite trend for each MEG for each year. Trends rates are as follows:

Nursing Home Level of Care: 3.8% (two year trend) from R2 (CY2018) to P1 (CY2020), 2.0% from P1 (CY2020) to P2 (CY2021), 2.0 % from P2 (CY2021) to P3 (CY2022), 2.0% from P3 (CY2022) to P4 (CY2023), and 2.0% from P4 (CY2023) to P5 (CY2024).

Non-Nursing Home Level of Care: 3.8% (two year trend) from R2 (CY2018) to P1 (CY2020), 2.0% from P1 (CY2020) to P2 (CY2021), 2.0 % from P2 (CY2021) to P3 (CY2022), 2.0% from P3 (CY2022) to P4 (CY2023), and 2.0% from P4 (CY2023) to P5 (CY2024).

**ii. National or regional factors that are predictive of this waivers future costs.**

Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waivers future costs. Finally, please note and explain if the States cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

**3. The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.**

Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

**i. Please indicate the years on which the utilization rate was based (if calculated separately only).**

**ii. Please document how the utilization did not duplicate separate cost increase trends.**

**Appendix D4 Adjustments in Projection**

**Section D: Cost-Effectiveness**

**Part I: State Completion Section**

**J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)**

**b. State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any

programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. An adjustment was necessary. The adjustment(s) is(are) listed and described below:
  - i. The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.  
Please list the changes.

For the list of changes above, please report the following:

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).  
PMPM size of adjustment
- B. The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment
- C. Determine adjustment based on currently approved SPA.  
PMPM size of adjustment
- D. Determine adjustment for Medicare Part D dual eligibles.
- E. Other:  
Please describe

- ii. The State has projected no externally driven managed care rate increases/decreases in the

managed care rates.

- iii. Changes brought about by legal action:  
Please list the changes.

For the list of changes above, please report the following:

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

- B. The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment

- C. Determine adjustment based on currently approved SPA.  
PMPM size of adjustment

- D. Other  
Please describe

- iv. Changes in legislation.  
Please list the changes.

For the list of changes above, please report the following:

- A. The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

- B. The size of the adjustment was based on pending SPA.  
Approximate PMPM size of adjustment

- C. Determine adjustment based on currently approved SPA  
PMPM size of adjustment

- D. Other  
Please describe

- v. Other  
Please describe:

**A.** The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

**B.** The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment

**C.** Determine adjustment based on currently approved SPA.

PMPM size of adjustment

**D.** Other

Please describe

Program adjustments are included each year to compensate for payment timing differences in the CMS 64.9 reports, PIHP enrollment mix changes, capitation rate policy adjustments, and other lump sum payments. DUE TO SPACE LIMITATIONS IN THE WMS, PLEASE REFER TO THIS SECTION IN THE SUPPLEMENTAL ATTACHMENT FOR A DETAILED DESCRIPTION.

## Section D: Cost-Effectiveness

### Part I: State Completion Section

#### J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

**c. Administrative Cost Adjustment:** This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. No adjustment was necessary and no change is anticipated.
2. An administrative adjustment was made.
  - i. Administrative functions will change in the period between the beginning of P1 and the end of P2.  
Please describe:

- ii. Cost increases were accounted for.
    - A. Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
    - B. Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
    - C. State Historical State Administrative Inflation. The actual trend rate used is PMPM size of adjustment

0.00

Please describe:

**D. Other**

Please describe:

Service cost trends of 3.8% in P1 (two years CY2018 – CY 2020) and 2.0% in P2 (CY 2021) through P5 (CY 2024) are used for both the Nursing Home and Non-Nursing Home levels of care. Family Care will become a greater proportion of overall Wisconsin Medicaid expenditures as the program grows, which will increase Family Care’s share of administrative costs proportionately as capitation rates increase.

**iii.** [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.  
Please document both trend rates and indicate which trend rate was used.

**A.** Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the States cost increase calculation includes more factors than a price increase.

**B.** Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from Section D.I.J.a. above

0.00

**Section D: Cost-Effectiveness**

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**J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)**

**d. 1915(b)(3) Adjustment:** The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in *Section D.I.H.a* above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

**1.** [Required, if the States BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).  
The actual documented trend is:

Please provide documentation.

2. [Required, when the States BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or States trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

**i. A. State historical 1915(b)(3) trend rates**

1. Please indicate the years on which the rates are based: base years

2. Please provide documentation.

**B. State Plan Service trend**

Please indicate the State Plan Service trend rate from Section D.I.J.a. above

**e. Incentives (not in capitated payment) Trend Adjustment:** If the State marked **Section D.I.H.d** , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a

3.8% in P1 (two years CY2018 – CY 2020) and 2.0% in P2 (CY 2021) through P5 (CY 2024)

2. List the Incentive trend rate by MEG if different from Section D.I.I.a

Not applicable. The State Plan service trend is used.

3. Explain any differences:

Money Follow the Person incentive payments are accounted for in capitation costs as required in H.d.1 above. Therefore the trend rate for services is used.

**Section D: Cost-Effectiveness**

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**J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)**

**p. Other adjustments** including but not limited to federal government changes.

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
- Once the States FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
  - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees

and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.

- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only) \***: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

*Basis and Method:*

1. Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population **which includes accounting for Part D dual eligibles**. Please account for this adjustment in **Appendix D5**.
2. The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractors providers do not prescribe drugs that are paid for by the State in FFS **or Part D for the dual eligibles**.
3. Other

*Please describe:*

1. No adjustment was made.
2. This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5. Please describe

## Section D: Cost-Effectiveness

### Part I: State Completion Section

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#### K. Appendix D5 Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

Please refer to sections D.I.J.a.1., D.I.J.a.2.i., D.I.J.b.2.v.D., D.I.J.c.2.ii.D., and D.I.J.e. for detailed explanations of the adjustments.

#### Appendix D5 Waiver Cost Projection

## Section D: Cost-Effectiveness

### Part I: State Completion Section

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#### L. Appendix D6 RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

## Appendix D6 RO Targets

### Section D: Cost-Effectiveness

#### Part I: State Completion Section

#### M. Appendix D7 - Summary

- a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

Program expansion occurred during R1 (CY2017) when Florence, Forest, Oneida, Taylor, and Vilas counties began operating the Family Care program. Dane and Adams counties began operating the Family Care program during R2 (CY2018). Members of federally recognized tribes receiving services under the legacy waivers were also enrolled during R2 (CY2018).

Member months are expected to increase throughout the proposed waiver period due to completing the enrollment of members on legacy waiver waitlists and growth that has historically been experienced in counties after Family Care becomes an entitlement.

The Family Care waiver is available statewide as of 7/1/2018; however, there are eight counties that have not yet reached entitlement with some having waitlists from the legacy waivers. Persons on a waitlist are assumed to be enrolled evenly over 36 months from the date Family Care begins operating in a county. Approximately 1,350 persons on waitlists for long-term care services are expected to gradually transition into Family Care by 7/1/2021. In counties with people on a waitlist, projected enrollment is based on the number of people remaining on the waitlist multiplied by the proportion of eligible individuals assumed to choose to enroll in the Family Care waiver. A county specific Family Care selection factor is used in counties with stable population. A statewide factor is used in counties with small populations or experiencing variability. On average, roughly 56% of new members are assumed to enroll in the Family Care program with the other 44% enrolling in the Self-Directed 1915(c) waiver option, PACE, or Partnership programs. When Family Care becomes an entitlement in a county beginning in the 37th month after program operations start, historical enrollment growth rates are used -- approximately 10% in a county's first year of entitlement, 6% in the second, 5% in the third, and 5% in the fourth.

A county specific historical growth rate is used for counties at entitlement with sufficiently stable experience.

Family Care member months are expected to increase by 5.1% from R1 (CY2017) to R2 (CY2018), 6.7% from R2 (CY2018) to P1 (CY2020), 3.2% from P1 (CY2020) to P2 (CY2021), 3.1% from P2 (CY2021) to P3 (CY2022), 2.9% from P3 (CY2022) to P4 (CY2023), and 2.8% from P4 (CY2023) to P5 (CY2024).

2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of cost increase given in Section D.I.I and D.I.J:

Medicaid unit cost increases may be known in advance, if the State Legislature has passed the relevant legislation. In those cases, the unit cost increases can be added into the capitation rate development in advance. This is appropriate because the Family Care PIHPs typically rely on the Medicaid fee schedule. If the Legislature acts after capitation rates have been developed, however, the rate increases may be added to the capitation rate in a retrospective adjustment.

The trends from R2 (CY2018) to CY2019 are based on trends developed by the State's contracted actuaries for CY2019 capitation rates. Detail for the CY2019 capitation rates and trend development can be found in the annual Capitation Rate Development Report. The trend estimates are developed for Developmentally Disabled, Physically Disabled, and Frail Elder target groups for both Medicaid Eligibility Groups using standard actuarial practices based on actual CY2015 – CY2017 program service costs.

The individual target group trends from CY2019 to P1 (CY2020) are the same trend used for CY2019 capitation rates adjusted to reflect State budget assumptions. The proposed State budget assumes an aggregate cost increase of 2.0% for CY2020. Analyses suggest the service cost trends for the Family Care program as a whole have been held down in recent years due to an increasing proportion of new members enrolling at a lower acuity level relative to a decreasing proportion of existing higher cost members that enrolled from the legacy waivers. As these proportions stabilize, overall cost increases will no longer be diluted by an increasing proportion of lower cost members. The trend in the State budget is, therefore, adjusted to reflect trends more consistent with the Consumer Price Index. Trends are weighted by target group enrollment to arrive at the composite trend for each MEG for each year.

3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the States explanation of utilization given in Section D.I.I and D.I.J:

A separate adjustment for utilization change is not included. Utilization change is incorporated into the aggregate service cost trend adjustment. In order to develop rates based on expected CY2019 member acuity levels, the State's contracted actuary applies one year of projected acuity trend to the June 2018 acuity-adjusted costs. As part of the historical trend study CY2015 to Cy2017 changes in average acuity were developed for each target population. The acuity trend study is performed in conjunction with the service cost trend study. These same acuity results are used to develop the risk adjusted service costs underlying the service cost trend development. These changes in average acuity are assumed to continue for future years.

- b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

Program adjustments are included each year to compensate for payment timing differences in the CMS 64.9 reports, PIHP enrollment mix changes, capitation rate policy adjustments, and other lump sum payments. DUE TO SPACE LIMITATIONS IN THE WMS, PLEASE REFER TO THIS SECTION IN THE SUPPLEMENTAL ATTACHMENT FOR A DETAILED DESCRIPTION.

## Appendix D7 - Summary

**Section D: Cost-Effectiveness**  
**Part I: State Completion Section**

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**J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)**

- b. State Plan Services Programmatic/Policy/Pricing Change Adjustment:** This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. **This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend.** If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee
- Graduate Medical Education (GME) Changes - This adjustment accounts for **changes** in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

**2. An adjustment was necessary. The adjustment(s) is (are) listed and described below:**

**v. Other. Please describe:**

**D. Other. Please describe:**

**Program adjustments are included each year to compensate for payment timing differences in the CMS 64.9 reports, PIHP enrollment mix changes, capitation rate policy adjustments, and other lump sum payments. The following program adjustments are included:**

**Adjustments of -0.08% are made to NH LOC and -0.87% to Non-NH LOC in P1 (CY2020) to reflect payments and recoveries reported in the CMS 64.9 for R2 (CY2018), but need to be excluded in projected future periods as these costs will not be incurred again in the projection period.**

To reflect changes from R2 (CY2018) capitation rates to actual CY2019 capitation rates which serve as the projection base, an adjustment of 2.23% is applied to NH LOC and 4.17% is applied to Non-NH LOC. Detail for the CY2019 capitation rate development can be found in the annual Capitation Rate Development Report prepared by the State's contracted actuaries.

Enrollment changes in PIHPs serving Family Care counties affect the average program-wide capitation rates in aggregate. This adjustment relates to the effect of PIHPs with different capitation rates having different enrollment growth rates. The aggregate capitation rate will increase if there is more enrollment growth MCOs with higher capitation rates and will decrease if enrollment is higher in MCOs with lower capitation rates. Adjustments to NH LOC are 0.03% in P1 (CY 2020), 0.03% in P2 (CY 2021), 0.02% in P3 (CY 2022), 0.02% in P4 (CY 2023), and 0.02% in P5 (CY 2024). Adjustments included in Non-NH LOC are 0.10% in P1 (CY 2020), 0.08% in P2 (CY 2021), 0.04% in P3 (CY 2022), 0.05% in P4 (CY 2023), and 0.05% in P5 (CY 2024).

Funding is included in all years for adjustments to capitation rates for PIHPs experiencing disproportionately high costs relative to the capitation rate model. These are contingent expenditures to stabilize PIHPs experiencing financial distress. There have been three PIHPs that have discontinued operations since the program began expanding in 2008 that required additional funding. Additional PIHPs are currently on either heightened financial monitoring or financial corrective action. Detailed review has indicated that PIHPs' operations to be the primary source of the financial difficulties, not the soundness of the capitation rates. The PIHPs are required to identify and implement efficiencies to reflect the payment model and will continue under enhanced financial monitoring, which includes monthly financial submissions to the State. Additional funding would be incorporated into capitation rates. Contract amendments would be executed if the rate adjustments occur after the initial contract for year is signed. These costs require a policy adjustment of 0.30% in P1 (CY 2020) to NH LOC. Total hardship funding is held constant each year; however, increasing enrollment reduces PMPM cost requiring an adjustment to the NH LOC of -0.01% each year in P2 (CY2021) – P5 (CY2024).

Money Follows the Person incentive payments will continue. These payments increase in aggregate proportionately with enrollment growth; however the payment is made the year following the year to which the payment relates. This timing difference decreases cost on a PMPM basis during periods of increasing enrollment requiring an adjustment of less than 0.01% each year P1 (CY2020) – P5 (CY2024) to the NH LOC MEG.

Payments for acuity adjustments made to PIHPs that expanded into new counties are discontinued in P1 (CY2020) for GSR 13 and GSR 14. The acuity adjustment for (GSR 12) Dane County begins after CMS 64 for R2 (CY2018) and decreases through P1 (CY2020) and P2 (CY2021) is

## 1915(b) Waiver: Draft WI.048.07.00 – Jan 01, 2020

### Appendix D - Supplemental Responses

discontinued P3 (CY2022). Net adjustments to NH LOC are 0.16% in P1 (CY2020), -0.10 in P2 (CY2022), and -0.09% in P3 (CY2023).

High cost risk pool payments are increased relative to the R2 (CY2018) CMS 64. These are withheld from initial plan capitation payments and paid out to PIHPs on a budget neutral basis proportional to plan costs above the high cost risk pool threshold. The payment increase reflected in P1 (CY2020) requires a 0.68% adjustment to NH LOC. Once the payments are added to P1 (CY2020) of the projection, they are automatically included in the cost base for future years; however, a timing difference decreases cost on a PMPM basis during periods of increasing enrollment requiring an adjustment of less than 0.01% each year P2 (CY2021) – P5 (CY2024).

A pay for performance withhold and incentive mechanism began in CY2018. The payments will not be made until CY2019 and are therefore not included in the R2 (CY2018) CMS 64. Pay for Performance withhold payments are based on results from the member satisfaction survey and competitive integrated employment plan. PIHPs may additionally be eligible for an incentive payment based on results from the member satisfaction survey, competitive integrated employment actions, and assisted living quality improvement incentive. Pay for performance details can be found in Article XVIII.E of the contract between the Department and the PIHP. An adjustment of 1.04% is added in P1 (CY2020) for the NH LOC MEG and 0.98% for the Non-NH MEG. Once the payments are added to P1 (CY2020) of the projection, they are automatically included in the cost base for future years; however, a timing difference requires adjustments of less than 0.01% each year P2 (CY2021) – P5 (CY2024) for both NH and Non-NH MEGs.

Funding for home care workers providing direct care to members is included in the R2 (CY2018) CMS 64. The payments budgeted for two years were paid out in one year, making the R2 base year appear artificially higher. Payments are included in the proposed State budget at the same annual levels and are assumed to continue through the waiver period. An adjustment of -0.92% was made to the NH LOC EG in P1 (CY2020) to bring the amount in the CMS 64 back to the annual budgeted level. Direct care workforce funding is held constant each year; however, increasing enrollment reduces PMPM cost requiring downward adjustments to the NH LOC of -0.07% in P2 (CY2021), -0.07% in P3 (CY2022), -0.06% in P4 (CY2023), and -0.06% in P5 (CY2024).

Net program adjustments in the NH LOC MEG are 3.4% in P1, -0.2% in P2, -0.1% in P3, 0.0% in P4, and 0.0% in P5.

Net program adjustments in the Non-NH LOC MEG are 4.4% in P1, 0.1% in P2, 0.0% in P3, 0.1% in P4, and 0.1% in P5.

**M. Appendix D7 – Summary**

- b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.**

Program adjustments are included each year to compensate for payment timing differences in the CMS 64.9 reports, PIHP enrollment mix changes, capitation rate policy adjustments, and other lump sum payments. The following program adjustments are included:

Adjustments of -0.08% are made to NH LOC and -0.87% to Non-NH LOC in P1 (CY2020) to reflect payments and recoveries reported in the CMS 64.9 for R2 (CY2018), but need to be excluded in projected future periods as these costs will not be incurred again in the projection period.

To reflect changes from R2 (CY2018) capitation rates to actual CY2019 capitation rates which serve as the projection base, an adjustment of 2.23% is applied to NH LOC and 4.17% is applied to Non-NH LOC. Detail for the CY2019 capitation rate development can be found in the annual Capitation Rate Development Report prepared by the State's contracted actuaries.

Enrollment changes in PIHPs serving Family Care counties affect the average program-wide capitation rates in aggregate. This adjustment relates to the effect of PIHPs with different capitation rates having different enrollment growth rates. The aggregate capitation rate will increase if there is more enrollment growth MCOs with higher capitation rates and will decrease if enrollment is higher in MCOs with lower capitation rates. Adjustments to NH LOC are 0.03% in P1 (CY 2020), 0.03% in P2 (CY 2021), 0.02% in P3 (CY 2022), 0.02% in P4 (CY 2023), and 0.02% in P5 (CY 2024). Adjustments included in Non-NH LOC are 0.10% in P1 (CY 2020), 0.08% in P2 (CY 2021), 0.04% in P3 (CY 2022), 0.05% in P4 (CY 2023), and 0.05% in P5 (CY 2024).

Funding is included in all years for adjustments to capitation rates for PIHPs experiencing disproportionately high costs relative to the capitation rate model. These are contingent expenditures to stabilize PIHPs experiencing financial distress. There have been three PIHPs that have discontinued operations since the program began expanding in 2008 that required additional funding. Additional PIHPs are currently on either heightened financial monitoring or financial corrective action. Detailed review has indicated that PIHPs' operations to be the primary source of the financial difficulties, not the soundness of the capitation rates. The PIHPs are required to identify and implement efficiencies to reflect the payment model and will continue under enhanced financial monitoring, which includes monthly financial submissions to the State. Additional funding would be incorporated into capitation rates. Contract amendments would be executed if the rate adjustments occur after the initial contract for year is signed. These costs require a policy adjustment of 0.30% in P1 (CY 2020) to NH LOC. Total hardship funding is held constant each year; however, increasing enrollment reduces PMPM cost requiring an adjustment to the NH LOC of -0.01% each year in P2 (CY2021) – P5 (CY2024).

Money Follows the Person incentive payments will continue. These payments increase in aggregate proportionately with enrollment growth; however the payment is made the year

## **1915(b) Waiver: Draft WI.048.07.00 – Jan 01, 2020**

### Appendix D - Supplemental Responses

following the year to which the payment relates. This timing difference decreases cost on a PMPM basis during periods of increasing enrollment requiring an adjustment of less than 0.01% each year P1 (CY2020) – P5 (CY2024) to the NH LOC MEG.

Payments for acuity adjustments made to PIHPs that expanded into new counties are discontinued in P1 (CY2020) for GSR 13 and GSR 14. The acuity adjustment for (GSR 12) Dane County begins after CMS 64 for R2 (CY2018) and decreases through P1 (CY2020) and P2 (CY2021) is discontinued P3 (CY2022). Net adjustments to NH LOC are 0.16% in P1 (CY2020), -0.10 in P2 (CY2022), and -0.09% in P3 (CY2023).

High cost risk pool payments are increased relative to the R2 (CY2018) CMS 64. These are withheld from initial plan capitation payments and paid out to PIHPs on a budget neutral basis proportional to plan costs above the high cost risk pool threshold. The payment increase reflected in P1 (CY2020) requires a 0.68% adjustment to NH LOC. Once the payments are added to P1 (CY2020) of the projection, they are automatically included in the cost base for future years; however, a timing difference decreases cost on a PMPM basis during periods of increasing enrollment requiring an adjustment of less than 0.01% each year P2 (CY2021) – P5 (CY2024).

A pay for performance withhold and incentive mechanism began in CY2018. The payments will not be made until CY2019 and are therefore not included in the R2 (CY2018) CMS 64. Pay for Performance withhold payments are based on results from the member satisfaction survey and competitive integrated employment plan. PIHPs may additionally be eligible for an incentive payment based on results from the member satisfaction survey, competitive integrated employment actions, and assisted living quality improvement incentive. Pay for performance details can be found in Article XVIII.E of the contract between the Department and the PIHP. An adjustment of 1.04% is added in P1 (CY2020) for the NH LOC MEG and 0.98% for the Non-NH MEG. Once the payments are added to P1 (CY2020) of the projection, they are automatically included in the cost base for future years; however, a timing difference requires adjustments of less than 0.01% each year P2 (CY2021) – P5 (CY2024) for both NH and Non-NH MEGs.

Funding for home care workers providing direct care to members is included in the R2 (CY2018) CMS 64. The payments budgeted for two years were paid out in one year, making the R2 base year appear artificially higher. Payments are included in the proposed State budget at the same annual levels and are assumed to continue through the waiver period. An adjustment of -0.92% was made to the NH LOC EG in P1 (CY2020) to bring the amount in the CMS 64 back to the annual budgeted level. Direct care workforce funding is held constant each year; however, increasing enrollment reduces PMPM cost requiring downward adjustments to the NH LOC of -0.07% in P2 (CY2021), -0.07% in P3 (CY2022), -0.06% in P4 (CY2023), and -0.06% in P5 (CY2024).

Net program adjustments in the NH LOC MEG are 3.4% in P1, -0.2% in P2, -0.1% in P3, 0.0% in P4, and 0.0% in P5.

Net program adjustments in the Non-NH LOC MEG are 4.4% in P1, 0.1% in P2, 0.0% in P3, 0.1% in P4, and 0.1% in P5.

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Renewal Waiver

Estimated Member Month Calculations

State: **Wisconsin**

5 Actual Enrollment for the Time Period - R1 = 1/1/17 through 12/31/17 R2 = 1/1/18 through 12/31/18 \*\*R1 and R2 include actual data and dates for cost effectiveness monitoring - no estimates  
 6 Enrollment Projections for the Time Period - P1 = 1/1/20 through 12/31/20 P2 = 1/1/21 through 12/31/21 \*Projections start on Quarter and include data for requested waiver period  
 7 Enrollment Projections for the Time Period - P3 = 1/1/22 through 12/31/22 P4 = 1/1/23 through 12/31/23 P5 = 1/1/24 through 12/31/24

Medicaid Eligibility Group (MEG)	Retrospective Year 1 (R1) 12/31/17	Retrospective Year 2 (R2) 12/31/18	Projected Quarter 1 1/1/20	Projected Quarter 2 4/1/20	Projected Quarter 3 7/1/20	Projected Quarter 4 10/1/20	Projected Year 1 (P1)	Projected Quarter 5 1/1/21	Projected Quarter 6 4/1/21	Projected Quarter 7 7/1/21	Projected Quarter 8 10/1/21	Projected Year 2 (P2)
Nursing Home Level of Care	530,743	559,968	147,978	149,168	150,336	151,488	598,970	152,656	153,861	155,060	156,256	617,833
Non-Nursing Home Level of Care	19,402	18,160	4,463	4,513	4,561	4,609	18,146	4,657	4,706	4,755	4,804	18,922
<b>Total Member Months</b>	<b>550,145</b>	<b>578,127</b>	<b>152,442</b>	<b>153,681</b>	<b>154,897</b>	<b>156,097</b>	<b>617,117</b>	<b>157,313</b>	<b>158,568</b>	<b>159,815</b>	<b>161,060</b>	<b>636,755</b>
<b>Quarterly % Increase</b>				<b>0.8%</b>	<b>0.8%</b>	<b>0.8%</b>		<b>0.8%</b>	<b>0.8%</b>	<b>0.8%</b>	<b>0.8%</b>	

NUMBER OF DAYS OF DATA	
R2	365
Gap (end of R2 to P1)	365
P1	366
P2	365
P3	365
P4	365
P5	366
TOTAL R2 to P2	1461
(Days-365)	1096
TOTAL R2 to P1	1096
(Days-366)	730
TOTAL R2 to P3	1826
(Days-365)	1461
TOTAL R2 to P4	2191
(Days-365)	1826
TOTAL R2 to P5	2557
(Days-366)	2191

	Total Projected 2 Year	Total Projected 5 Year
Nursing Home Level of Care	1,216,804	3,182,227
Non-Nursing Home Level of Care	37,068	98,458
	<b>1,253,872</b>	<b>3,280,684</b>

21 Modify Line items as necessary to fit the MEGs of the program.  
 22 State Completion Sections  
 23 To modify the formulas as necessary to fit the length of the program complete this section.  
 24 The formulas will automatically update given this data.  
 25 Use Quarter Starting Dates on Appendix D1. Appendix D6 will automatically become Quarter Ending Dates to sync with CMS-64.

Medicaid Eligibility Group (MEG)	Projected Quarter 9 1/1/22	Projected Quarter 10 4/1/22	Projected Quarter 11 7/1/22	Projected Quarter 12 10/1/22	Projected Year 3 (P3)	Projected Quarter 13 1/1/23	Projected Quarter 14 4/1/23	Projected Quarter 15 7/1/23	Projected Quarter 16 10/1/23	Projected Year 4 (P4)	Projected Quarter 17 1/1/24	Projected Quarter 18 4/1/24	Projected Quarter 19 7/1/24	Projected Quarter 20 10/1/24	Projected Year 5 (P5)
Nursing Home Level of Care	157,443	158,608	159,770	160,930	636,751	162,083	163,226	164,368	165,510	655,186	166,653	167,799	168,944	170,090	673,486
Non-Nursing Home Level of Care	4,852	4,900	4,948	4,996	19,697	5,044	5,092	5,140	5,188	20,464	5,235	5,283	5,331	5,379	21,229
<b>Total Member Months</b>	<b>162,295</b>	<b>163,509</b>	<b>164,718</b>	<b>165,926</b>	<b>656,447</b>	<b>167,128</b>	<b>168,318</b>	<b>169,508</b>	<b>170,697</b>	<b>675,650</b>	<b>171,888</b>	<b>173,082</b>	<b>174,275</b>	<b>175,469</b>	<b>694,715</b>
<b>Quarterly % Increase</b>	<b>0.8%</b>	<b>0.7%</b>	<b>0.7%</b>	<b>0.7%</b>		<b>0.7%</b>	<b>0.7%</b>	<b>0.7%</b>	<b>0.7%</b>		<b>0.7%</b>	<b>0.7%</b>	<b>0.7%</b>	<b>0.7%</b>	

	R1 to R2	R2 to P1	P1 to P2	P2 to P3	P3 to P4	P4 to P5	R2 to P2	R2 to P5
<b>Annualized % Increase</b>	<b>5.1%</b>	<b>6.7%</b>	<b>3.2%</b>	<b>3.1%</b>	<b>2.9%</b>	<b>2.8%</b>	<b>10.1%</b>	<b>20.2%</b>

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Services in Actual Waiver Cost (Comprehensive and Expedited)

State: Wisconsin

Renewal Waiver

Instructions: Modify columns as applicable to the waiver entity type and structure to note services in different MEGs.

\* Please note with a \* if there are any proposed changes.

State Plan Services	Nursing Home Level of Care ((B)/(C) Enrollees)					Non-Nursing Home Level of Care ((B) Only Enrollees)				
	State Plan Approved Services	1915(b)(3) Services	PIHP Capitated Reimbursement	FFS Reimbursement	FFS Impacted Services	State Plan Approved Services	1915(b)(3) Services	PIHP Capitated Reimbursement	FFS Reimbursement	FFS Impacted Services
Adaptive Aids – General			X							
Adaptive Aids – Vehicles			X							
Adult Day Care			X							
Alcohol and Other Drug Abuse Day Treatment	X		X			X		X		
AODA Treatment (except those provided by a physician or on an inpatient basis)	X		X			X		X		
Case Management	X		X			X		X		
Communication Aids/Assistive Technologies			X							
Community Support Program	X		X			X		X		
Consultative Clinical and Therapeutic Services for Caregivers			X							
Consumer Directed Supports (Self Directed Supports) Support Broker			X							
Consumer Education and Training			X							
Counseling/ Therapeutic Resources			X							
Daily Living Skills Training			X							
Day Habilitation Services			X							
Disposable Medical Supplies	X		X			X		X		
Durable Medical Equipment (excluding hearing aids and prosthetics)	X		X			X		X		
Financial Management Services			X							
Home Health Services	X		X			X		X		
Home Modifications			X							
Housing Counseling			X							
Meals-Home Delivered			X							
Mental Health Counseling/Therapy (except those provided by a physician or on an inpatient basis)	X		X			X		X		
Mental Health Day Treatment	X		X			X		x		
Nursing Home Stays (Nursing Home, Institution for Mental Disease (IMD) and ICF-I/ID Facility)	X		X			X		x		
Occupational Therapy	X		X			X		X		
Personal Care	X		X			X		X		
Personal Emergency Response System Services			X							
Physical Therapy	X		X			X		X		
Prevocational Services			X							
Relocation Services			X							
Residential Services – RCAC, CBRF, Adult Family Home			X							
Respiratory Therapy by Independent Nurse or therapist employed by Home Health Agency	X		X			X		X		
Respite Care			X							
Self-directed Personal Care			X							
Skilled Nursing	X		X			X		X		
Specialized Medical Supplies			X							
Speech and Language Pathology Services (except in inpatient hospital settings)	X		X			X		X		
Supported Employment - Individual Employment Support			X							
Supported Employment - Small Group Employment Support			X							

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Services in Actual Waiver Cost (Comprehensive and Expedited)

State: Wisconsin

Renewal Waiver

Instructions: Modify columns as applicable to the waiver entity type and structure to note services in different MEGs.

\* Please note with a \* if there are any proposed changes.

State Plan Services	Nursing Home Level of Care ((B)/(C) Enrollees)					Non-Nursing Home Level of Care ((B) Only Enrollees)				
	State Plan Approved Services	1915(b)(3) Services	PIHP Capitated Reimbursement	FFS Reimbursement	FFS Impacted Services	State Plan Approved Services	1915(b)(3) Services	PIHP Capitated Reimbursement	FFS Reimbursement	FFS Impacted Services
Supportive Home Care			X							
Training Services for Unpaid Caregivers			X							
Transportation - Common Carrier	X		X			X		X		
Transportation - Community - Non-medical			X							
Transportation - Community - Self-directed non-emergency medical			X							
Transportation - Medical (including specialized medical vehicle)	X		X			X		X		
Vocational Futures Planning and Support			X							

Modify Line items as necessary to fit the services of the program.

State Completion Sections

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Administration in Actual Waiver Cost (Comprehensive and Expedited)

State: Wisconsin

Renewal Waiver

Instructions: Modify columns as applicable to the waiver entity type and structure to note administration in different MEGs, etc.

CMS 64.10 line Item	CMS 64.10 Explanation	Contract	Match Rate	R1 Expenses		R2 Expenses	
				Nursing Home Level of Care	Non-Nursing Home Level of Care	Nursing Home Level of Care	Non-Nursing Home Level of Care
1.	FAMILY PLANNING		90% FFP	\$0	\$0	\$0	\$0
2. A.	DESIGN DEVELOPMENT OR INSTALLATION OF MMIS - IN-HOUSE ACTIVITIES		90% FFP	\$0	\$0	\$0	\$0
B.	DESIGN DEVELOPMENT OR INSTALLATION OF MMIS - PRIVATE CONTRACTORS		90% FFP	\$0	\$0	\$0	\$0
3. A.	SKILLED PROFESSIONAL MEDICAL PERSONNEL - SINGLE STATE AGENCY		75% FFP	\$810,587	\$7,127	\$650,114	\$8,746
B.	SKILLED PROFESSIONAL MEDICAL PERSONNEL - OTHER AGENCY		75% FFP	\$11,400	\$111	\$39,807	\$499
4. A.	OPERATION OF AN APPROVED MMIS: IN-HOUSE & OTHER STATE AGENCIES AND INSTITUTIONS		75% FFP	\$727,509	\$6,723	\$767,044	\$8,847
B.	OPERATION OF AN APPROVED MMIS: PRIVATE SECTOR CONTRACTORS		75% FFP	\$6,989,832	\$57,841	\$6,973,204	\$76,855
5. A.	MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES: IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS		50% FFP	\$2,032,919	\$25,307	\$1,009,546	\$15,242
B.	MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES: PRIVATE SECTOR CONTRACTORS		50% FFP	\$4,116,015	\$37,248	\$2,764,033	\$12,284
C.	MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES: INTERAGENCY		50% FFP	\$0	\$0	\$0	\$0
6.	QUALITY IMPROVEMENT ORGANIZATIONS		75% FFP	\$197,972	\$1,618	\$192,205	\$3,303
7. A.	THIRD PARTY LIABILITY RECOVERY PROCEDURE - BILLING OFFSET		50% FFP	\$0	\$0	\$0	\$0
B.	THIRD PARTY LIABILITY ASSIGNMENT OF RIGHTS - BILLING OFFSET		50% FFP	\$0	\$0	\$0	\$0
8.	IMMIGRATION STATUS VERIFICATION SYSTEM COSTS		100% FFP	\$0	\$0	\$0	\$0
9.	NURSE AIDE TRAINING COSTS		50% FFP	\$17,424	\$133	\$10,920	\$112
10.	PREADMISSION SCREENING COSTS		75% FFP	\$358,566	\$2,881	\$344,841	\$4,220
11.	RESIDENT REVIEW ACTIVITIES COSTS		75% FFP	\$0	\$0	\$0	\$0
12.	DRUG USE REVIEW PROGRAM		50% FFP	\$0	\$0	\$0	\$0
13.	OUTSTATIONED ELIGIBILITY WORKERS		50% FFP	\$0	\$0	\$0	\$0
14.	TANF BASE		90% FFP	\$0	\$0	\$0	\$0
15.	TANF SECONDARY 90%		90% FFP	\$0	\$0	\$0	\$0
16.	TANF SECONDARY 75%		75% FFP	\$0	\$0	\$0	\$0
17.	EXTERNAL REVIEW		75% FFP	\$0	\$0	\$0	\$0
18.	ENROLLMENT BROKERS		50% FFP	\$0	\$0	\$0	\$0
19.	SCHOOL BASED ADMINISTRATION		50% FFP	\$3,447,681	\$69,714	\$4,343,671	\$21,872
20.	PROGRAM INTEGRITY/FRAUD, WASTE, AND ABUSE ACTIVITIES		50% FFP	\$81,302	\$917	\$86,529	\$455
21.	COUNTY/LOCAL ADM CASES		50% FFP	\$17,107,941	\$132,007	\$18,660,648	\$238,657
22.	INTERAGENCY COSTS		50% FFP	\$358,210	\$5,031	\$439,217	\$2,623
23.	TRANSLATION AND INTERPRETATION		75% FFP	\$0	\$0	\$0	\$0
24.	HEALTH INFORMATION TECHNOLOGY ADMINISTRATION						
A.	HIT: PLANNING: COST OF IN-HOUSE ACTIVITIES		90% FFP	\$0	\$0	\$0	\$0
B.	HIT: PLANNING: COST OF PRIVATE CONTRACTORS		90% FFP	\$0	\$0	\$0	\$0
C.	HIT: IMPLEMENTATION AND OPERATION: COST OF IN-HOUSE ACTIVITIES		90% FFP	\$32,360	\$292	\$64,352	\$539
D.	HIT: IMPLEMENTATION AND OPERATION: COST OF PRIVATE CONTRACTORS		90% FFP	\$327,045	\$4,125	\$554,633	\$7,075
E.	HIT INCENTIVE PAYMENTS - ELIGIBLE PROFESSIONALS		100% FFP	\$0	\$0	\$0	\$0
F.	HIT INCENTIVE PAYMENTS - ELIGIBLE HOSPITALS		100% FFP	\$0	\$0	\$0	\$0
25.	CITIZENSHIP VERIFICATION TECHNOLOGY						
A.	CVT DEVELOPMENT - CHIPRA		90% FFP	\$0	\$0	\$0	\$0
B.	CVT OPERATION - CHIPRA		75% FFP	\$0	\$0	\$0	\$0
26.	PLANNING FOR HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS		Benefit FFP	\$0	\$0	\$0	\$0
27.	RECOVERY AUDIT CONTRACTORS STATE ADMINISTRATION		50% FFP	\$0	\$0	\$0	\$0
28.A.	DESIGN DEV/INSTALL OF MEDICAID ELIG DETERM SYS - IN-HOUSE ACTIVITIES		90% FFP	\$0	\$0	\$0	\$0
B.	DESIGN DEV/INSTALL OF MEDICAID ELIG DETERM SYS - PRIVATE CONTRACTORS		90% FFP	\$0	\$0	\$0	\$0
C.	OPERATION OF AN APPROVED MEDICAID ELIG DETERM SYS - IN-HOUSE ACTIVITIES		75% FFP	\$665,140	\$8,221	\$777,444	\$10,036
D.	OPERATION OF AN APPROVED MEDICAID ELIG DETERM SYS - PRIVATE CONTRACTORS		75% FFP	\$1,804,745	\$19,383	\$2,612,525	\$25,982
E.	ELIGIBILITY DETERMINATION STAFF - IN-HOUSE ACTIVITIES		75% FFP	\$0	\$0	\$0	\$0
F.	ELIGIBILITY DETERMINATION STAFF - PRIVATE CONTRACTORS		75% FFP	\$0	\$0	\$0	\$0
G.	ELIGIBILITY DETERMINATION STAFF - IN-HOUSE ACTIVITIES		50% FFP	\$0	\$0	\$0	\$0
H.	ELIGIBILITY DETERMINATION STAFF - PRIVATE CONTRACTORS		50% FFP	\$0	\$0	\$0	\$0
29.	NON-EMERGENCY MEDICAL TRANSPORTATION		50% FFP	\$0	\$0	\$0	\$0
49.	OTHER FINANCIAL PARTICIPATION		50% FFP	\$0	\$0	\$0	\$0
50.	<b>Total</b>			<b>\$51,701,635</b>	<b>\$476,716</b>	<b>\$56,210,067</b>	<b>\$597,115</b>

\*Allocation basis is X % of Medicaid costs OR     % of Medicaid eligibles OR     other, please explain:

Add multiple line items as necessary to fit the administration of the program (i.e. if you have more than one contract on line 19, detail the contracts separately).

State Completion Sections

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**Actual Waiver Cost Renewal Comprehensive Version**  
State: Wisconsin

**Actual Waiver Cost Renewal Comprehensive Version**  
State: Wisconsin

Medicaid Eligibility Group (MEG)	R1 Member Months	Retrospective Year 1 (R1) Aggregate Costs							R1 Per Member Per Month (PMPM) Costs				
		MCO/PIHP Capitated Costs (including incentives and risksharing payouts/withholds) or PCCM Case Management Fees	Fee-for-Service Costs	State Plan Service Costs (D+E)	FFS Incentive Costs (not included in capitation rates, provide documentation)	1915(b)(3) service costs (provide documentation)	Administration Costs	Total Actual Waiver Costs (F+G+H+I)	State Plan Service Costs (F/C)	Incentive Costs (G/C)	1915(b)(3) Service Costs (H/C)	Administration Costs (I/C)	Total Actual Waiver Costs (J/C)
Nursing Home Level of Care	530,743	\$ 1,656,538,438	\$ -	\$ 1,656,538,438	\$ -	\$ -	\$ 51,701,635	\$ 1,708,240,073	\$ 3,121.17	\$ -	\$ -	\$ 97.41	\$ 3,218.58
Non-Nursing Home Level of Care	19,402	\$ 8,924,778	\$ -	\$ 8,924,778	\$ -	\$ -	\$ 476,716	\$ 9,401,494	\$ 460.00	\$ -	\$ -	\$ 24.57	\$ 484.57
<b>Total</b>	<b>550,145</b>	<b>\$ 1,665,463,216</b>	<b>\$ -</b>	<b>\$ 1,665,463,216</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 52,178,351</b>	<b>\$ 1,717,641,567</b>					
<b>R1 Overall PMPM Casemix for R1 (R1 MMs)</b>									\$ 3,027.32	\$ -	\$ -	\$ 94.84	\$ 3,122.16

Medicaid Eligibility Group (MEG)	R2 Member Months	Retrospective Year 2 (R2) Aggregate Costs							R2 Per Member Per Month (PMPM) Costs				
		MCO/PIHP Capitated Costs (including incentives and risksharing payouts/withholds) or PCCM Case Management Fees	Fee-for-Service Costs	State Plan Service Costs (D+E)	FFS Incentive Costs (not included in capitation rates, provide documentation)	1915(b)(3) service costs (provide documentation)	Administration Costs (Attach list using CMS 64.10 Waiver schedule categories)	Total Actual Waiver Costs (F+G+H+I)	State Plan Service Costs (F/C)	Incentive Costs (G/C)	1915(b)(3) Service Costs (H/C)	Administration Costs (I/C)	Total Actual Waiver Costs (J/C)
Nursing Home Level of Care	559,968	\$ 1,785,695,709	\$ -	\$ 1,785,695,709	\$ -	\$ -	\$ 56,210,067	\$ 1,841,905,776	\$ 3,188.93	\$ -	\$ -	\$ 100.38	\$ 3,289.31
Non-Nursing Home Level of Care	18,160	\$ 8,775,381	\$ -	\$ 8,775,381	\$ -	\$ -	\$ 597,115	\$ 9,372,496	\$ 483.24	\$ -	\$ -	\$ 32.88	\$ 516.12
<b>Total</b>	<b>578,127</b>	<b>\$ 1,794,471,090</b>	<b>\$ -</b>	<b>\$ 1,794,471,090</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 56,807,182</b>	<b>\$ 1,851,278,272</b>					
<b>R2 Overall PMPM Casemix for R2 (R2 MMs)</b>									\$ 3,103.94	\$ -	\$ -	\$ 98.26	\$ 3,202.20

Modify Line items as necessary to fit the MEGs of the program.  
State Completion Sections

Note: The States completing the Expedited Test will only attach the most recent waiver Schedule D, and the corresponding quarters of waiver forms from the CMS-64.9 Waiver and CMS-64.21U Waiver and CMS 64.10 Waiver. Completion of this Appendix is not necessary for expedited waivers.

Note: The States completing the Comprehensive Test will attach the most recent waiver Schedule D, and the corresponding quarters of waiver forms from the CMS-64.9 Waiver and CMS-64.21U Waiver and CMS 64.10 Waiver. Completion of this Appendix is required for Comprehensive Waivers.

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**Adjustments and Services in Waiver Cost Projection (Comprehensive and Expedited)**

State: Wisconsin

**Prospective Years 1 through 5 (P1 - P5) or Years 1 though 2 (P1 -P2)**

**Renewal Waiver**

**\* If a change please note**

Adjustments to the Waiver Cost Projection	Adjustments Made	Location of Adjustment
State Plan Trend	x	D5. Waiver Cost Projection J13, J14, J30, J31, J43, J44, J57, J58, J70, J71
State Plan Programmatic/policy/pricing changes	x	D5. Waiver Cost Projection L13, L14, L30, L31, L43, L44, L57, L58, L70, L71
Administrative Cost Adjustment	x	D5. Waiver Cost Projection Y13, Y14, Y30, Y31, Y43, Y44, Y57, Y58, Y70, Y71
1915(b)(3) service Trend		
Incentives (not in cap payment) Adjustments		
Other		

State Completion Sections

Appendix D5. Waiver Cost Projection

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B C D E F G H I J K L M N O

Waiver Cost Projection Renewal Waiver Comprehensive Version  
 State: Wisconsin  
 Note: Complete this Appendix for all Prospective Years

Modify Line items as necessary to fit the MEGs of the program.

State Completion Sections

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	R2 Per Member Per Month (PMPM) Costs					Prospective Year 1 (P1) Projection for State Plan Services**						
		State Plan Service Costs*	Incentive Costs*	1915(b)(3) Service Costs*	Administration Costs*	Total Actual Waiver Costs*	R2 PMPM State Plan Service Costs*	State Plan Inflation Adjustment (2 Year, Base+Gap)	PMPM Effect of Inflation Adjustment (I x J)	Program Adjustment R2 Reporting Adj., Retro Acuity, & Other Payments	PMPM Effect of Program Adjustment ((I+K)xL)	Aggregate PMPM Effect of State Plan Service Adj. (K+M)	Total P1 PMPM State Plan Service Cost Projection (I+N)
		Nursing Home Level of Care	559,968	\$ 3,188.93	\$ -	\$ -	\$ 100.38	\$ 3,289.31	\$ 3,188.93	3.8%	\$ 121.45	3.4%	\$ 114.13
Non-Nursing Home Level of Care	18,160	\$ 483.24	\$ -	\$ -	\$ 32.88	\$ 516.12	\$ 483.24	3.8%	\$ 18.40	4.4%	\$ 21.96	\$ 40.36	\$ 523.60
<b>Total</b>	<b>578,127</b>												
<b>P1 PMPM Casemix for R2 (R2 MMs)</b>		<b>\$ 3,103.94</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 98.26</b>	<b>\$ 3,202.20</b>	<b>\$ 3,103.94</b>	<b>3.8%</b>	<b>\$ 118.21</b>	<b>3.5%</b>	<b>\$ 111.24</b>	<b>\$ 229.45</b>	<b>\$ 3,333.38</b>

\* For comprehensive waivers, Columns D, E, F, G and H are columns K, L, M, N, and O from the Actual Waiver Cost Spreadsheet D3. For expedited waivers, sum the CMS-64.9 WAV and 64.21UWAV forms and divide by the member months for column D. Sum the CMS 64.10 WAV forms and divide by the member months for Column G. Sum D+G for Column H.  
 \*\* If additional columns are needed in order to identify all of the adjustments being made, please insert the appropriate number of columns and label them accordingly.

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	P1 Per Member Per Month (PMPM) Costs					Prospective Year 2 (P2) Projection for State Plan Services**						
		P1 PMPM State Plan Service Costs	P1 PMPM Incentive Service Costs	P1 PMPM 1915(b)(3) Service Costs	P1 PMPM Administration Service Costs	P1 PMPM Total Actual Waiver Costs	P1 PMPM State Plan Service Cost Projection	State Plan Inflation Adjustment (Annual Year 2)	PMPM Effect of Inflation Adjustment (I x J)	Program Adjustment Retro Acuity & Other Payments	PMPM Effect of Program Adjustment ((I+K)xL)	Aggregate PMPM Effect of State Plan Service Adj. (K+M)	Total P2 PMPM State Plan Service Cost Projection (I+N)
		Nursing Home Level of Care	559,968	\$ 3,424.50	\$ -	\$ -	\$ 104.20	\$ 3,528.71	\$ 3,424.50	2.0%	\$ 68.49	-0.2%	\$ (5.55)
Non-Nursing Home Level of Care	18,160	\$ 523.60	\$ -	\$ -	\$ 34.13	\$ 557.73	\$ 523.60	2.0%	\$ 10.47	0.1%	\$ 0.43	\$ 10.90	\$ 534.50
<b>Total</b>	<b>578,127</b>												
<b>P2 PMPM Casemix for R2 (R2 MMs)</b>		<b>\$ 3,333.38</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 102.00</b>	<b>\$ 3,435.39</b>	<b>\$ 3,333.38</b>	<b>2.0%</b>	<b>\$ 66.67</b>	<b>-0.2%</b>	<b>\$ (5.36)</b>	<b>\$ 61.30</b>	<b>\$ 3,394.69</b>

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	P2 Per Member Per Month (PMPM) Costs					Prospective Year 3 (P3) Projection for State Plan Services**						
		P2 PMPM State Plan Service Costs	P2 PMPM Incentive Service Costs	P2 PMPM 1915(b)(3) Service Costs	P2 PMPM Administration Service Costs	P2 PMPM Total Actual Waiver Costs	P2 PMPM State Plan Service Cost Projection	State Plan Inflation Adjustment (Annual Year 3)	PMPM Effect of Inflation Adjustment	Program Adjustment Retro Acuity & Other Payments	PMPM Effect of Program Adjustment	Aggregate PMPM Effect of State Plan Service Adj.	Total P3 PMPM State Plan Service Cost Projection
		Nursing Home Level of Care	559,968	\$ 3,487.44	\$ -	\$ -	\$ 106.29	\$ 3,593.73	\$ 3,487.44	2.0%	\$ 69.75	-0.1%	\$ (5.22)
Non-Nursing Home Level of Care	18,160	\$ 534.50	\$ -	\$ -	\$ 34.82	\$ 569.31	\$ 534.50	2.0%	\$ 10.69	0.0%	\$ 0.23	\$ 10.92	\$ 545.42
<b>Total</b>	<b>578,127</b>												
<b>P3 PMPM Casemix for R2 (R2 MMs)</b>		<b>\$ 3,394.69</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 104.04</b>	<b>\$ 3,498.73</b>	<b>\$ 3,394.69</b>	<b>2.0%</b>	<b>\$ 67.90</b>	<b>-0.1%</b>	<b>\$ (5.05)</b>	<b>\$ 62.84</b>	<b>\$ 3,457.53</b>

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Waiver Cost Projection Renewal Waiver Comprehensive Version  
State: Wisconsin

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Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	P3 Per Member Per Month (PMPM) Costs					Prospective Year 4 (P4) Projection for State Plan Services**						
		P3 PMPM State Plan Service Costs	P3 PMPM Incentive Service Costs	P3 PMPM 1915(b)(3) Service Costs	P3 PMPM Administration Service Costs	P3 PMPM Total Actual Waiver Costs	P3 PMPM State Plan Service Cost Projection	State Plan Inflation Adjustment (Annual Year 4)	PMPM Effect of Inflation Adjustment	Program Adjustment Retro Acuity & Other Payments	PMPM Effect of Program Adjustment	Aggregate PMPM Effect of State Plan Service Adj.	Total P4 PMPM State Plan Service Cost Projection
		Nursing Home Level of Care	559,968	\$ 3,551.97	\$ -	\$ -	\$ 108.41	\$ 3,660.38	\$ 3,551.97	2.0%	\$ 71.04	0.0%	\$ (1.70)
Non-Nursing Home Level of Care	18,160	\$ 545.42	\$ -	\$ -	\$ 35.51	\$ 580.93	\$ 545.42	2.0%	\$ 10.91	0.1%	\$ 0.28	\$ 11.19	\$ 556.61
<b>Total</b>	<b>578,127</b>												
<b>P4 PMPM Casemix for R2 (R2 MMs)</b>		<b>\$ 3,457.53</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 106.12</b>	<b>\$ 3,563.65</b>	<b>\$ 3,457.53</b>	<b>2.0%</b>	<b>\$ 69.15</b>	<b>0.0%</b>	<b>\$ (1.64)</b>	<b>\$ 67.52</b>	<b>\$ 3,525.05</b>

Medicaid Eligibility Group (MEG)	Retrospective Year 2 (R2) Member Months	P4 Per Member Per Month (PMPM) Costs					Prospective Year 5 (P5) Projection for State Plan Services**						
		P4 PMPM State Plan Service Costs	P4 PMPM Incentive Service Costs	P4 PMPM 1915(b)(3) Service Costs	P4 PMPM Administration Service Costs	P4 PMPM Total Actual Waiver Costs	P4 PMPM State Plan Service Cost Projection	State Plan Inflation Adjustment (Annual Year 5)	PMPM Effect of Inflation Adjustment	Program Adjustment Retro Acuity & Other Payments	PMPM Effect of Program Adjustment	Aggregate PMPM Effect of State Plan Service Adj.	Total P5 PMPM State Plan Service Cost Projection
		Nursing Home Level of Care	559,968	\$ 3,621.31	\$ -	\$ -	\$ 110.58	\$ 3,731.89	\$ 3,621.31	2.0%	\$ 72.43	0.0%	\$ (1.63)
Non-Nursing Home Level of Care	18,160	\$ 556.61	\$ -	\$ -	\$ 36.22	\$ 592.83	\$ 556.61	2.0%	\$ 11.13	0.1%	\$ 0.29	\$ 11.42	\$ 568.03
<b>Total</b>	<b>578,127</b>												
<b>P5 PMPM Casemix for R2 (R2 MMs)</b>		<b>\$ 3,525.05</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 108.25</b>	<b>\$ 3,633.29</b>	<b>\$ 3,525.05</b>	<b>2.0%</b>	<b>\$ 70.50</b>	<b>0.0%</b>	<b>\$ (1.57)</b>	<b>\$ 68.93</b>	<b>\$ 3,593.97</b>

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5 Modify Line items as necessary to fit the MEGs of the program.  
6 State Completion Sections

Actual Waiver Cost Conversion Renewal Comprehensive Version  
State: Wisconsin  
Note: Complete this Appendix for all Prospective Years  
Waiver Cost Projection

Medicaid Eligibility Group (MEG)	P1 Projection for Incentive Costs not Included in Capitation Rates**				P1 Projection for 1915(b)(3) Service Costs**				P1 Projection for Administration Costs**				Total P1 PMPM Projected Waiver Costs (O+S+W+AA)
	R2 PMPM Incentive Costs*	Incentive Cost Inflation Adjustment (2 Year, Base+Gap)	PMPM Effect of Inflation Adjustment (PxQ)	Total P1 PMPM Incentive Cost Projection (P+R)	R2 PMPM 1915(b)(3) Service Costs*	1915(b)(3) Service Costs Inflation Adjustment (2 Year, Base+Gap)	PMPM Effect of Inflation Adjustment (TxU)	Total P1 PMPM 1915(b)(3) Service Cost Projection (T+V)	R2 PMPM Administration Costs*	Administration Costs Inflation Adjustment (2 Year, Base+Gap)	PMPM Effect of Inflation Adjustment (XxY)	Total P1 PMPM Administration Cost Projection (X+Z)	
	Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	100.38	3.8%	\$ 3.82	
Non-Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	32.88	3.8%	\$ 1.25	\$ 34.13	\$ 557.73
<b>Total</b>													
<b>P1 PMPM Casemix for R2 (R2 MMs)</b>	\$ -	0.0%	\$ -	\$ -	\$ -	0.0%	\$ -	\$ -	98.26	3.8%	\$ 3.74	\$ 102.00	\$ 3,435.39

Medicaid Eligibility Group (MEG)	P2 Projection for Incentive Costs not Included in Capitation Rates**				P2 Projection for 1915(b)(3) Service Costs**				P2 Projection for Administration Costs**				Total P2 PMPM Projected Waiver Costs (O+S+W+AA)
	P1 PMPM Incentive Cost Projection	Incentive Cost Inflation Adjustment (Annual Year 2)	PMPM Effect of Inflation Adjustment (PxQ)	Total P2 PMPM Incentive Cost Projection (P+R)	P1 PMPM 1915(b)(3) Service Cost Projection	1915(b)(3) Service Costs Inflation Adjustment (Annual Year 2)	PMPM Effect of Inflation Adjustment (TxU)	Total P2 PMPM 1915(b)(3) Service Cost Projection (T+V)	P1 PMPM Administration Cost Projection	Administration Costs Inflation Adjustment (Annual Year 2)	PMPM Effect of Inflation Adjustment (XxY)	Total P2 PMPM Administration Cost Projection (X+Z)	
	Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	104.20	2.0%	\$ 2.08	
Non-Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	34.13	2.0%	\$ 0.68	\$ 34.82	\$ 569.31
<b>Total</b>													
<b>P2 PMPM Casemix for R2 (R2 MMs)</b>	\$ -	0.0%	\$ -	\$ -	\$ -	0.0%	\$ -	\$ -	102.00	2.0%	\$ 2.04	\$ 104.04	\$ 3,498.73

Medicaid Eligibility Group (MEG)	P3 Projection for Incentive Costs not Included in Capitation Rates**				P3 Projection for 1915(b)(3) Service Costs**				P3 Projection for Administration Costs**				Total P3 PMPM Projected Waiver Costs
	P2 PMPM Incentive Cost Projection	Incentive Cost Inflation Adjustment (Annual Year 3)	PMPM Effect of Inflation Adjustment	Total P3 PMPM Incentive Cost Projection	P2 PMPM 1915(b)(3) Service Cost Projection	1915(b)(3) Service Costs Inflation Adjustment (Annual Year 3)	PMPM Effect of Inflation Adjustment	Total P3 PMPM 1915(b)(3) Service Cost Projection	P2 PMPM Administration Cost Projection	Administration Costs Inflation Adjustment (Annual Year 3)	PMPM Effect of Inflation Adjustment	Total P3 PMPM Administration Cost Projection	
	Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	106.29	2.0%	\$ 2.13	
Non-Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	34.82	2.0%	\$ 0.70	\$ 35.51	\$ 580.93
<b>Total</b>													
<b>P3 PMPM Casemix for R2 (R2 MMs)</b>	\$ -	0.0%	\$ -	\$ -	\$ -	0.0%	\$ -	\$ -	104.04	2.0%	\$ 2.08	\$ 106.12	\$ 3,563.65

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Actual Waiver Cost Conversion Renewal Comprehensive Version  
State: Wisconsin

Medicaid Eligibility Group (MEG)	P4 Projection for Incentive Costs not Included in Capitation Rates**				P4 Projection for 1915(b)(3) Service Costs**				P4 Projection for Administration Costs**				Total P4 PMPM Projected Waiver Costs
	P3 PMPM Incentive Cost Projection	Incentive Cost Inflation Adjustment (Annual Year 4)	PMPM Effect of Inflation Adjustment	Total P4 PMPM Incentive Cost Projection	P3 PMPM 1915(b)(3) Service Cost Projection	1915(b)(3) Service Costs Inflation Adjustment (Annual Year 4)	PMPM Effect of Inflation Adjustment	Total P4 PMPM 1915(b)(3) Service Cost Projection	P3 PMPM Administration Cost Projection	Administration Costs Inflation Adjustment (Annual Year 4)	PMPM Effect of Inflation Adjustment	Total P4 PMPM Administration Cost Projection	
	Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	\$ 108.41	2.0%	\$ 2.17	
Non-Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	\$ 35.51	2.0%	\$ 0.71	\$ 36.22	\$ 592.83
<b>Total</b>													
<b>P4 PMPM Casemix for R2 (R2 MMs)</b>	\$ -	0.0%	\$ -	\$ -	\$ -	0.0%	\$ -	\$ -	\$ 106.12	2.0%	\$ 2.12	\$ 108.25	\$ 3,633.29

Medicaid Eligibility Group (MEG)	P5 Projection for Incentive Costs not Included in Capitation Rates**				P5 Projection for 1915(b)(3) Service Costs**				P5 Projection for Administration Costs**				Total P5 PMPM Projected Waiver Costs
	P4 PMPM Incentive Cost Projection	Incentive Cost Inflation Adjustment (Annual Year 5)	PMPM Effect of Inflation Adjustment	Total P5 PMPM Incentive Cost Projection	P4 PMPM 1915(b)(3) Service Cost Projection	1915(b)(3) Service Costs Inflation Adjustment (Annual Year 5)	PMPM Effect of Inflation Adjustment	Total P5 PMPM 1915(b)(3) Service Cost Projection	P4 PMPM Administration Cost Projection	Administration Costs Inflation Adjustment (Annual Year 5)	PMPM Effect of Inflation Adjustment	Total P5 PMPM Administration Cost Projection	
	Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	\$ 110.58	2.0%	\$ 2.21	
Non-Nursing Home Level of Care	\$ -		\$ -	\$ -	\$ -		\$ -	\$ -	\$ 36.22	2.0%	\$ 0.72	\$ 36.95	\$ 604.98
<b>Total</b>													
<b>P5 PMPM Casemix for R2 (R2 MMs)</b>	\$ -	0.0%	\$ -	\$ -	\$ -	0.0%	\$ -	\$ -	\$ 108.25	2.0%	\$ 2.16	\$ 110.41	\$ 3,704.39

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2	Modify Line items as necessary to fit the MEGs of the program.															
3	CMS RO Completion Sections															
4	State Completion Section															
5	<b>Projected Year 1</b>															

Medicaid Eligibility Group (MEG)	Total Projected Year 1 Member Months (P1)	P1 Projected PMPM Costs from Appendix D5 (Totals weighted on Projected Year 1 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
Nursing Home Level of Care	598,970	\$ 3,424.50	\$ -	\$ -	\$ 104.20	\$ 3,528.71	\$ 3,424.50
Non-Nursing Home Level of Care	18,146	\$ 523.60	\$ -	\$ -	\$ 34.13	\$ 557.73	\$ 523.60
<b>Total</b>	<b>617,117</b>						
<b>P1 Weighted Average PMPM Casemix for P1 (P1 MMs)</b>		<b>\$ 3,339.20</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 102.14</b>	<b>\$ 3,441.35</b>	

Medicaid Eligibility Group (MEG)	Member Months Projections	Q1 Quarterly Projected Costs			Q2 Quarterly Projected Costs			Q3 Quarterly Projected Costs			Q4 Quarterly Projected Costs			Total P1 Projected Waiver Costs
		64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	64.10 Waiver Administration Costs	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	64.10 Waiver Administration Costs	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	64.10 Waiver Administration Costs	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs		
Nursing Home Level of Care	147,978	\$ 506,753,028	\$ 15,419,923	\$ 149,168	\$ 510,827,544	\$ 15,543,906	150,336	\$ 514,826,455	\$ 15,665,588	151,488	\$ 518,770,234	\$ 15,785,593	\$ 2,113,592,271	
Non-Nursing Home Level of Care	4,463	\$ 2,337,028	\$ 152,353	4,513	\$ 2,362,761	\$ 154,031	4,561	\$ 2,388,157	\$ 155,686	4,609	\$ 2,413,319	\$ 157,326	\$ 10,120,661	
<b>Total</b>	<b>152,442</b>	<b>\$ 509,090,056</b>	<b>\$ 15,572,276</b>	<b>153,681</b>	<b>\$ 513,190,305</b>	<b>\$ 15,697,936</b>	<b>154,897</b>	<b>\$ 517,214,612</b>	<b>\$ 15,821,274</b>	<b>156,097</b>	<b>\$ 521,183,553</b>	<b>\$ 15,942,919</b>	<b>\$ 2,123,712,932</b>	

Medicaid Eligibility Group (MEG)	Total Projected Year 2 Member Months (P2)	P2 Projected PMPM Costs from Appendix D5 (Totals weighted on Projected Year 2 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
Nursing Home Level of Care	617,833	\$ 3,487.44	\$ -	\$ -	\$ 106.29	\$ 3,593.73	\$ 3,487.44
Non-Nursing Home Level of Care	18,922	\$ 534.50	\$ -	\$ -	\$ 34.82	\$ 569.31	\$ 534.50
<b>Total</b>	<b>636,755</b>						
<b>P2 Weighted Average PMPM Casemix for P2 (P2 MMs)</b>		<b>\$ 3,399.69</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 104.16</b>	<b>\$ 3,503.85</b>	

Medicaid Eligibility Group (MEG)	Member Months Projections	Q5 Quarterly Projected Costs			Q6 Quarterly Projected Costs			Q7 Quarterly Projected Costs			Q8 Quarterly Projected Costs			Total P2 Projected Waiver Costs
		64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	64.10 Waiver Administration Costs	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	64.10 Waiver Administration Costs	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	64.10 Waiver Administration Costs	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs		
Nursing Home Level of Care	152,656	\$ 532,377,339	\$ 16,225,435	153,861	\$ 536,582,229	\$ 16,353,588	155,060	\$ 540,762,715	\$ 16,480,998	156,256	\$ 544,934,651	\$ 16,608,148	\$ 2,220,325,103	
Non-Nursing Home Level of Care	4,657	\$ 2,489,369	\$ 162,155	4,706	\$ 2,515,491	\$ 163,856	4,755	\$ 2,541,511	\$ 165,551	4,804	\$ 2,567,492	\$ 167,244	\$ 10,772,669	
<b>Total</b>	<b>157,313</b>	<b>\$ 534,866,708</b>	<b>\$ 16,387,589</b>	<b>158,568</b>	<b>\$ 539,097,720</b>	<b>\$ 16,517,445</b>	<b>159,815</b>	<b>\$ 543,304,226</b>	<b>\$ 16,646,550</b>	<b>161,060</b>	<b>\$ 547,502,144</b>	<b>\$ 16,775,392</b>	<b>\$ 2,231,097,772</b>	

Medicaid Eligibility Group (MEG)	Total Projected Year 3 Member Months (P3)	P3 Projected PMPM Costs from Appendix D5 (Totals weighted on Projected Year 3 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
Nursing Home Level of Care	636,751	\$ 3,551.97	\$ -	\$ -	\$ 108.41	\$ 3,660.38	\$ 3,551.97
Non-Nursing Home Level of Care	19,697	\$ 545.42	\$ -	\$ -	\$ 35.51	\$ 580.93	\$ 545.42
<b>Total</b>	<b>656,447</b>						
<b>P3 Weighted Average PMPM Casemix for P3 (P3 MMs)</b>		<b>\$ 3,461.76</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 106.23</b>	<b>\$ 3,567.98</b>	

Medicaid Eligibility Group (MEG)	Member Months Projections	Q9 Quarterly Projected Costs			Q10 Quarterly Projected Costs			Q11 Quarterly Projected Costs			Q12 Quarterly Projected Costs			Total P3 Projected Waiver Costs
		64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	64.10 Waiver Administration Costs	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	64.10 Waiver Administration Costs	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	64.10 Waiver Administration Costs	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs		
Nursing Home Level of Care	157,443	\$ 559,231,677	\$ 17,068,944	158,608	\$ 563,372,120	\$ 17,195,319	159,770	\$ 567,497,971	\$ 17,321,249	160,930	\$ 571,616,526	\$ 17,446,956	\$ 2,330,750,761	
Non-Nursing Home Level of Care	4,852	\$ 2,646,368	\$ 172,310	4,900	\$ 2,672,630	\$ 174,020	4,948	\$ 2,698,858	\$ 175,727	4,996	\$ 2,725,070	\$ 177,434	\$ 11,442,417	
<b>Total</b>	<b>162,295</b>	<b>\$ 561,878,045</b>	<b>\$ 17,241,254</b>	<b>163,509</b>	<b>\$ 566,044,750</b>	<b>\$ 17,369,339</b>	<b>164,718</b>	<b>\$ 570,196,829</b>	<b>\$ 17,496,976</b>	<b>165,926</b>	<b>\$ 574,341,596</b>	<b>\$ 17,624,390</b>	<b>\$ 2,342,193,178</b>	

Row # / Column Letter

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2 Modify Line items as necessary to fit the MEGs of the program.

3 CMS RO Completion Sections

State: Wisconsin

**Projected Year 4**

Medicaid Eligibility Group (MEG)	Total Projected Year 4 Member Months (P4)	P4 Projected PMPM Costs from Appendix D5 (Totals weighted on Projected Year 4 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
Nursing Home Level of Care	655,186	\$ 3,621.31	\$ -	\$ -	\$ 110.58	\$ 3,731.89	\$ 3,621.31
Non-Nursing Home Level of Care	20,464	\$ 556.61	\$ -	\$ -	\$ 36.22	\$ 592.83	\$ 556.61
<b>Total</b>	<b>675,650</b>						
<b>P4 Weighted Average PMPM Casemix for P4 (P4 MMs)</b>		<b>\$ 3,528.49</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 108.33</b>	<b>\$ 3,636.82</b>	

Medicaid Eligibility Group (MEG)	Q13 Quarterly Projected Costs			Q14 Quarterly Projected Costs			Q15 Quarterly Projected Costs			Q16 Quarterly Projected Costs			Total P4 Projected Waiver Costs
	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	
Nursing Home Level of Care	162,083	\$ 586,954,113	\$ 17,923,489	163,226	\$ 591,090,641	\$ 18,049,804	164,368	\$ 595,226,564	\$ 18,176,101	165,510	\$ 599,362,236	\$ 18,302,389	\$ 2,445,085,357
Non-Nursing Home Level of Care	5,044	\$ 2,807,693	\$ 182,721	5,092	\$ 2,834,299	\$ 184,452	5,140	\$ 2,860,894	\$ 186,183	5,188	\$ 2,887,484	\$ 187,913	\$ 12,131,638
<b>Total</b>	<b>167,128</b>	<b>\$ 589,761,805</b>	<b>\$ 18,106,210</b>	<b>168,318</b>	<b>\$ 593,924,939</b>	<b>\$ 18,234,256</b>	<b>169,508</b>	<b>\$ 598,087,478</b>	<b>\$ 18,362,284</b>	<b>170,697</b>	<b>\$ 602,249,720</b>	<b>\$ 18,490,302</b>	<b>\$ 2,457,216,995</b>

**Projected Year 5**

Medicaid Eligibility Group (MEG)	Total Projected Year 5 Member Months (P5)	P5 Projected PMPM Costs from Appendix D5 (Totals weighted on Projected Year 5 Member Months)					Total PMPM Projected Service Costs (Column H-G)
		Total PMPM State Plan Service Cost Projection	Total PMPM Incentive Cost Projection	Total PMPM 1915(b)(3) Service Cost Projection	Total PMPM Administration Cost Projection	Total PMPM Projected Waiver Costs	
Nursing Home Level of Care	673,486	\$ 3,692.10	\$ -	\$ -	\$ 112.79	\$ 3,804.90	\$ 3,692.10
Non-Nursing Home Level of Care	21,229	\$ 568.03	\$ -	\$ -	\$ 36.95	\$ 604.98	\$ 568.03
<b>Total</b>	<b>694,715</b>						
<b>P5 Weighted Average PMPM Casemix for P5 (P5 MMs)</b>		<b>\$ 3,596.64</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 110.48</b>	<b>\$ 3,707.12</b>	

Medicaid Eligibility Group (MEG)	Q17 Quarterly Projected Costs			Q18 Quarterly Projected Costs			Q19 Quarterly Projected Costs			Q20 Quarterly Projected Costs			Total P5 Projected Waiver Costs
	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	Member Months Projections	64.9W /64.21U W Service Costs include incentives	64.10 Waiver Administration Costs	
Nursing Home Level of Care	166,653	\$ 615,299,852	\$ 18,797,386	167,799	\$ 619,529,516	\$ 18,926,602	168,944	\$ 623,759,883	\$ 19,055,839	170,090	\$ 627,990,602	\$ 19,185,087	\$ 2,562,544,767
Non-Nursing Home Level of Care	5,235	\$ 2,973,876	\$ 193,437	5,283	\$ 3,001,041	\$ 195,204	5,331	\$ 3,028,211	\$ 196,972	5,379	\$ 3,055,382	\$ 198,739	\$ 12,842,862
<b>Total</b>	<b>171,888</b>	<b>\$ 618,273,728</b>	<b>\$ 18,990,823</b>	<b>173,082</b>	<b>\$ 622,530,557</b>	<b>\$ 19,121,806</b>	<b>174,275</b>	<b>\$ 626,788,094</b>	<b>\$ 19,252,811</b>	<b>175,469</b>	<b>\$ 631,045,984</b>	<b>\$ 19,383,826</b>	<b>\$ 2,575,387,629</b>

P Q R S T U

**Quarterly CMS Targets for RO CMS-64 Review Renewal**  
 State: Wisconsin  
 Projection for Upcoming Waiver Period  
 Projections for RO CMS-64 Certification - Aggregate Cost

**Projected Year 1** 1/1/20 through 12/31/20

Waiver Form	Medicaid Eligibility Group (MEG)	Q1 Quarterly Projected Costs 3/31/20	Q2 Quarterly Projected Costs 6/30/20	Q3 Quarterly Projected Costs 9/30/20	Q4 Quarterly Projected Costs 12/31/20
64.9 Waiver Form	Nursing Home Level of Care	\$ 506,753,028	\$ 510,827,544	\$ 514,826,455	\$ 518,770,234
64.9 Waiver Form	Non-Nursing Home Level of Care	\$ 2,337,028	\$ 2,362,761	\$ 2,388,157	\$ 2,413,319
64.10 Waiver Form		\$ 15,572,276	\$ 15,697,936	\$ 15,821,274	\$ 15,942,919

**Projected Year 2** 1/1/21 through 12/31/21

Waiver Form	Medicaid Eligibility Group (MEG)	Q5 Quarterly Projected Costs 3/31/21	Q6 Quarterly Projected Costs 6/30/21	Q7 Quarterly Projected Costs 9/30/21	Q8 Quarterly Projected Costs 12/31/21
64.9 Waiver Form	Nursing Home Level of Care	\$ 532,377,339	\$ 536,582,229	\$ 540,762,715	\$ 544,934,651
64.9 Waiver Form	Non-Nursing Home Level of Care	\$ 2,489,369	\$ 2,515,491	\$ 2,541,511	\$ 2,567,492
64.10 Waiver Form		\$ 16,387,589	\$ 16,517,445	\$ 16,646,550	\$ 16,775,392

**Projected Year 3** 1/1/22 through 12/31/22

Waiver Form	Medicaid Eligibility Group (MEG)	Q9 Quarterly Projected Costs 3/31/22	Q10 Quarterly Projected Costs 6/30/22	Q11 Quarterly Projected Costs 9/30/22	Q12 Quarterly Projected Costs 12/31/22
64.9 Waiver Form	Nursing Home Level of Care	\$ 559,231,677	\$ 563,372,120	\$ 567,497,971	\$ 571,616,526
64.9 Waiver Form	Non-Nursing Home Level of Care	\$ 2,646,368	\$ 2,672,630	\$ 2,698,858	\$ 2,725,070
64.10 Waiver Form		\$ 17,241,254	\$ 17,369,339	\$ 17,496,976	\$ 17,624,390

P Q R S T U

Quarterly CMS Targets for RO CMS-64 Review Renewal

State: Wisconsin

Projected Year 4 1/1/23 through 12/31/23

Waiver Form	Medicaid Eligibility Group (MEG)	Q13 Quarterly Projected Costs 3/31/23	Q14 Quarterly Projected Costs 6/30/23	Q15 Quarterly Projected Costs 9/30/23	Q16 Quarterly Projected Costs 12/31/23
64.9 Waiver Form	Nursing Home Level of Care	\$ 586,954,113	\$ 591,090,641	\$ 595,226,584	\$ 599,362,236
64.9 Waiver Form	Non-Nursing Home Level of Care	\$ 2,807,693	\$ 2,834,299	\$ 2,860,894	\$ 2,887,484
64.10 Waiver Form		\$ 18,106,210	\$ 18,234,256	\$ 18,362,284	\$ 18,490,302

Projected Year 5 1/1/24 through 12/31/24

Waiver Form	Medicaid Eligibility Group (MEG)	Q17 Quarterly Projected Costs 3/31/24	Q18 Quarterly Projected Costs 6/30/24	Q19 Quarterly Projected Costs 9/30/24	Q20 Quarterly Projected Costs 12/31/24
64.9 Waiver Form	Nursing Home Level of Care	\$ 615,299,852	\$ 619,529,516	\$ 623,759,883	\$ 627,990,602
64.9 Waiver Form	Non-Nursing Home Level of Care	\$ 2,973,876	\$ 3,001,041	\$ 3,028,211	\$ 3,055,382
64.10 Waiver Form		\$ 18,990,823	\$ 19,121,806	\$ 19,252,811	\$ 19,383,826

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Quarterly CMS Targets for RO Cost-Effectiveness Monitoring

State: Wisconsin

Projection for Upcoming Waiver Period

Worksheet for RO PMPM Cost-Effectiveness Monitoring

Projected Year 1

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission	
		P1 Projected PMPM From Column I (services)	From Column G (Administration)
64.9 Waiver Form	Nursing Home Level of Care	\$	3,424.50
64.9 Waiver Form	Non-Nursing Home Level of Care	\$	523.60
64.10 Waiver Form	All MEGS	\$	102.14

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring		
		Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.9 Waiver Form	Nursing Home Level of Care	3/31/20		#DIV/0!	6/30/20		#DIV/0!	9/30/20		#DIV/0!	12/31/20		#DIV/0!
64.9 Waiver Form	Non-Nursing Home Level of Care			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.10 Waiver Form	All MEGS			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

Projected Year 2

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission	
		P2 Projected PMPM From Column I (services)	From Column G (Administration)
64.9 Waiver Form	Nursing Home Level of Care	\$	3,487.44
64.9 Waiver Form	Non-Nursing Home Level of Care	\$	534.50
64.10 Waiver Form	All MEGS	\$	104.16

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring		
		Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.9 Waiver Form	Nursing Home Level of Care	3/31/21		#DIV/0!	6/30/21		#DIV/0!	9/30/21		#DIV/0!	12/31/21		#DIV/0!
64.9 Waiver Form	Non-Nursing Home Level of Care			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.10 Waiver Form	All MEGS			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

Projected Year 3

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission	
		P3 Projected PMPM From Column I (services)	From Column G (Administration)
64.9 Waiver Form	Nursing Home Level of Care	\$	3,551.97
64.9 Waiver Form	Non-Nursing Home Level of Care	\$	545.42
64.10 Waiver Form	All MEGS	\$	106.23

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring		
		Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.9 Waiver Form	Nursing Home Level of Care	3/31/22		#DIV/0!	6/30/22		#DIV/0!	9/30/22		#DIV/0!	12/31/22		#DIV/0!
64.9 Waiver Form	Non-Nursing Home Level of Care			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!
64.10 Waiver Form	All MEGS			#DIV/0!			#DIV/0!			#DIV/0!			#DIV/0!

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Quarterly CMS Targets for RO Cost-Effectiveness Monitoring

State: Wisconsin

Projected Year 4

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission	
		P4 Projected PMPM From Column I (services)	From Column G (Administration)
64.9 Waiver Form		\$	3,621.31
64.9 Waiver Form		\$	556.61
64.10 Waiver Form	All MEGS	\$	108.33

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring		
		Q13 Quarterly Actual Costs			Q14 Quarterly Actual Costs			Q15 Quarterly Actual Costs			Q16 Quarterly Actual Costs		
		Member Months Actuals 3/31/23	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals 6/30/23	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals 9/30/23	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals 12/31/23	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.9 Waiver Form													
64.9 Waiver Form													
64.10 Waiver Form	All MEGS												

Projected Year 5

Waiver Form	Medicaid Eligibility Group (MEG)	State Completion Section - For Waiver Submission	
		P5 Projected PMPM From Column I (services)	From Column G (Administration)
64.9 Waiver Form		\$	3,692.10
64.9 Waiver Form		\$	568.03
64.10 Waiver Form	All MEGS	\$	110.48

Waiver Form	Medicaid Eligibility Group (MEG)	RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring			RO Completion Section - For ongoing monitoring		
		Q17 Quarterly Actual Costs			Q18 Quarterly Actual Costs			Q19 Quarterly Actual Costs			Q20 Quarterly Actual Costs		
		Member Months Actuals 3/31/24	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals 6/30/24	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals 9/30/24	Actual Aggregate Waiver Form Costs	Actual PMPM Costs	Member Months Actuals 12/31/24	Actual Aggregate Waiver Form Costs	Actual PMPM Costs
64.9 Waiver Form													
64.9 Waiver Form													
64.10 Waiver Form	All MEGS												

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**Cost Effectiveness Summary Sheet Renewal Waiver**  
State: Wisconsin

Costs to be input below are from the prior waiver submission. Compare the prospective years from the prior waiver submission to the retrospective years of the current waiver submission.

**Retrospective Period**

Medicaid Eligibility Group (MEG)	R1 Member Months	R1 Per Member Per Month (PMPM) Costs				
		R1 PMPM State Plan Service Costs	R1 PMPM Incentive Costs	R1 PMPM 1915(b)(3) Service Costs	R1 PMPM Administration Costs	R1 PMPM Total Actual Waiver Costs
Nursing Home Level of Care	530,743	\$ 3,121.17	\$ -	\$ -	\$ 97.41	\$ 3,218.58
Non-Nursing Home Level of Care	19,402	\$ 460.00	\$ -	\$ -	\$ 24.57	\$ 484.57
<b>Total</b>	<b>550,145</b>					
<b>R1 Overall PMPM Casemix for R1 (R1 MMs)</b>		<b>\$ 3,027.32</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 94.84</b>	<b>\$ 3,122.16</b>
<b>Total R1 Expenditures</b>						<b>\$1,717,641,567</b>

P4 Per Member Per Month (PMPM) Costs from the prior waiver submission				
P4 PMPM State Plan Service Costs	P4 PMPM Incentive Costs	P4 PMPM 1915(b)(3) Service Costs	P4 PMPM Administration Costs	P4 PMPM Total Actual Waiver Costs
\$ 3,310.47	\$ -	\$ -	\$ 128.33	\$ 3,438.80
\$ 632.12	\$ -	\$ -	\$ 25.45	\$ 657.57
<b>\$ 3,216.01</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 124.70</b>	<b>\$ 3,340.71</b>
<b>Total Previous P4 Projection using R1 member months</b>				<b>\$1,837,876,569</b>

Medicaid Eligibility Group (MEG)	R2 Member Months	R2 Per Member Per Month (PMPM) Costs (Totals weighted on Retrospective Year 2 Member Months)					Overall R1 to R2 Change (annual)
		R2 PMPM State Plan Service Costs	R2 PMPM Incentive Costs	R2 PMPM 1915(b)(3) Service Costs	R2 PMPM Administration Costs	R2 PMPM Total Actual Waiver Costs	
Nursing Home Level of Care	559,968	\$ 3,188.93	\$ -	\$ -	\$ 100.38	\$ 3,289.31	2.2%
Non-Nursing Home Level of Care	18,160	\$ 483.24	\$ -	\$ -	\$ 32.88	\$ 516.12	6.5%
<b>Total</b>	<b>578,127</b>						
<b>R2 Weighted Average PMPM Casemix for R1 (R1 MMs)</b>		<b>\$ 3,093.51</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 98.00</b>	<b>\$ 3,191.51</b>	<b>2.2%</b>
<b>R2 Overall PMPM Casemix for R2 (R2 MMs)</b>		<b>\$ 3,103.94</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 98.26</b>	<b>\$ 3,202.20</b>	<b>2.6%</b>
<b>Total R2 Expenditures</b>							<b>\$1,851,278,272</b>

P5 Per Member Per Month (PMPM) Costs from the prior waiver submission				
P5 PMPM State Plan Service Costs	P5 PMPM Incentive Costs	P5 PMPM 1915(b)(3) Service Costs	P5 PMPM Administration Costs	P5 PMPM Total Actual Waiver Costs
\$ 3,385.25	\$ -	\$ -	\$ 132.07	\$ 3,517.32
\$ 649.81	\$ -	\$ -	\$ 26.19	\$ 676.00
<b>\$ 3,299.33</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 128.74</b>	<b>\$ 3,428.07</b>
<b>Total Previous P5 Projection using R2 member months</b>				<b>\$1,981,860,308</b>

<b>Total Previous Waiver Period Expenditures (Casemix for R1 and R2)</b>							<b>\$3,568,919,839</b>
<b>Total Difference between Projections and Actual Waiver Cost for Previous Waiver Period</b>							<b>\$250,817,039</b>

							<b>\$3,819,736,878</b>
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**Prospective Period**

Medicaid Eligibility Group (MEG)	Projected Year 1 Member Months (P1)	P1 Projected PMPM Costs (Totals weighted on Projected Year 1 Member Months)					Overall R2 to P1 Change (2 year)
		P1 PMPM State Plan Service Cost Projection	P1 PMPM Incentive Cost Projection	P1 PMPM 1915(b)(3) Service Cost Projection	P1 PMPM Administration Cost Projection	P1 PMPM Projected Waiver Costs	
Nursing Home Level of Care	598,970	\$ 3,424.50	\$ -	\$ -	\$ 104.20	\$ 3,528.71	7.3%
Non-Nursing Home Level of Care	18,146	\$ 523.60	\$ -	\$ -	\$ 34.13	\$ 557.73	8.1%
<b>Total</b>	<b>617,117</b>						
<b>P1 Weighted Average PMPM Casemix for R2 (R2 MMs)</b>		<b>\$ 3,333.38</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 102.00</b>	<b>\$ 3,435.39</b>	<b>7.3%</b>
<b>P1 Weighted Average PMPM Casemix for P1 (P1 MMs)</b>		<b>\$ 3,339.20</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 102.14</b>	<b>\$ 3,441.35</b>	<b>7.5%</b>
<b>Total Projected Waiver Expenditures P1(P1 MMs)</b>							<b>\$2,123,712,932</b>

Medicaid Eligibility Group (MEG)	Projected Year 2 Member Months (P2)	P2 Projected PMPM Costs (Totals weighted on Projected Year 2 Member Months)					Overall P1 to P2 Change (annual)
		P2 PMPM State Plan Service Cost Projection	P2 PMPM Incentive Cost Projection	P2 PMPM 1915(b)(3) Service Cost Projection	P2 PMPM Administration Cost Projection	P2 PMPM Projected Waiver Costs	
Nursing Home Level of Care	617,833	\$ 3,487.44	\$ -	\$ -	\$ 106.29	\$ 3,593.73	1.8%
Non-Nursing Home Level of Care	18,922	\$ 534.50	\$ -	\$ -	\$ 34.82	\$ 569.31	2.1%
<b>Total</b>	<b>636,755</b>						
<b>P2 Weighted Average PMPM Casemix for P1 (P1 MMs)</b>		<b>\$ 3,400.61</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 104.19</b>	<b>\$ 3,504.80</b>	<b>1.8%</b>
<b>P2 Weighted Average PMPM Casemix for P2 (P2 MMs)</b>		<b>\$ 3,399.69</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 104.16</b>	<b>\$ 3,503.85</b>	<b>1.8%</b>
<b>Total Projected Waiver Expenditures P2 (P2 MMs)</b>							<b>\$2,231,097,772</b>

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**Cost Effectiveness Summary Sheet Renewal Waiver**  
State: Wisconsin

Medicaid Eligibility Group (MEG)	Projected Year 3 Member Months (P3)	P3 Projected PMPM Costs (Totals weighted on Projected Year 3 Member Months)					Overall P2 to P3 Change (annual)
		P3 PMPM State Plan Service Cost Projection	P3 PMPM Incentive Cost Projection	P3 PMPM 1915(b)(3) Service Cost Projection	P3 PMPM Administration Cost Projection	P3 PMPM Projected Waiver Costs	
Nursing Home Level of Care	636,751	\$ 3,551.97	\$ -	\$ -	\$ 108.41	\$ 3,660.38	1.9%
Non-Nursing Home Level of Care	19,697	\$ 545.42	\$ -	\$ -	\$ 35.51	\$ 580.93	2.0%
<b>Total</b>	<b>656,447</b>						
<b>P3 Weighted Average PMPM Casemix for P2 (P2 MMs)</b>		<b>\$ 3,462.62</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 106.25</b>	<b>\$ 3,568.87</b>	<b>1.9%</b>
<b>P3 Weighted Average PMPM Casemix for P3 (P3 MMs)</b>		<b>\$ 3,461.76</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 106.23</b>	<b>\$ 3,567.98</b>	<b>1.8%</b>
<b>Total Projected Waiver Expenditures P3 (P3 MMs)</b>						<b>\$2,342,193,178</b>	

Medicaid Eligibility Group (MEG)	Projected Year 4 Member Months (P4)	P4 Projected PMPM Costs (Totals weighted on Projected Year 4 Member Months)					Overall P3 to P4 Change (annual)
		P4 PMPM State Plan Service Cost Projection	P4 PMPM Incentive Cost Projection	P4 PMPM 1915(b)(3) Service Cost Projection	P4 PMPM Administration Cost Projection	P4 PMPM Projected Waiver Costs	
Nursing Home Level of Care	655,186	\$ 3,621.31	\$ -	\$ -	\$ 110.58	\$ 3,731.89	2.0%
Non-Nursing Home Level of Care	20,464	\$ 556.61	\$ -	\$ -	\$ 36.22	\$ 592.83	2.0%
<b>Total</b>	<b>675,650</b>						
<b>P4 Weighted Average PMPM Casemix for P3 (P3 MMs)</b>		<b>\$ 3,529.36</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 108.35</b>	<b>\$ 3,637.71</b>	<b>2.0%</b>
<b>P4 Weighted Average PMPM Casemix for P4 (P4 MMs)</b>		<b>\$ 3,528.49</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 108.33</b>	<b>\$ 3,636.82</b>	<b>1.9%</b>
<b>Total Projected Waiver Expenditures P4 (P4 MMs)</b>						<b>\$2,457,216,995</b>	

Medicaid Eligibility Group (MEG)	Projected Year 5 Member Months (P5)	P5 Projected PMPM Costs (Totals weighted on Projected Year 5 Member Months)					Overall P4 to P5 Change (annual)
		P5 PMPM State Plan Service Cost Projection	P5 PMPM Incentive Cost Projection	P5 PMPM 1915(b)(3) Service Cost Projection	P5 PMPM Administration Cost Projection	P5 PMPM Projected Waiver Costs	
Nursing Home Level of Care	673,486	\$ 3,692.10	\$ -	\$ -	\$ 112.79	\$ 3,804.90	2.0%
Non-Nursing Home Level of Care	21,229	\$ 568.03	\$ -	\$ -	\$ 36.95	\$ 604.98	2.0%
<b>Total</b>	<b>694,715</b>						
<b>P5 Weighted Average PMPM Casemix for P4 (P4 MMs)</b>		<b>\$ 3,597.48</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 110.50</b>	<b>\$ 3,707.98</b>	<b>2.0%</b>
<b>P5 Weighted Average PMPM Casemix for P5 (P5 MMs)</b>		<b>\$ 3,596.64</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 110.48</b>	<b>\$ 3,707.12</b>	<b>1.9%</b>
<b>Total Projected Waiver Expenditures P5 (P5 MMs)</b>						<b>\$2,575,387,629</b>	

Medicaid Eligibility Group (MEG)	Projected Year 1 and 2 Member Months (P1 +P2)	Projected Year 1 - 5 Member Months (SUM of P1:P5)
Nursing Home Level of Care	1,216,804	3,182,227
Non-Nursing Home Level of Care	37,068	98,458
<b>Total</b>	<b>1,253,872</b>	<b>3,280,684</b>

Overall R1 to P2 Change (monthly)	Overall R1 to P5 Change (monthly)	Overall R1 to P2 Change (annualized)	Overall R1 to P5 Change (annualized)
0.184%	0.174%	2.229%	2.114%
0.269%	0.231%	3.276%	2.813%

<b>Weighted Average PMPM Casemix for R1 (R1 MMs)</b>		0.184%	0.175%	2.235%	2.118%
<b>Weighted Average PMPM Casemix for P2 or P5 (P2 or P5 MMs)</b>		0.192%	0.179%	2.334%	2.170%
<b>Total Projected Waiver Expenditures P1 + P2 (Casemix for P1 and P2)</b>	<b>\$4,354,810,704</b>				
<b>Total Projected Waiver Expenditures P1:P5 (Casemix for P1 through P5)</b>	<b>\$11,729,608,506</b>				

115 Modify Line Items as necessary to fit the MEGs of the program.  
 116 State Completion Sections  
 117 To modify the formulas as necessary to fit the length of the program complete this section. The formulas will automatically update given this data.  
 118 PMPM from previously approved waiver.

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

## PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

### 1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Appendix C.2.a. - Required all providers who have regular direct contact with a member to be subject to caregiver and criminal background checks. Previous language excluded providers serving self-directing members.

Appendix C.1/C.3. - Expanded existing supportive home care service to add bed bug inspection and/or extermination services.

Appendix B.6.c. - Updated qualifications for individuals performing initial member level-of-care determinations. Previous qualifications: four-year social work degree and specialized knowledge of managed long-term care target populations. New qualifications: Bachelor of Arts in a health or human services related field (e.g. social work, rehabilitation, psychology) and a minimum of one year experience working with at least one of the target populations.

Appendix D.1.b. - Allowed United Community Center to provide both case management and other waiver services to Hispanic members in Milwaukee County.

Appendix D.1.d. - Updated to reflect that PIHPs must obtain provider signatures on the Member-Centered Plan (MCP) and distribute the MCP to the member's essential providers (as defined by the SMA).

Appendix G.3.b.i. - Removed MCP documentation requirements for members with complex medication regimens as it duplicates documentation requirements for the member assessment.

Appendix.5.b. - Defined one consistent methodology to determine member room and board financial obligation to be used by all PIHPs.

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

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

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

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

Family Care Waiver Renewal 2020

**C. Type of Request: renewal**

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

3 years    5 years

**Original Base Waiver Number: WI.0367**

**Draft ID: WI.018.04.00**

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

Regular Waiver

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

01/01/20

**1. Request Information (2 of 3)**

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

**Hospital**

Select applicable level of care

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

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

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

**Nursing Facility**

Select applicable level of care

**Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

Not applicable.

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

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

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

Not applicable.

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

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

Select one:

**Not applicable**

**Applicable**

Check the applicable authority or authorities:

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

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

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

WI.0007 is the previously approved 1915(b) waiver. With this 1915(c) waiver renewal, the State has also submitted a corresponding 1915(b) waiver renewal.

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

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

**§1915(b)(2) (central broker)**

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

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

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

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

A State Plan Amendment (SPA) approved by CMS and effective 1/1/2008 amended Wisconsin's Medicaid state plan to extend the highly successful Medicaid/Medicaid Family Care Partnership program, which was originally authorized under §1115 waiver authority and provides integrated primary and acute care and long-term care to individuals with long-term support needs. The SPA allows certain categories of Medicaid beneficiaries to voluntarily enroll in managed care entities while complying with provisions of §1902 of the Social Security Act on statewideness, freedom of choice, or comparability.

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

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

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

*Specify the program:*

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

Check if applicable:

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

## **2. Brief Waiver Description**

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

Family Care is a comprehensive and flexible managed long-term care program, which strives to foster independence and quality of life while recognizing the need for individualized support. Family Care gives frail elders and adults with physical or intellectual disabilities the choice to receive long-term care in their own homes and integrated community settings. The goals of managed long-term care are:

**CHOICE** – Give people better choices about the services and supports available to meet their needs

**ACCESS** – Improve access to services

**QUALITY** – Improve overall quality of the long-term care system by focusing on achieving people's health and social outcomes

**COST-EFFECTIVENESS** – Create a cost-effective long-term care system for the future

Family Care is a risk-based capitated program that incorporates the consumer-centered values of Wisconsin's home and community-based programs and services in a managed care service delivery system. The target groups are frail elders, adults with physical disabilities, and adults with intellectual disabilities who have long-term care needs. The State Medicaid Agency (SMA) contracts directly with prepaid inpatient health plans (PIHPs) to deliver comprehensive long-term care waiver services plus long-term care Medicaid State Plan services, including nursing facility services, home health, personal care, durable medical equipment, disposable medical supplies, therapies, and outpatient mental health and AODA services.

The program is designed to provide incentives for PIHPs to deliver the most effective and efficient set of services tailored to each individual member's unique needs, circumstances, and preferences. The most recent independent evaluation of Family Care showed that, when measured against a fee-for-service comparison group, PIHPs have significantly reduced costs and maintained members' health and functioning.

The SMA monitors the contracts with PIHPs. The SMA also uses an external quality review organization (EQRO) to help implement a multi-level quality management system within the PIHPs and for managed long-term care on a statewide level. Monitoring activities include annual on-site quality reviews with each PIHP; annual care management reviews, which include review of a sample of member individualized service plans; review of quarterly narrative reports submitted by the PIHP; ongoing review of grievances and appeals; review of critical incidents and other adverse events for members; and ongoing review of utilization data for each PIHP. In particular, under the direction of the SMA, the EQRO undertakes discovery activities in accordance with the SMA's quality strategy, while the SMA executes remediation and quality improvement efforts.

On 7/1/18, Family Care became statewide. Family Care has achieved lower per person costs than the fee-for-service HCBS waiver programs that it replaced. Furthermore, in 14 counties, including the State's two largest, Milwaukee and Dane, eligible persons may choose the Family Care Partnership Program. Partnership is a §1932(a)/1915(c) managed care model that provides one-stop, fully integrated health and long-term care services, combining the Family Care long-term care benefit with primary and acute health care services, including Medicaid and Medicare services. For dual eligibles, Medicare services are provided through a Medicare Advantage Fully Integrated Dual Eligible (FIDE) Special Needs Plan.

The SMA believes that its practice and policy with respect to paraprofessional direct home care services provided under this waiver are aligned with the federal Fair Labor Standards Act (FLSA). The SMA bases this judgment on the delineation of responsibilities for hiring, directing, and managing such workers, as specified in Appendix E, for members who self-direct their home care services as common law employers. When applying the Department of Labor's written interpretation, such workers would be solely the member's employee and not the joint employee of the member and the PIHP or the member and the SMA. As such, the waiver aligns with the FLSA. However, the SMA notes that, under the FLSA, a judgment on employer status ultimately depends on the unique facts of each case. Accordingly, because individual case facts may vary from the responsibilities specified in Appendix E, employer status might conceivably vary as well.

Pursuant to a waiver amendment, effective 7/1/18, PIHPs are not at risk for services rendered to Indian members who receive care management from an Indian Health Care Provider (IHCP).

### 3. Components of the Waiver Request

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

**A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.

**B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid

eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

**C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

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

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

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

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

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

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

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

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

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

#### 4. Waiver(s) Requested

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

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

**Not Applicable**

**No**

**Yes**

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

**No**

**Yes**

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

**Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

**Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect

to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

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

## 5. Assurances

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

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

**I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

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

## 6. Additional Requirements

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

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

processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the state secures public input into the development of the waiver:

In September 2018, the SMA extended an invitation to all of its stakeholders (contracted PIHPs, tribes, members of the long-term care community, advocates, providers, etc.) to provide any ideas they would like the SMA to consider in preparing this waiver renewal. The SMA received numerous submissions and conducted extensive review of the submissions.

Major Wisconsin newspapers contained public notices on 5/31/2019 that the draft Family Care 1915(c) and (b) waiver renewal applications were available on the SMA's website for a 30-day public input period. The draft Family Care 1915(c) and (b) waiver renewal applications were posted for a 30-day public input period.

Wisconsin tribes received written notice that the draft Family Care waiver renewal applications were available on the SMA's website for a 30-day tribal input period on 5/31/19. The SMA also provided in person tribal consultation on 5/7/19 at the Mid-Year Tribal Consultation Meeting and on 5/8/19 at the Tribal Health Directors Meeting. The written notice, agendas, and meeting notes are included with this waiver renewal submission.

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

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

## 7. Contact Person(s)

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

**Last Name:**

Poole

**First Name:**

Diane

**Title:**

Chief of Family Care Policy and Federal Relations

**Agency:**

DHS/Division of Medicaid Services

**Address:**

1 W. Wilson Street, Room 527

**Address 2:**

P.O. Box 7851

**City:**

Madison

**State:**

Wisconsin

Zip:

53707-7851

Phone:

(608) 267-4896

Ext:

TTY

Fax:

(608) 266-5629

E-mail:

Diane.Poole@dhs.wisconsin.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

Wisconsin

Zip:

Phone:

Ext:

TTY

Fax:

E-mail:

## 8. Authorizing Signature

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This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified

in Section 6 of the request.

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Signature:

State Medicaid Director or Designee

Submission Date:

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**Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.**

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: Wisconsin

Zip:

Phone:  Ext:  TTY

Fax:

E-mail:

**Attachments**

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**Attachment #1: Transition Plan**

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

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

**Combining waivers.**

**Splitting one waiver into two waivers.**

**Eliminating a service.**

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

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

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

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

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

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

Specify the transition plan for the waiver:

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

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

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

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

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

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

The State assures that this waiver renewal will be subject to any provisions or requirements included in the State's most recent and/or approved home and community-based settings Statewide Transition Plan. The State will implement any CMCS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

**Additional Needed Information (Optional)**

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Provide additional needed information for the waiver (optional):

Public comments received and SMA response for this renewal are summarized below:

1. XXX

STATE RESPONSE: XXX

NOTE: Tribal comments and the SMA responses are attached separately to the waiver submission.

**Appendix A: Waiver Administration and Operation**

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

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

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

**The Medical Assistance Unit.**

Specify the unit name:

Division of Medicaid Services

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

## Appendix A: Waiver Administration and Operation

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### 2. Oversight of Performance.

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

**As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.**

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

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

## Appendix A: Waiver Administration and Operation

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

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

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

PIHPs (private or public entities):

- 1) Conduct home visits with each assigned member and their support system to develop a comprehensive member-centered plan;
- 2) Conduct annual level of care re-evaluation activities using the State's automated long term care functional screen;
- 3) Continually assess members' physical, environmental, and social needs and identify and respond accordingly to member health and safety risks;
- 4) Develop individual member centered plans (MCPs);
- 5) Perform prior authorization of waiver services;
- 6) Conduct utilization management functions;
- 7) Recruit and contract with providers;
- 8) Execute the Medicaid provider agreements; and
- 9) Develop and implement local QA/QI plans.

External Quality Review Organization (EQRO):

- 1) Reviews MCPs to ensure waiver requirements are met;
- 2) Assists the SMA in conducting training and technical assistance concerning waiver requirements;
- 3) Assists the SMA in QA/QI monitoring of PIHPs;
- 4) Evaluates PIHP performance improvement projects and assists with training and technical assistance for PIHP staff that are responsible for performance improvement projects;
- 5) Validates PIHP performance measures;
- 6) Assesses compliance with federal requirements related to member rights, access to services, structure and operations, measurement and improvement, and grievance systems;
- 7) Performs an Information Systems Capability Assessment of PIHPs;
- 8) Provides technical assistance to both the SMA and the PIHPs with regard to quality management activities and responsibilities, such as assisting in the development of indicators of member health and well-being;
- 9) Administers or validates consumer or provider surveys of quality of care, including collaborating with the SMA in developing and testing new quality-discovery methods;
- 10) Administers the Family Care hotline for member complaints;
- 11) Offers members assistance upon member request for a State Fair Hearing; and
- 12) Gathers information about member complaints, mediate, and refer members to advocacy representatives or the SMA.

Family Care Ombudsman Program:

- 1) Provides information and education on member rights;
- 2) Investigates member complaints;
- 3) Attempts resolution to resolve member complaints through informal strategies (negotiation, and mediation, support of consumer self-advocacy, and work with internal advocates);
- 4) Assists members in filing grievances, complaints and appeals, and administrative hearing requests;
- 5) Assists members in filing for administrative hearings;
- 6) Provides individual case advocacy to members in the grievance, appeal, and administrative hearing processes;
- 7) Provides legal representation for members in the grievance, appeal, and administrative hearing processes; and
- 8) Identifies and reports to the SMA patterns of member issues and ADRC or PIHP non-compliance issues.

Aging and Disability Resource Centers (ADRCs) (independent public entities):

- 1) Provide information and assistance;
- 2) Provide preadmission pre-enrollment options counseling;
- 3) Conduct level of care evaluation activities using the SMA's automated long term care functional screen;
- 4) Coordinate other program eligibility activities on behalf of the SMA; and
- 5) Carry out prevention and community outreach activities.

Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

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

## Appendix A: Waiver Administration and Operation

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

**Not applicable**

**Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.  
Check each that applies:

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

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

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

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

## Appendix A: Waiver Administration and Operation

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

DHS Division of Medicaid Services

## Appendix A: Waiver Administration and Operation

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

Methods used to assess performance vary by agency type:

1. PIHPs are the primary agencies performing waiver operational and administrative functions.

a. The SMA-PIHP contract identifies federal & state requirements, including waiver assurances: i.) PIHP administration of the level of care tool; ii.) care planning, such as assessment, member-centered plan, service authorization process, training plan, self-directed supports options, and member rights); iii.) provider management - verification of licensure/certification, verification providers are not barred from providing Medicaid services, and background checks; iv.) monitoring of member health and safety - reporting and investigation of member incidents and restrictive measures policies; and v.) financial accountability. The contract provides the vehicle for implementing many system improvements. SMA oversight teams and content experts monitor compliance with the contract through review of policies and procedures, regular reports, and complaint investigations. The contract is reviewed and renewed every two years.

b. Wisconsin statutes require the SMA to certify PIHPs annually and prohibit the SMA from contracting with a PIHP that has not been certified. During the initial and annual certification process, the SMA reviews: provider network and capacity; marketing plan and materials; member handbook; contract template; functional screen quality; cost share; claims adjudication/provider appeals; financial reporting; incurred but not reported (IBNR); investment policy; managing capitation and enrollment discrepancies; and encounter reporting and claims system. Other areas the SMA reviews as needed are: 24-hour on call; comprehensive member assessments; member-centered plan policy, procedure, and template; service authorization policy; care management training plan; safety and risk policy; restrictive measures policy; prevention and wellness policy; self-directed supports policy; notice of action procedures; and quality management plan and activities. A site readiness visit is completed by the SMA prior to issuance of initial certification. Certification criteria are reviewed and modified, where appropriate, on an annual basis.

c. An SMA oversight team is assigned to each PIHP. The team includes contract, fiscal, and quality content experts. Additional experts are consulted as needed. Teams monitor ongoing operations of the PIHP through review of periodic reports. Member-specific concerns are reviewed and responded to as they are submitted. Teams review the following reports: grievances and appeals, member incidents, encounters, financial, annual EQRO, audited PIHP year-end financial, and others required by contract. The team initiates immediate remedial action, imposes corrective action plans, monitors the plans, and documents the remediation. Teams hold regular meetings with PIHPs to discuss care management and provider issues, as well as program changes, expectations, and contract clarifications.

Teams provide technical assistance and monitoring of PIHP activities; provide support and recommendations for resolving issues including relocations of members from institutions and care for members with complex behaviors; respond to and investigate complaints about member-centered plans (MCPs), services, poor quality, abuse, and discrimination; and track and close member issues in the SMA's tracking system. When significant changes are needed, the SMA requires PIHPs to create and implement remediation plans. The teams verify and document compliance with those plans.

2. EQRO - The SMA contracts with an External Quality Review Organization (EQRO) to conduct independent quality reviews of PIHP processes and outcomes, including the MCP and provider quality assurances.

a. The EQRO is selected via a competitive process and must meet federal requirements for an EQRO under 42 CFR § 438.354. SMA oversight includes contract and programmatic oversight to ensure that reviews are conducted consistent with the SMA's priorities. The SMA reviews sampling criteria, determines review criteria to be used by the EQRO, reviews and provides input into criteria for identifying trends, reviews all reports produced by the EQRO, meets regularly with the EQRO, and reviews contract requirements as needed. EQRO performance is measured by: 1) the level and quality of assistance and support provided to the SMA in quality monitoring activities; 2) the quality of periodic monitoring reports and an annual EQRO report; 3) performance of optional EQRO activities; and 4) compliance with the EQRO contract. EQRO activities occur annually unless specified below.

b. The EQRO conducts a comprehensive on-site Annual Quality Review (AQR) at each PIHP to validate PIHP compliance with federal regulations and SMA contract components, including waiver requirements. The AQR consists of the Care Management Review and the Quality Compliance Review:

i. Care Management Review - EQRO completes a file review focusing on how members' needs are being met. The

EQRO reviews the standards regarding member assessments and MCPs to ascertain if they are comprehensive, timely, and responsive to member changes.

ii. Quality Compliance Review (QCR) - The EQRO conducts the mandatory QCR and evaluates PIHPs' compliance with 42 CFR § 438, Subpart E, using the CMS EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations, A Mandatory Protocol for External Quality Reviews (EQR), Version 2.0. The EQRO and the SMA coordinate in identifying SMA expectations or standards for PIHPs, including compliance thresholds and rules for compliance scoring for each federal and/or regulatory provision or contract requirement. A three-point rating structure is used to assess the level of compliance of each PIHP with the standards. The QCR occurs on a three-year cycle. The first year is a comprehensive review of all standards. The second and third years review standards not met in the previous years of the cycle.

c. The EQRO conducts an Information Systems Capability Assessment at least once every three years, and more frequently when needed, such as when a PIHP replaces a claims processing system. The EQRO may also review data integrity of encounter reporting by PIHPs.

d. The EQRO conducts performance measure validation annually, and as needed, and conducts focused studies as directed by the SMA.

e. Recommendations for improvement may be identified as a result of EQRO review activities. The SMA reviews the recommendations, identifies priorities, and monitors PIHP progress.

f. When issues that require mandatory remediation are identified, the SMA requires a remediation plan. The PIHP provides status information to the SMA, and the SMA gives feedback to the PIHP on its progress.

g. The SMA reviews quality trends identified by the EQRO with PIHPs and the EQRO. Trends requiring action are prioritized by the SMA.

3. PIHP Leadership - SMA managers meet regularly with PIHP leadership to identify and prioritize issues, including systems improvement opportunities.

4. Hotline - The EQRO staffs the SMA hotline, through which members can report their concerns and request SMA review.

5. Office of Inspector General (OIG) - The SMA's OIG monitors and audits providers that participate in the Medicaid program. The OIG responds to and investigates complaints of fraud and abuse.

6. Aging and Disability Resource Centers (ADRCs) - ADRCs disseminate information regarding the waiver to potential members; review options counseling materials annually; assist individuals in waiver enrollment; monitor enrollment processes on an ongoing basis; review grievances and appeals quarterly; and conduct level of care evaluation activities.

a. The SMA provides ADRCs with unbiased, person-centered enrollment counseling materials that meet CMS requirements for readability, availability in prevalent languages, and annual updates. The enrollment process is monitored regularly via an enrollment plan and documentation that outlines the roles, responsibilities, and processes for eligibility and enrollment. The SMA provides ADRC oversight and directs quality improvement activities. The SMA also provides technical assistance and oversight for adherence to documented procedures. Quality of ADRC services for determination of functional eligibility, facilitation of the financial eligibility process, and enrollment is ensured by ongoing ADRC training both in-person and online.

b. ADRC governing boards review grievances and appeals. A statewide grievance and appeal policy is followed to resolve complaints and to inform individuals of their appeal rights. Additionally, the SMA can access ADRC client tracking databases for quality assurance reviews and independent investigations of complaints and grievances.

c. The SMA conducts quality reviews of level of care evaluations using the automated Long Term Care Functional Screen on an ongoing basis and provides feedback and remediation to the ADRCs and PIHPs. Certified screener continuing knowledge and skills are tested at a minimum of every two years. The SMA offers functional screen administration trainings to ADRCs multiple times per year, conducts quarterly screen liaison calls, and provides screen

reviews upon request.

d. ADRCs operate under a contract with the SMA. They submit periodic reports to the SMA regarding information and assistance functions and monthly expenditures. ADRCs also submit annual narrative reports. On-site reviews are conducted annually by the SMA. ADRC customers are surveyed via a neutral third party evaluator to evaluate their options and enrollment counseling experience.

7. Ombudsman - The SMA-Ombudsman contract has the following Ombudsman performance expectations:

- a. Respond timely to member's calls: 100% of all initial contacts must receive an attempted follow up call within two business days;
- b. Provide informative written communication to members: 95% of brief cases and 100% of full cases must receive an opening and closing letter;
- c. Be knowledgeable and professional: 100% of ombudsman must meet the ombudsman entity's core competency expectations as measured in annual performance reviews;
- d. Maintain an effective relationship with the entity that provides ombudsman services to individuals age 60 and older to identify issues and coordinate improvement efforts;
- e. Maintain a collaborative relationship with the PIHPs: Ombudsman must meet at least annually with the PIHPs to discuss advocacy issues and promote collaboration on patterns of issues; and
- f. Use informal means (i.e. without PIHP appeal for fair hearing) for case resolution when possible: Ombudsman must resolve at least 75% of cases informally.

The SMA-Ombudsman contract requires a quarterly report to the SMA on the performance expectations and requires the Ombudsman to perform the following quality assurance activities:

- a. Distribute an annual recipient survey to individuals it has assisted to measure consumer satisfaction with the Ombudsman's service and report results to the SMA. If the results are unsatisfactory, the SMA can require a corrective action plan;
- b. Participate in and present data at meetings upon SMA request; and
- c. Conduct ongoing internal quality assurance activities, including:
  - i. Regular supervisory case progress reviews;
  - ii. Monthly team case rounds;
  - iii. Annual supervisory file reviews;
  - iv. Annual performance reviews of all staff.

The Ombudsman provides monthly, quarterly, and annual reports to the SMA: # of member contacts and issue; member result/outcome(resolved to member's full, partial, or no satisfaction); resolution method (informal, PIHP appeal, or fair hearing); # resolved member cases; # cases that identified pattern; ADRC or PIHP non-compliance; and public outreach efforts.

8. Other performance issues may be reported by agencies that provide advocacy services.

## Appendix A: Waiver Administration and Operation

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

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

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment		

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

## Appendix A: Waiver Administration and Operation

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

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

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

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

#### i. Performance Measures

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

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

*Where possible, include numerator/denominator.*

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

#### Performance Measure:

**PIHPs implement corrective actions within the timeframe required by the SMA.**

**Numerator: Number of corrective actions implemented within timeframe determined by**

**SMA. Denominator: Number of corrective actions required by SMA.**

**Data Source (Select one):**

**Provider performance monitoring**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

**Performance Measure:**

All PIHPs undergo an annual Quality Compliance Review (QCR) conducted by the EQRO.

**Numerator:** Quality Compliance Review points earned by PIHPs in annual EQRO review process. **Denominator:** Total Quality Compliance Review points possible.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**EQRO Report**

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

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 80%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 80%; height: 20px;" type="text"/>

**Performance Measure:**

The SMA reviews the findings of each PIHP’s annual quality review and orders corrective action for any finding determined to require remediation. **Numerator:** Number of PIHPs needing remediation for which the SMA requires a corrective action plan. **Denominator:** Number of all PIHPs that have findings determined to require remediation.

**Data Source (Select one):**

**Other**

If 'Other' is selected, specify:

**EQRO Report**

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

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

**Data Source** (Select one):

**Provider performance monitoring**

If 'Other' is selected, specify:

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

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

**Data Aggregation and Analysis:**

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

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

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

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

In general, SMA oversight teams direct the correction of individual problems. The team assigned to each PIHP discovers problems and issues through EQRO reports related to individual member concerns; Ombudsman program reports; review of grievances and appeals; review of member incident reports; review of requests for use of restrictive measures; the provision of technical assistance; complaints to the SMA; and other sources. Teams interact with PIHPs on a regular basis and may identify concerns through such communication and direct observation. As needed, teams direct remediation of individual member concerns, as well as isolated operational concerns. Teams also use information gathered through direct interaction with the PIHP, and from many available sources, to identify and direct remediation of systemic problems or issues within the PIHP. Teams have the ability to respond quickly to any issue that affects member health or safety identified through routine discovery activities, and can respond quickly to other issues as they are identified. Each team documents issues and concerns and any resolution or remediation in a tracking system maintained by the SMA. An issue cannot be closed in the tracking system without approval of the team's SMA supervisor. The SMA has also developed policies and procedures for the EQRO and SMA oversight teams to report concerns that rise to a level where they require the immediate attention of SMA leadership.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

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

**a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<b>Aged or Disabled, or Both - General</b>					
		Aged	65		
		Disabled (Physical)	18	64	
		Disabled (Other)	18	64	
<b>Aged or Disabled, or Both - Specific Recognized Subgroups</b>					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
<b>Intellectual Disability or Developmental Disability, or Both</b>					
		Autism			
		Developmental Disability	18		
		Intellectual Disability	18		
<b>Mental Illness</b>					
		Mental Illness			
		Serious Emotional Disturbance			

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

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

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

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

*Specify:*

Members in the aged or disabled target group who have physical or other disabilities and reach the age of 65 while participating in this waiver are considered to be part of the Aged target group. No other change occurs for the member.

## Appendix B: Participant Access and Eligibility

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

**a. Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

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

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

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

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

Specify the percentage:

**Other**

*Specify:*

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

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

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

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

**The following dollar amount:**

Specify dollar amount:

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

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

Specify the formula:

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

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

Specify percent:

**Other:**

*Specify:*

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## Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

**Other safeguard(s)**

Specify:

---

## Appendix B: Participant Access and Eligibility

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

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

**Table: B-3-a**

Waiver Year	Unduplicated Number of Participants
Year 1	

Waiver Year	Unduplicated Number of Participants
	65311
Year 2	67531
Year 3	69707
Year 4	71840
Year 5	73973

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

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

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

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

Table: B-3-b

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

## Appendix B: Participant Access and Eligibility

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

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

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

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

the waiver.

**e. Allocation of Waiver Capacity.**

Select one:

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

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

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

County service areas covered under this Waiver for more than 3 years are at full entitlement for all eligible individuals.

When Family Care expands into new counties, the Aging and Disability Resource Centers (ADRCs) are responsible for managing waiver capacity by managing the wait list for enrollment during the initial three year transition period. One thirty-sixth of the number of people waiting at the time Family Care starts in a service area are allowed to enroll in each of the first 36 months. After 36 months, all eligible individuals must be enrolled without waiting. At that point, there is no longer a role for ADRCs in managing waiver capacity.

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

All persons who have a nursing home or ICF level of care who enroll in the CMS-approved companion § 1915 (b) waiver or § 1932(a) SPA are entitled to entrance into this waiver.

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## Appendix B: Participant Access and Eligibility

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

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

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## Appendix B: Participant Access and Eligibility

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

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

§1634 State

SSI Criteria State

209(b) State

**2. Miller Trust State.**

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

No

Yes

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

---

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

---

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

**SSI recipients**

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

**Optional state supplement recipients**

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

*Select one:*

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

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

Specify percentage:

**Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)**

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

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

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

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

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

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

*Specify:*

- Other caretaker relatives specified in 42 CFR §435.110
- Pregnant women specified in 42 CFR §435.116
- Children specified in 42 CFR §435.118
- All other mandatory and optional groups under the state plan are included.

---

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

---

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

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

*Select one and complete Appendix B-5.*

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

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

*Check each that applies:*

**A special income level equal to:**

*Select one:*

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

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

Specify percentage:

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

Specify dollar amount:

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

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

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

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

*Select one:*

**100% of FPL**

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

Specify percentage amount:

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

*Specify:*

Medically needy with spend down: For individuals who are aged or have a physical disability, the SMA will use the average monthly cost for private patients in nursing facilities as used for assessing a transfer of assets penalty to reduce an individual's income to an amount at or below the medically needy income limit. For individuals with an intellectual disability, the SMA will use the average of the monthly rates charged to PIHPs for inpatient care in a State Center for the Developmentally Disabled to reduce an individual's income to an amount at or below the medically needy income limit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Select one:*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

*(select one):*

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

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

Specify the percentage:

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

Specify dollar amount:

**A percentage of the Federal poverty level**

Specify percentage:

**Other standard included under the state Plan**

*Specify:*

**The following dollar amount**

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

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

*Specify:*

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

In FFS waivers, Medicaid pays the actual cost of the § 1915(c) services that a member receives. In a managed care program, Medicaid pays a capitation rate to the PIHP for § 1915(c) and other services. Accordingly, under a capitated system, the benefit becomes the amount the SMA expends on behalf of the member, or the capitated payment. To ensure that excess income is only applied to the cost of the § 1915(c) waiver services, the SMA uses the portion of the average capitation rate that is attributable to § 1915(c) waiver services as the dollar amount that the individual is liable for because the capitated portion of the rate that is attributable to § 1915(c) waiver services is the actual amount that the SMA pays to the PIHP for these services. This amount represents the member's maximum cost share (PETI).

**Other**

*Specify:*

---

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

---

**Not Applicable**

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

*Specify:*

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

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

---

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

---

**Not Applicable (see instructions)**

**AFDC need standard**

**Medically needy income standard**

**The following dollar amount:**

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

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

*Specify:*

**Other**

*Specify:*

---

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

---

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

Select one:

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

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

**The state establishes the following reasonable limits**

*Specify:*

---

## Appendix B: Participant Access and Eligibility

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

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

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

---

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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

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

*(select one):*

**SSI standard**

**Optional state supplement standard**

**Medically needy income standard**

**The special income level for institutionalized persons**

**A percentage of the Federal poverty level**

Specify percentage:

**The following dollar amount:**

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

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

*Specify formula:*

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

In FFS waivers, Medicaid pays the actual cost of the § 1915(c) services that a member receives. In a managed care program, Medicaid pays a capitation rate to the PIHP for § 1915(c) and other services. Accordingly, under a capitated system, the benefit becomes the amount the SMA expends on behalf of the member, or the capitated payment. To ensure that excess income is only applied to the cost of the § 1915(c) waiver services, the SMA uses the portion of the average capitation rate that is attributable to § 1915(c) waiver services as the dollar amount that the individual is liable for because the capitated portion of the rate that is attributable to § 1915(c) waiver services is the actual amount that the SMA pays to the PIHP for these services. This amount represents the member's maximum cost share (PETI).

**Other**

*Specify:*

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

explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

**Allowance is the same**

**Allowance is different.**

*Explanation of difference:*

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

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

Select one:

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

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

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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**Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.**

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## Appendix B: Participant Access and Eligibility

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

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

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

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

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## Appendix B: Participant Access and Eligibility

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

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

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

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

expenses for medical or remedial care (as specified below).

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**Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.**

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

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

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

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

**i. Minimum number of services.**

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

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

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

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

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

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

**Directly by the Medicaid agency**

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

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

*Specify the entity:*

Level of care evaluations for new applicants are conducted by Aging and Disability Resource Centers or Tribal Aging and Disability Resource Specialists. Reevaluations of level of care for members are performed by PIHPs.

**Other**

*Specify:*

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

Initial evaluation of level of care is performed by individuals who have a license to practice as a registered nurse in Wisconsin, pursuant to Wis. Stat. § 441.06, or a Bachelor of Arts or Science degree in a health or human services related field (e.g. social work, rehabilitation, psychology), and a minimum of one year experience working with at least one of the target populations. Individuals permitted to perform level of care evaluations are certified as screeners after confirming that they have the required education and experience and passing an online course, which includes tests of their knowledge of instructions and criteria for level of care determination. To maintain their certification, the SMA requires each screener to pass a test of continuing knowledge and skills at least once every two years. The SMA maintains electronic records of these test results.

Records of each screener's education and experience credentials are created and maintained by the Aging and Disability Resource Centers and PIHPs. In addition, the SMA collects information regarding education and experience at the time each potential screener applies to take the online screener instructions training course and tests.

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

The level of care criteria for Nursing Home level of care are the same as the criteria for Medicaid reimbursement of nursing facility care in Wisconsin. The specific nursing home levels of care are intensive skilled nursing, skilled nursing facility and intermediate care facility 1 and 2. The level of care criteria for the ICF/IID level of care are the same as the criteria for Medicaid reimbursement for ICF/IID facility care in Wisconsin. The level of care tool used is the Wisconsin long-term care functional screen.

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

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

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

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

The long-term care functional screen (LTCFS) is an automated tool developed by the SMA to determine the appropriate nursing home level of care for waiver applicants. The functional screen was developed with SMA registered nurses who evaluated Physician Plans of Care to determine Medicaid eligibility for nursing home residents. It has been evaluated by the SMA and determined to be valid, reliable, and to result in comparable level of care.

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

Information used in level of care assessments for new enrollees is gathered by certified screeners at Aging and Disability Resource Centers during a face-to-face meeting with the applicant using the State Medicaid Agency's automated long-term care functional screen. When assessment information is entered into the secure, online functional screen tool, the tool returns a level of care for the individual. Information for annual reevaluations of level of care is gathered during face-to-face meetings between a certified screener at the PIHP and the enrolled program member.

The same tool is used to reevaluate level of care.

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

**Every three months**

**Every six months**

**Every twelve months**

**Other schedule**

*Specify the other schedule:*

Every 365 days.

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

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

**The qualifications are different.**

*Specify the qualifications:*

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

Annual reevaluation of level of care is a PIHP responsibility. Each PIHP uses an internal tracking system to ensure that a member's level of care is reevaluated at least every 365 days.

The long-term care functional screen's result is automatically sent from the functional screen electronic system to the Medicaid Management Information System (MMIS) and the Medicaid eligibility system. The MMIS system also verifies both Medicaid and functional eligibility for all members on a monthly basis and disenrolls members who do not meet eligibility requirements. When an annual Medicaid eligibility recertification is completed, the Income Maintenance (IM) agency verifies that members have a completed annual functional screen. If a functional screen has not been completed within the last 365 days, the IM agency closes the long-term care Medicaid eligibility.

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

All functional screens are maintained by the SMA in its automated long-term care functional screen computer system (FSIA). Each PIHP has electronic access to all active and historical level of care evaluations for each member who is currently enrolled in the PIHP. Indian Health Care Providers will have access to prior screens for individuals who are receiving their case management services.

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

### Quality Improvement: Level of Care

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

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

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

##### **i. Sub-Assurances:**

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

**Performance Measures**

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

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

**Performance Measure:**

All applicants enrolled in a PIHP have a valid Family Care level of care based on an evaluation using the Long-Term Care Functional Screen. Numerator: New enrollees during waiver year who do not have a completed Long-Term Care Functional Screen that indicates a valid Family Care level of care. Denominator: All new enrollees during waiver year.

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**Functional Screen Information Access System**

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

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

**Data Aggregation and Analysis:**

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

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

**Performance Measures**

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

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

- c. Sub-assurance: The processes and instruments described in the approved waiver are applied**

*appropriately and according to the approved description to determine participant level of care.*

**Performance Measures**

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

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

**Performance Measure:**

**PIHPs remediate level of care evaluation errors within 90 days of notification of error by SMA. Numerator: Number of level of care evaluation errors remediated by PIHP within 90 days of notification by SMA. Denominator: Number of level of care evaluation errors identified by SMA.**

**Data Source** (Select one):

**Other**

If 'Other' is selected, specify:

**SMA Administrative Data**

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

	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 20px;" type="text"/>

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

Typical reasons for errors in level of care evaluation (LOC) include misinterpretation of the written level of care instructions that are provided by the SMA to the evaluator and human error in keying selections in the online level of care application (FSIA).

The SMA uses a combination of LOC data generated by the online LOC application (FSIA) and evidence gathered during direct audit of the evaluator’s LOC records to identify errors. Under contracts between the SMA and LOC evaluators, evaluators are required to remediate all errors identified by the SMA during quality assurance audits. The SMA verifies that 100% remediation has occurred prior to providing the reviewer with written approval of remediation.

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

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

Individual problems with level of care determinations are typically discovered by the SMA in one of three ways: (1) the screener contacts the SMA about unexpected results of the functional screen; (2) the SMA discovers errors when reviewing screens with results that are under appeal; or (3) the SMA quality reviewers discover errors during regular sampling of past screens. In all cases, the SMA contacts the Aging and Disability Resource Center, Tribal Aging and Disability Resource Specialist, or PIHP to ascertain the correct facts and to direct correction of the screen, if possible. Correction is verified via observation of the corrected screen in the functional screen information access system. The SMA maintains a record of individual level of care remediation.

**ii. Remediation Data Aggregation**

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix B: Participant Access and Eligibility**

**B-7: Freedom of Choice**

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

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

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

request through the Medicaid agency or the operating agency (if applicable).

The ADRC or TADRS is required by contract to inform the potential enrollee and/or his or her legal representative about the available service and enrollment options, including but not limited to home care, community services, residential care, nursing home care, post hospital care, and case management services. A potential member documents his or her choice by signing an enrollment form, which is maintained by the ADRC or TADRS.

If the individual is an Indian, the ADRC or TADRS informs the potential enrollee and/or his or her legal representative of 1) the option to choose between an Indian Health Care Provider (IHCP) (if available) and the PIHP for care management services and 2) the option to choose to receive benefit package services from the IHCP (if available) or PIHP network providers.

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

Copies of SMA-developed and owned enrollment forms are maintained by the Aging and Disability Resource Center or Tribal Aging and Disability Resource Specialist. Copies of member-centered plans are maintained by the PIHP.

## Appendix B: Participant Access and Eligibility

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

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

Aging and Disability Resource Centers (ADRCs) and Tribal Aging and Disability Resource Specialists (TADRS) are required to have enrollment forms and other materials related to managed long-term care, including an SMA-developed brochure and the PIHP member handbook, available in the prevalent foreign languages spoken in Wisconsin: Arabic, Chinese (Mandarin), Hmong, Laotian, Serbo-Croatian, Somali, Russian, and Spanish. ADRCs are also required to obtain interpreters or telephonic interpretation services when needed by an applicant or member.

The SMA requires PIHPs to include, in all written materials for potential members, taglines in the prevalent non-English languages, as well as large print (no smaller than 18-point font), explaining the availability of written translation or oral translation to understand the information, the toll free number of the ADRC providing choice counseling, and the toll free and TTY/TDY telephone number of the PIHP's member/customer service unit. PIHPs must also make all written materials that are critical to obtaining services, including provider directories, handbooks, appeal and grievance notices, and denial and termination notices, available in all prevalent, non-English languages in the PIHP's service area. Members may also request auxiliary aids and services or for materials produced and/or used by the PIHP to be made available in alternative formats, at no cost. Finally, PIHPs must provide interpreter services when needed by members to ensure effective communication regarding treatment, medical history, and health education and information. The PIHP must offer interpretation services 24 hours a day, 7 days a week, in any language spoken by the member. Professional interpreters shall be used when needed where technical, medical, or treatment information is discussed.

## Appendix C: Participant Services

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

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

Service Type	Service
Statutory Service	Adult Day Care Services
Statutory Service	Care Management
Statutory Service	Daily Living Skills Training

Service Type	Service		
Statutory Service	Day Habilitation Services		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment - Individual Employment Support		
Supports for Participant Direction	Consumer Directed Supports (Self-Directed Supports) Broker		
Supports for Participant Direction	Financial Management Services		
Other Service	Adaptive aids		
Other Service	Adult residential care - 1-2 bed adult family homes		
Other Service	Adult Residential Care - 3-4 Bed Adult Family Homes		
Other Service	Adult Residential Care - Community-Based Residential Facilities (CBRF)		
Other Service	Adult Residential Care - Residential Care Apartment Complexes (RCAC)		
Other Service	Assistive Technology/Communication aids		
Other Service	Consultative Clinical and Therapeutic Services for Caregivers		
Other Service	Consumer Education and Training		
Other Service	Counseling and Therapeutic Resources		
Other Service	Environmental Accessibility Adaptations (Home Modifications)		
Other Service	Home Delivered Meals		
Other Service	Housing Counseling		
Other Service	Personal Emergency Response Systems (PERS)		
Other Service	Relocation services		
Other Service	Self-Directed Personal Care		
Other Service	Skilled Nursing Services RN/LPN		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Supported Employment - Small Group Employment Support		
Other Service	Supportive Home Care		
Other Service	Training Services for Unpaid Caregivers		
Other Service	Transportation (Specialized Transportation) - Community Transportation		
Other Service	Transportation (Specialized Transportation) - Other Transportation		
Other Service	Vocational Futures Planning and Support		

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Adult Day Health

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

Adult Day Care Services

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

04 Day Services

04050 adult day health

**Category 2:**

**Sub-Category 2:**

04 Day Services

04060 adult day services (social model)

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Adult day care services are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision and/or protection. Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site. Transportation between the member's place of residence and the adult day care center may be provided as a component part of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care services. Meals provided as part of adult day care may not constitute a "full nutritional regimen" (3 meals per day). The PIHP may only enter a provider agreement with adult day care centers that have been certified by the Department, under Wis. Stat. § 49.45(2)(a)(11), to provide adult day care services.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult day center services/treatment

## Appendix C: Participant Services

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

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**Service Type: Statutory Service**  
**Service Name: Adult Day Care Services**

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**Provider Category:**

Agency

**Provider Type:**

Adult day center services/treatment

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Stat. § 49.45

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

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## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Case Management

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

Care Management

**HCBS Taxonomy:**

**Category 1:**

01 Case Management

**Sub-Category 1:**

01010 case management

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Care management services (sometimes called support and service coordination) are provided by an interdisciplinary care management team (IDT). The member is the center of the IDT. The IDT consists of, at minimum, a registered nurse and a social services coordinator, and may also include other professionals as appropriate to the needs of the member, as well as family or other informal supports requested by the member. The IDT initiates and oversees the initial comprehensive assessment of needs and reassessment process, the results of which are used in developing the individual's member-centered plan (MCP). The IDT identifies the member's preferred outcomes and the services needed to achieve those outcomes and monitors the member's health and welfare, the delivery of services, and progress in achieving identified outcomes. The IDT also carries out activities that help members and their families to identify other service needs and gain access to medical, social, rehabilitation, vocational, educational and other services identified.

Care management is always provided by individuals employed by the PIHP or by a sub-contract agency of the PIHP. In addition, care management can be provided to Indian members by an Indian Health Care Provider (IHCP) under Provision 5006(d) of the American Recovery and Reinvestment Act of 2009. With the exception of IHCPs, providers of home and community based services, or those who have an interest in or are employed by a provider of home and community based services, cannot provide care management or develop the MCP. When the only willing and qualified entity to provide care management and/or develop MCPs in a geographic area also provides home and community based services, the SMA may consider granting a waiver of this prohibition following specific, prior approval from CMS. Care management services are provided by the IDT with the member and other participants of the interdisciplinary team and include:

- A comprehensive assessment of the member's strengths, abilities, functional limitations, lifestyle, personal circumstances, values, preferences and choices.
- Development of the MCP.
- Authorization for the purchase of paid services identified in the MCP.
- Monitoring of the delivery of and quality of the paid services identified in the plan of care.
- Monitoring of the member's circumstances and ongoing health and well-being.
- Maintenance of a member record and all documentation associated with the delivery of services and any required waiver procedures.
- Development of a plan to assure continuity of the member's independence, care, living arrangements and preferences in the face of changes in circumstances.

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

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	PIHP or contracted Social Service Coordinator
Agency	Indian Health Care Provider
Agency	PIHP or contracted Registered Nurse

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Care Management**

**Provider Category:**

Agency

**Provider Type:**

PIHP or contracted Social Service Coordinator

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Social worker certified in Wisconsin under Wis. Stat. Ch. 457, or have a minimum of a four year bachelor's degree in human services area, or a four year bachelor's degree in any other area with a minimum of three (3) years' experience in social service care management or related social service experience with persons in the Family Care target population.

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

Minimum of one year experience working with at least one of the Family Care target populations.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Care Management**

**Provider Category:**

Agency

**Provider Type:**

Indian Health Care Provider

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Indian Health Care Provider as defined by the American Recovery and Reinvestment Act of 2009

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

State Medicaid Agency (SMA)

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Care Management**

**Provider Category:**

Agency

**Provider Type:**

PIHP or contracted Registered Nurse

**Provider Qualifications**

**License (specify):**

PIHP RN - Wis. Stat. Ch. 441 (exception is nurses working for IHS/638 facilities do not need to be licensed in the state in which they are working BUT they do need to be licensed in a state.)

**Certificate (specify):**

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

Minimum of one year experience working with at least one of the Family Care target populations.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Education

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

Daily Living Skills Training

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08010 home-based habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Daily living skills training is the provision of education and skill development to teach members the skills involved in performing activities of daily living, including skills intended to increase the member's independence and participation in community life. This service may include teaching money management, home care maintenance, food preparation, mobility training, self-care skills, and the skills necessary for accessing and using community resources. Daily living skills training may involve training the member or the natural support person to assist the member.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Daily living skills trainer
Agency	Daily living skills training agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Daily Living Skills Training**

**Provider Category:**

Individual

**Provider Type:**

Daily living skills trainer

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

The PHIP shall assure that the provider has the ability and qualifications to provide this service, including a minimum of two years of experience working with the target population in providing this service, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services. However, a member self-directing this service may employ qualified persons with less experience. In that event, the PHIP and member must ensure that the individual provider receives member-specific training sufficient to enable the individual to competently provide the daily living skills training services to the member consistent with the member-centered plan. If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Daily Living Skills Training**

**Provider Category:**

Agency

**Provider Type:**

Daily living skills training agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing daily living skills training, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment, or similar services.

If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Habilitation

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

Day Habilitation Services

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04020 day habilitation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Day habilitation services are the provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills that enhance social development and develop skills in performing activities of daily living and full community citizenship. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence, and personal choice.

Day habilitation services focus on enabling the member to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the member-centered plan, such as physical, occupational, or speech therapy. For members with degenerative conditions, day habilitation activities may include training and supports to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Day habilitation services may also be used to provide retirement activities. As some members get older they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities.

Day habilitation may be furnished in a variety of settings in the community except for the member's residence. Day habilitation services are not limited to fixed-site facilities but may take place in stores, restaurants, libraries, parks, recreational facilities, community centers, or any other place in the community.

Transportation may be provided between a member's place of residence and the site of day habilitation activities or between habilitation activities sites (in cases where the member receives habilitation services in more than one place) as a component part of day habilitation activities. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Personal care/assistance may be a component part of day habilitation services as necessary to meet the need of members, but may not comprise the entirety of the service. Members who receive day habilitation services may also receive educational, supported employment, and prevocational services. Day habilitation may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adult day center services/treatment

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Day Habilitation Services**

**Provider Category:**

Agency

**Provider Type:**

Adult day center services/treatment

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Wis. Admin. Code §§ DHS 61.41, 61.75

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

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment, or similar services.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

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

**Service Type:**

Statutory Service

**Service:**

Prevocational Services

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

**HCBS Taxonomy:**

**Category 1:**

04 Day Services

**Sub-Category 1:**

04010 prevocational services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Prevocational services are designed to create a path to integrated community-based employment for which an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services allow the member to develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time as determined by the member and his or her care planning team. Services are expected to specifically involve strategies that enhance a member's employability in integrated, community settings.

Prevocational services should enable each member to attain the highest possible wage and work in the most integrated setting that is matched to the member's interests, strengths, priorities, and abilities. Services intend to develop general skills that lead to employment, including the ability to communicate effectively and establish appropriate boundaries with supervisors, co-workers, and customers; express and understand expectations; engage in generally accepted community workplace conduct and adopt appropriate workplace dress; follow directions; attend to tasks; problem-solve; manage conflicts; and adhere to general workplace safety. Services may include mobility training.

Prevocational services may be delivered in a variety of locations in the community and are not limited to fixed-site facilities. Some examples of community sites include the library, job center, banks, or businesses.

Prevocational services, regardless of how and where they are delivered, are expected to help people make reasonable and continued progress toward participation in at least part-time, integrated employment. Prevocational services are not considered outcomes; competitive employment and supported employment are considered successful outcomes of prevocational services. The optimal outcome of the provision of prevocational services is permanent integrated employment at or above the minimum wage in the community.

Prevocational services may not duplicate services that are provided as part of an Individualized Plan for Employment (IPE), under the Rehabilitation Act of 1973, as amended, or as part of an Individualized Education Plan (IEP), under the Individuals with Disabilities Education Act (IDEA).

The contracted provider of pre-vocational services must complete a six-month progress report and service plan document for the interdisciplinary care management team (IDT). The purpose is to ensure and document that prevocational services are assisting the member in progressing toward a goal of at least part-time, integrated employment. Timely completion of this document is required for the IDT to consider reauthorization of prevocational services.

Participation in prevocational services is not a prerequisite for individual or small group supported employment services provided under the waiver. Members who receive prevocational services may also receive educational, supported employment, and/or day services. A member-center plan may include two or more types of non-residential services. However, different types of non-residential services may not be billed for the same period of time.

Members participating in prevocational services shall be compensated in accordance with applicable Federal and State laws and regulations.

Transportation may be provided between the member's residence and the site of the prevocational services or between prevocational service sites – in cases where the member receives prevocational services in more than one place – as a component part of prevocational services or under specialized (community) transportation but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met. If the transportation is provided by the prevocational services provider, the cost of this transportation is included in the rate paid to the provider.

Personal care provided to a member during the receipt of prevocational services may be included in the reimbursement paid to the prevocational services provider, or it may be covered and reimbursed under another waiver service so long as there is no duplication of payment.

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

Prevocational services may be provided to supplement, but may not duplicate supported employment or vocational futures planning and support services.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Prevocational Services

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Prevocational Services**

**Provider Category:**

Agency

**Provider Type:**

Prevocational Services

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

The PIHP shall assure the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable experience for a qualified entity, including a minimum of two years of experience working with the target population providing employment-related services that have a goal of integrated employment in the community at or above minimum wage.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA), and, if personal care services are provided, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Respite

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

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09012 respite, in-home

**Category 2:**

09 Caregiver Support

**Sub-Category 2:**

09011 respite, out-of-home

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Respite care services are services provided for a member on a short-term basis to ease the member's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in an institution such as a certified Medicaid setting (hospital, nursing home) or other licensed facility. Respite care may also be provided in a residential facility such as a certified or licensed adult family home, licensed community-based residential facility, certified residential care apartment complex, in the member's own home, or the home of a respite care provider.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	1-2 bed adult family home, residential care apartment complex (RCAC)
Agency	Supportive home care agency
Agency	Hospital, nursing home, community-based residential facility, 3-4 bed adult family home
Individual	Individual respite provider
Agency	Personal care agency

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

1-2 bed adult family home, residential care apartment complex (RCAC)

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Certified 1-2 bed adult family home - WI Medicaid Waiver Standards and Wis. Admin. Code Ch. DHS 82 for Barrett Homes; residential care apartment complex (RCAC)- Wis. Admin. Code Ch. DHS 89

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Supportive home care agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Agency

**Provider Type:**

Hospital, nursing home, community-based residential facility, 3-4 bed adult family home

**Provider Qualifications**

**License** (*specify*):

Hospital: Wis. Admin. Code Ch. DHS 124

Nursing home: Wis. Admin. Code Ch. DHS 132 and Ch. DHS 134

Community-based residential facility: Wis. Admin. Code Ch. DHS 83

3-4 bed adult family home - Wis. Admin. Code Ch. DHS 88

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Statutory Service**

**Service Name: Respite**

**Provider Category:**

Individual

**Provider Type:**

Individual respite provider

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

---

**Appendix C: Participant Services**

---

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

---

**Service Type: Statutory Service**

**Service Name: Respite**

---

**Provider Category:**

Agency

**Provider Type:**

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

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

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

**Service Type:**

Statutory Service

**Service:**

Supported Employment

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

Supported Employment - Individual Employment Support

**HCBS Taxonomy:**

**Category 1:**

03 Supported Employment

**Sub-Category 1:**

03021 ongoing supported employment, individual

**Category 2:**

03 Supported Employment

**Sub-Category 2:**

03010 job development

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Supported employment-individual employment support services are the ongoing supports provided to members who, because of their disabilities, need intensive ongoing support to obtain and maintain competitive, customized, or self-employment, in an integrated work setting, in the general workforce. A member receiving this service shall be compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above minimum wage, in an integrated setting, in the general workforce, and in a job that meets personal and career goals.

Individual employment support services are individualized and may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, job supports, work incentive benefits analysis and counseling, training and work planning, transportation, and career advancement services. Additional services include those that are not specifically related to job skill training that enable the member to be successfully integrated into the job setting.

Individual employment supports may include support to maintain self-employment, including home-based self-employment. This service may also include services and supports that assist the member in achieving self-employment; however, Medicaid funds may not be used to defray the expenses associated with starting or operating a business. Assistance for self-employment may include the following: assistance in identifying potential business opportunities; assistance in developing a business plan, including identifying potential sources of business financing and developing and launching a business; identification of the supports that are necessary in order for the member to operate the business; and ongoing assistance, counseling, and guidance once the business has been launched.

Individual employment support does not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers in similar positions in the business. Individual employment support services may be provided by a co-worker or other job site personnel when (a) the services are not part of the normal duties of the coworker, supervisor, or other personnel; and (b) the individual meets the established qualifications for individual providers of this service. Employers may be reimbursed for supported employment services provided by co-workers.

Supported employment services do not include vocational services that are provided in facility-based work settings and not in general community work places. Supported employment services may not include volunteer work.

Members receiving individual employment supports may also receive educational, pre-vocational, and/or day services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded under the §110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §1401 et seq).

Coverage does not include incentive payments, subsidies, or unrelated vocational training expenses, such as (a) incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment or (b) wages or other payments that are passed through to users of supported employment services.

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

The cost of transportation for a member to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider or may be reimbursed under specialized (community) transportation but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but it may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider or may be reimbursed under supportive home care or self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

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

When personal care/assistance, transportation, or both are a component of this service, payment may not be made for personal care/assistance or transportation under another waiver service for the same period of time.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

**Appendix C: Participant Services**

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

**Service Type: Statutory Service**

**Service Name: Supported Employment - Individual Employment Support**

**Provider Category:**

Individual

**Provider Type:**

On the job support person

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

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

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA), and, if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

#### Verification of Provider Qualifications

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

### Appendix C: Participant Services

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

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**Service Type: Statutory Service**

**Service Name: Supported Employment - Individual Employment Support**

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**Provider Category:**

Agency

**Provider Type:**

Supported employment agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

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

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA), and, if personal care services are provided, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

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

**Service Type:**

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

Other Supports for Participant Direction

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

Consumer Directed Supports (Self-Directed Supports) Broker

**HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction

**Sub-Category 1:**

12020 information and assistance in support of self-direction

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

A support broker is an individual who assists a member in planning, securing and directing self-directed supports. The services of a support broker are paid for from the member's self-directed supports budget authority. Support brokers are subject to criminal background checks and must be independent of any other waiver service provider. A support broker shall be knowledgeable of the local service delivery system and local community-integrated services and resources available to the member. A support broker shall also be knowledgeable of the typical kinds of needs of persons in the member's target group. The member and interdisciplinary team staff are responsible to assure that a support broker selected by the member has the appropriate knowledge. (See Appendix E for more information.)

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Excludes the cost of any direct services authorized and obtained by a member through an SDS plan, which is paid for and reported under the appropriate service definition.

Excludes the cost of fiscal agent services, which is paid for and reported as financial management services.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Support broker agency
Individual	Individual support broker

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**

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**Service Name: Consumer Directed Supports (Self-Directed Supports) Broker**

---

**Provider Category:**

Agency

**Provider Type:**

Support broker agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Knowledge of the unique needs/preferences of the member and the service system

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

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**Appendix C: Participant Services**

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

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**Service Type: Supports for Participant Direction**

**Service Name: Consumer Directed Supports (Self-Directed Supports) Broker**

---

**Provider Category:**

Individual

**Provider Type:**

Individual support broker

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Knowledge of the unique needs/preferences of the member and the service system

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

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

**Service Type:**

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

**Support for Participant Direction:**

Financial Management Services

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

**HCBS Taxonomy:**

**Category 1:**

12 Services Supporting Self-Direction

**Sub-Category 1:**

12010 financial management services in support of self-direction

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Financial management services assist members and their families to manage service dollars or their personal finances to prevent institutionalization. This service includes a person or agency paying service providers after the member, guardian, or other authorized representative authorizes payment to be made for services included in the member's approved self-directed supports plan. Financial management services providers, sometimes referred to as fiscal intermediaries or fiscal agents, are organizations or individuals who pay personnel costs, tax withholding, worker's compensation, health insurance premiums, and other taxes and benefits as indicated in the member's self-directed supports plan and budget for services. Financial management services are purchased directly by the PIHP or IHCP and made available to the member/family to ensure that appropriate compensation is paid to providers. Additionally, this service includes the provision of assistance to members who are unable to manage their own personal funds. This service includes assistance to the member to effectively budget personal funds to ensure sufficient resources are available for housing, board, and other essential costs. This service includes paying bills authorized by the member or his or her guardian and keeping an account of disbursements.

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

Excludes payments to court-appointed guardians or court-appointed protective payees if the court has directed them to perform any of these functions.

Excludes payment for the cost of room and board.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Financial management assistant
Agency	Financial management agency

## Appendix C: Participant Services

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

**Service Type: Supports for Participant Direction**

**Service Name: Financial Management Services**

**Provider Category:**

Individual

**Provider Type:**

Financial management assistant

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

A PIHP or IHCP must have standards in place that ensure at minimum that a financial management services provider 1) is an agency, unit of an agency, or individual that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include self-directed supports; 2) has training and experience in accounting or bookkeeping; and 3) has a system in place that recognizes the authorization of payment by the member or legal representative, promptly issues payments as authorized, documents budget authority, and summarizes payments in a manner that can be readily understood by the member or legal representative.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP or IHCP

**Frequency of Verification:**

Annually

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## Appendix C: Participant Services

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

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**Service Type: Supports for Participant Direction**

**Service Name: Financial Management Services**

---

**Provider Category:**

Agency

**Provider Type:**

Financial management agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

A PIHP or IHCP must have standards in place that ensure at minimum that a financial management services provider 1) is an agency, unit of an agency, or individual that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include self-directed supports; 2) has training and experience in accounting or bookkeeping; and 3) has a system in place that recognizes the authorization of payment by the member or legal representative, promptly issues payments as authorized, documents budget authority, and summarizes payments in a manner that can be readily understood by the member or legal representative.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP or IHCP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Adaptive aids

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Adaptive aids are controls or appliances that enable members to increase their abilities to perform ADLs and IADLs or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services and material benefits that enable members to access, participate and function in their community and competitive integrated employment. These include the purchase of vehicle modifications (such as van lifts, hand controls, equipment modifications etc. that allow the vehicle to be used by the member to access the community), or those costs associated with the maintenance of these items. The adaptive aids service includes the evaluation of the adaptive aids needs of a member, including a functional evaluation of the impact of the provision of appropriate adaptive aids in the customary environment of the member.

The adaptive aids service also includes (1) the purchase of a fully trained service dog from a reputable provider with experience providing structured training for service dogs; (2) the post-purchase training necessary to partner a fully trained service dog with its owner (i.e. enable the fully trained service dog and the member to work together); and (3) the ongoing maintenance costs of a fully trained service dog based on DHS guidelines. For the purpose of coverage as an adaptive aid benefit, a service dog is a dog that has been individually trained to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the person's disability.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Costs related to a dog that does not meet the definition of a service dog (i.e. emotional support dog, therapy dog, dog training to become a service dog, household pet).

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Adaptive aids vendors

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Adaptive aids**

**Provider Category:**

Agency

**Provider Type:**

Adaptive aids vendors

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services**

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

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

**Service Type:**

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

02 Round-the-Clock Services

02031 in-home residential habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Adult family homes of 1-2 beds are places in which the operator provides care, treatment, support, or services above the level of room and board to up to two adults. Services typically include supportive home care, personal care, and supervision. Services may also include recreational/social activities, behavior and social supports, daily living skills training, and transportation if provided by the operator or designee of the operator. The service includes homes that are the primary domicile of the operator and homes that are controlled and operated by a third party that hires staff to provide support and services.

Adult family home services also include coordination with other services and providers, including health care, vocational, or day services. Services may also include the provision of other waiver services as specified in the contract between the PIHP and residential provider.

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

Waiver funds are not used to pay for the cost of room and board.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Adult family home sponsor

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adult residential care - 1-2 bed adult family homes**

**Provider Category:**

Individual

**Provider Type:**

Adult family home sponsor

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

WI Medicaid Waiver Standards for Certified 1-2 Bed AFH and Wis. Admin. Code Ch. DHS 82 for Barrett Homes.

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Adult Residential Care - 3-4 Bed Adult Family Homes

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02011 group living, residential habilitation

**Category 2:**

02 Round-the-Clock Services

**Sub-Category 2:**

02013 group living, other

**Category 3:**

**Sub-Category 3:**

02 Round-the-Clock Services

02021 shared living, residential habilitation

**Category 4:**

**Sub-Category 4:**

02 Round-the-Clock Services

02023 shared living, other

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Adult family homes of 3-4 beds are licensed under Wis. Admin. Code Ch. DHS 88 and are places where 3-4 adults, who are not related to the licensee, reside; receive care, treatment, or services above the level of room and board; and may include up to seven hours per week of nursing care per resident. Services typically include supportive home care, personal care, and supervision. Other services provided may include behavior and social supports, daily living skills training, and transportation performed by the operator or designee of the operator. This service type also includes homes of 3-4 beds, specified under Wis. Stat. § 50.01(1)(a), which are licensed as a foster home under Wis. Stat. § 48.62 and certified by a certifying agency as defined under Wis. Admin. Code Ch. DHS 82. The latter are owner-occupied homes for persons with intellectual disabilities who are aging out of foster care. This category of homes permits such persons to remain in the same home, promoting continuity of care.

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

Waiver funds are not used to pay for the cost of room and board.  
  
This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed adult family home

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Adult Residential Care - 3-4 Bed Adult Family Homes**

**Provider Category:**

Agency

**Provider Type:**

Licensed adult family home

**Provider Qualifications**

**License** (*specify*):

Wis. Admin. Code Ch. DHS 88

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Adult Residential Care - Community-Based Residential Facilities (CBRF)

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02011 group living, residential habilitation

**Category 2:**

02 Round-the-Clock Services

**Sub-Category 2:**

02013 group living, other

**Category 3:**

02 Round-the-Clock Services

**Sub-Category 3:**

02012 group living, mental health services

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

A community-based residential facility (CBRF) is a residence where five (5) or more adults, not related to the operator or administrator of the facility, reside and receive care, treatment, support, supervision, and training. An individual with an intellectual disability may only reside in a CBRF that is licensed for eight (8) or fewer residents, unless that person has been determined to require No Active Treatment (NAT) for her or his intellectual disability. Services may include supportive home care, personal care, supervision, behavior and social supports, daily living skills training, transportation, and up to three hours per week of nursing care per resident.

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

Waiver funds are not used to pay for the cost of room and board.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Licensed CBRF

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Adult Residential Care - Community-Based Residential Facilities (CBRF)**

**Provider Category:**

Agency

**Provider Type:**

Licensed CBRF

**Provider Qualifications**

**License (specify):**

Wis. Admin. Code Ch. DHS 83

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Adult Residential Care - Residential Care Apartment Complexes (RCAC)

**HCBS Taxonomy:**

**Category 1:**

02 Round-the-Clock Services

**Sub-Category 1:**

02033 in-home round-the-clock services, other

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Residential care apartment complexes (RCAC) are services provided in a homelike, community-based setting where 5 or more adults reside in their own living units that are separate and distinct from each other. Persons who reside in the facility also receive the following services: supportive services (e.g., laundry, house cleaning), personal assistance (e.g., personal care), nursing services (e.g., wound care, medication management), and assistance in the event of an emergency (e.g., PERS and response).

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

Waiver funds are not used to pay for the cost of room and board.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Certified RCAC

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Adult Residential Care - Residential Care Apartment Complexes (RCAC)**

**Provider Category:**

Agency

**Provider Type:**

Certified RCAC

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Wis. Admin. Code Ch. DHS 89

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Assistive Technology/Communication aids

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

17 Other Services

**Sub-Category 2:**

17020 interpreter

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Assistive technology is an item, piece of equipment, or product system – whether acquired commercially, modified, or customized – that enables members to (1) increase their ability to perform ADLs and IADLs or control the environment in which they live and (2) access, participate, and function in their community and in competitive integrated employment. Assistive technology service is a service that directly assists a member in the selection, acquisition, or use of an assistive technology device. Assistive technology includes the following:

(A) evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services in the customary environment of the member;

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for the member;

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the member-centered plan;

(E) training or technical assistance for the member or, where appropriate, family members, guardians, advocates, or authorized representatives of the member; and

(F) training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of members. Assistive Technology includes communication aids, which are devices or services needed to assist members with hearing, speech, communication, or vision impairments. These items or services assist the member to effectively communicate with others, decrease reliance on paid staff, increase personal safety, enhance independence, and improve social and emotional well-being.

Communication aids include any device that addresses these objectives, such as augmentative and alternative communication systems, hearing or speech amplification devices, aids and assistive devices, interpreters, cognitive retraining aids, and the repair and/or servicing of such systems. Communication aids also include electronic technology, such as tablets, mobile devices, and related software that assists with communication, when the use provides assistance to a member who needs such assistance. Applications for mobile devices or other technology also are covered under this service when the use is primarily medical in nature or provides assistance to a member who needs such assistance. This list is intended to be illustrative and is not exhaustive.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

This service excludes interpreter services that are otherwise available, including for communication with the managed care organization, its contractors, or other health care professionals that are required to provide interpreter services as part of their rate.

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

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

**Provider managed**

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

**Legally Responsible Person**

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual interpreters
Agency	Communications aids vendors

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology/Communication aids

Provider Category:

Individual

Provider Type:

Individual interpreters

Provider Qualifications

License (specify):

Certificate (specify):

State or national registry

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

## Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology/Communication aids

Provider Category:

Agency

Provider Type:

Communications aids vendors

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

**Appendix C: Participant Services**

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

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

**Service Type:**

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

The purpose of consultative services is to improve the ability of unpaid caregivers and paid direct support staff to carry out therapeutic interventions. Clinical and therapeutic services assist unpaid caregivers and/or paid support staff in carrying out the member’s treatment/support plans, are not covered by the Medicaid State Plan and are necessary to improve the member’s independence and inclusion in their community. The service includes assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans, and monitoring of the member and the caregiver/staff in the implementation of the plans. This service includes the provision of training for caregivers/staff that are or will be serving members with complex needs (beyond routine care). For example, when an individual with complex needs is relocating from one of the State Centers for the Intellectually Disabled, this service could be used to train caregivers/staff on the behavioral support plans necessary for community integration. This service may also include consultation with service providers and potential providers to identify providers that can meet the unique needs of the member and to identify additional supports necessary for caregivers to perform therapeutic interventions.

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

Excludes training in member self-advocacy or caregiver advocacy on behalf of a member, which are covered under consumer education and training.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Counseling agencies
Individual	Individual counselors

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Consultative Clinical and Therapeutic Services for Caregivers**

**Provider Category:**

Agency

**Provider Type:**

Counseling agencies

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Admin. Code § DHS 61.35

**Other Standard (specify):**

Employing or contracting with professionals with current state licensure or certification in their field of practice.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At the time of authorization/purchase.

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**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Consultative Clinical and Therapeutic Services for Caregivers**

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**Provider Category:**

Individual

**Provider Type:**

Individual counselors

**Provider Qualifications**

**License (specify):**

Professionals with current state licensure in their field of practice

**Certificate (specify):**

Professionals with current state certification in their field of practice

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Consumer Education and Training

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09020 caregiver counseling and/or training

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Consumer education and training services are designed to help members develop self-advocacy skills, support self-determination, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. Self-advocacy skills enable members to communicate wants and needs, make informed decisions, voice their choices, and develop trusted supports with whomever they can share concerns. The consumer education and training service includes education and training for members, their caregivers, and legal representatives that is directly related to developing such skills. PIHPs assure that information about educational and/or training opportunities is available to members, their caregivers, and legal representatives. Covered expenses may include enrollment fees, books and other educational materials, and transportation related to participation in training courses, conferences, and other similar events.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Excludes educationally related services available under Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §1401 et seq) or other relevant funding sources.

Excludes education/training costs exceeding \$2500 per member annually.

Excludes payment for hotel and meal expenses while members or their legal representatives attend allowable training/education events.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Education and training agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Consumer Education and Training**

**Provider Category:**

Agency

**Provider Type:**

Education and training agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Competent and qualified providers of consumer education and training have expertise in problem solving, self-advocacy skills development, self-determination, community integration, financial management, and decision-making.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Counseling and Therapeutic Resources

**HCBS Taxonomy:**

**Category 1:**

11 Other Health and Therapeutic Services

**Sub-Category 1:**

11040 nutrition consultation

**Category 2:**

11 Other Health and Therapeutic Services

**Sub-Category 2:**

11020 health assessment

**Category 3:**

11 Other Health and Therapeutic Services

**Sub-Category 3:**

11030 medication assessment and/or management

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Counseling and therapeutic services is the provision of professional, treatment-oriented services to address a member's identified needs for personal, social, physical, medical, behavioral, emotional, cognitive, mental, or substance abuse disorders.

Counseling and therapeutic services may include assistance in adjusting to aging and/or disabilities including understanding capabilities and limitations. Services may also include assistance with interpersonal relationships, recreational therapies, music therapy, art therapy, nutritional counseling, medical counseling, weight counseling and grief counseling.

Counseling and therapeutic services must meet clearly defined outcomes, be proven effective for the member's condition or outcome and be cost effective. Any alternative therapies and treatments must meet DHS requirements.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Excludes inpatient services, services provided by a physician, and services covered by the Medicare program (except for payment of any Medicare cost share).

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Counseling agencies
Individual	Individual counselors

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Counseling and Therapeutic Resources**

**Provider Category:**

Agency

**Provider Type:**

Counseling agencies

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Wis. Admin. Code § DHS 61.35

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

Employing or contracting with professionals with current state licensure or certification in their field of practice

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

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**Appendix C: Participant Services**

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

---

**Service Type: Other Service**

**Service Name: Counseling and Therapeutic Resources**

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**Provider Category:**

Individual

**Provider Type:**

Individual counselors

**Provider Qualifications**

**License** (*specify*):

Professionals with current state licensure in their field of practice

**Certificate** (*specify*):

Professionals with current state certification in their field of practice

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Environmental Accessibility Adaptations (Home Modifications)

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14020 home and/or vehicle accessibility adaptations

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Home modifications are the provision of services and items to assess the need for, arrange for, and provide modifications and/or improvements to a member's living quarters in order to increase accessibility or safety. Modifications may provide for safe access to and within the home, reduce the risk of injury, facilitate independence and self-reliance, enable members to increase their abilities to perform ADLs or IADLs, and decrease reliance on paid providers. Home modifications may include materials and services, such as ramps; stair lifts, wheelchair lifts or other mechanical devices to lift persons with impaired mobility from one vertical level to another; kitchen and/or bathroom modifications; specialized accessibility/safety adaptations; and voice-activated, light-activated, motion-activated, and other electronic devices that increase the member's self-reliance and capacity to function independently. Home modifications may include modifications that add to the square footage of the residence if the modifications are to assure the health, safety, or independence of the person; prevent institutionalization; and are the most cost effective means of meeting the accessibility or safety need.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual carpenters
Agency	Contractor

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Environmental Accessibility Adaptations (Home Modifications)**

**Provider Category:**

Individual

**Provider Type:**

Individual carpenters

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

In accordance with local and/or state housing and building codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At the time of authorization/purchase.

## Appendix C: Participant Services

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

**Service Type:** Other Service

**Service Name:** Environmental Accessibility Adaptations (Home Modifications)

**Provider Category:**

Agency

**Provider Type:**

Contractor

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

In accordance with local and/or state housing and building codes.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase.

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Home Delivered Meals

**HCBS Taxonomy:**

**Category 1:**

06 Home Delivered Meals

**Sub-Category 1:**

06010 home delivered meals

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Home delivered meals are meals provided to recipients who are unable to prepare or obtain nourishing meals without assistance, including those who may be unable to manage a special diet recommended by their physician. Home delivered meal costs may include the costs associated with the purchase and planning of food, nutrition services, supplies, equipment, labor and transportation to deliver one or two meals a day.

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

Home delivered meals may not constitute a "full nutritional regimen" (3 meals per day).

This service does not include payment for meals at federally subsidized nutrition sites.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Aging network agencies
Agency	Restaurants
Agency	Hospitals or nursing homes

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Home Delivered Meals**

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**Provider Category:**

Agency

**Provider Type:**

Aging network agencies

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Wis. Stat. § 46.82(3)

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Home Delivered Meals**

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**Provider Category:**

Agency

**Provider Type:**

Restaurants

**Provider Qualifications**

**License** (*specify*):

Wis. Admin. Code Ch. ATCP 75

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

---

**Appendix C: Participant Services**

---

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

---

**Service Type: Other Service**

**Service Name: Home Delivered Meals**

---

**Provider Category:**

Agency

**Provider Type:**

Hospitals or nursing homes

**Provider Qualifications**

**License (specify):**

Wis. Admin. Code Ch. DHS 124, Ch. DHS 132, and Ch. DHS 134

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

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**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Housing Counseling

**HCBS Taxonomy:**

**Category 1:**

17 Other Services

**Sub-Category 1:**

17030 housing consultation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Housing counseling provides assistance to a member who is acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of housing counseling is to promote consumer choice and control, increase access to affordable housing, and promote community inclusion. Housing counseling includes exploring home ownership and rental options and individual and shared housing options, including options where the member lives with his or her family. Services include counseling and assistance in identifying housing options; identifying financial resources and determining affordability; identifying preferences of location and type of housing; identifying accessibility and modification needs; locating available housing; identifying and assisting in access to financing; explaining the rights and responsibilities of a tenant with disabilities, including how to ask for reasonable accommodations and modifications and how to file a complaint; and planning for ongoing management and maintenance. Housing counseling is not a one-time service and may be accessed by a member at any time. A qualified provider must be an agency, or unit of an agency, that provides housing counseling to people who need assistance with housing as a regular part of its mission or activities. Counseling providers must have specialized training and experience in housing issues.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Waiver funds may not be used to purchase this service if it is otherwise provided free to the general public.

This service may not be provided by an agency that also provides residential support services or support/service coordination to the member.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Housing counseling agency

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Housing Counseling**

**Provider Category:**

Agency

**Provider Type:**

Housing counseling agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Providers must have expertise in housing issues relevant to the participant and may not be a provider of residential support services to the participant.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Personal Emergency Response Systems (PERS)

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14010 personal emergency response system (PERS)

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Personal emergency response system (PERS) is a service that provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate response and assistance in the event of a physical, emotional, or environmental emergency. This service may include devices and services necessary for operation of PERS when otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as appropriate.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	PERS Vendors

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Personal Emergency Response Systems (PERS)**

**Provider Category:**

Individual

**Provider Type:**

PERS Vendors

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

UL Standards for electronic devices or FCC regulations for telephonic devices

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Relocation services

**HCBS Taxonomy:**

**Category 1:**

16 Community Transition Services

**Sub-Category 1:**

16010 community transition services

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Relocation services are services and essential items needed to establish a community living arrangement for members who are relocating from an institution, or a family home, to an independent living arrangement. This service includes person-specific services, supports, or goods that are put in place to prepare for the member's relocation to a safe, accessible, affordable community living arrangement. Services or items covered by this service may not be purchased more than 180 days prior to the date that the member relocates to the new community living arrangement. Relocation services may include the purchase of necessary furniture, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings, and kitchen appliances that are not otherwise included in a rental arrangement if applicable. Relocations services may include the payment of a security deposit, utility connection costs, and telephone installation charges. This service includes payment for moving the member's personal belongings to the new community living arrangement, general cleaning, and household organization needed to prepare the selected community living arrangement for occupancy.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Relocation services exclude home modifications necessary to address safety and accessibility in the member's living arrangement, which may be provided under the waiver's home modification service. This service excludes housekeeping services provided after occupancy, which are considered the waiver service supportive home care.

Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.)

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Moving companies, public utilities, real estate agencies, vendors of home furnishings
Individual	Individual movers/individual landlords

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Relocation services**

**Provider Category:**

Agency

**Provider Type:**

Moving companies, public utilities, real estate agencies, vendors of home furnishings

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Reputable companies

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

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## Appendix C: Participant Services

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

---

**Service Type: Other Service**

**Service Name: Relocation services**

---

**Provider Category:**

Individual

**Provider Type:**

Individual movers/individual landlords

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Reputable contractors

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

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## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not

specified in statute.

**Service Title:**

Self-Directed Personal Care

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Self-directed personal care services are activities to assist a member with activities of daily living, instrumental activities of daily living, and housekeeping services directly related to the care of the person to maintain the member in his or her place of residence and to assist the member to access the community. Services may include the following:

1. Assistance with activities of daily living (ADLs): bathing; getting in and out of bed; oral, hair and skin care excluding skilled wound care; help with toileting; simple transfers; assistance with mobility and ambulation; assistance with eating; and assistance with dressing and undressing.
2. Assistance with instrumental activities of daily living (IADLs): managing medications and treatments normally self-administered, care of eyeglasses and hearing aids, meal preparation and serving, bill paying and other aspects of money management, using the telephone or other forms of communication, arranging and using transportation, and physical assistance to function at a job site.
3. Housekeeping services related to the care of the person: cleaning in essential areas of the home used when assisting with ADLs and IADLs, laundry of the member's clothes and bedding and changing of bedding, and shopping for the member's food.
4. Accompanying and assisting the member to access the community for medical care, employment, recreation, shopping and other purposes, as long as the provision of assistance with ADLs and IADLs is required during such trips.
5. Medically-oriented tasks delegated by a registered nurse pursuant to an agreement between the member and the interdisciplinary care team (IDT) staff.

Services are provided by either an individual or agency selected by the member, pursuant to a physician's order (a state law requirement) and following a member-centered plan (MCP) developed jointly by the member and IDT staff including a registered nurse. The MCP shall specify delegated nursing tasks, if any. The member may use as a provider any individual who passes a background check including a legally responsible relative who qualifies under Appendix C-2 d. and e. of this waiver, or an agency or individual that is not barred from participating in the Medicaid or Medicare program. The MCP, including self-directed personal care and all other services received, is reviewed by the member and IDT at least every six months or more often as needed. Visits by the consulting RN, who may be a member of the IDT or other nurse consultant, to the member's residence will occur at least once a year unless the member and RN agree on a more frequent visits or the RN determines that delegated nursing tasks need to be reviewed more often. The member and IDT will determine any training needed by selected providers and how it will be obtained. The member shall be the common law employer of individual providers; if the member selects an agency, the member shall be a managing, co-employer of the worker and the agency shall hire any worker referred by the member who passes the background check and is, or can become competent in required tasks. Services may be provided both in the member's residence and outside the residence in other community settings.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days where there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment, or if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

#### Medically-Related

- Hospitalization
- Nursing home or ICF/IID admission
- Receipt of medical or rehabilitative care entailing at least an overnight absence
- Participation in a therapeutic rehabilitative program as defined in Wis. Admin. § DHS 101.03(175)

There shall be no yearly limit on the number of medically-related episodes for which retainer payments may be made.

#### Non-Medically Related

- Planned vacation entailing at least an overnight absence and unaccompanied by the worker
- Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence
- Obtaining education, employment or job, habilitative, or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence
- Recreational activities unaccompanied by the worker entailing at least an overnight absence

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

PIHPs shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

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

Members must have budget authority over an allocation of waiver funding through the Self-Directed Services option to receive personal care through this service and must function themselves or through a representative as either the common law employer of an individual worker or the managing, co-employer of an agency-provided worker. Members without budget authority who are authorized to receive personal care services would receive them through the State Plan personal care benefit instead.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Member-employed individual worker
Agency	Agency-employed, member-directed workers

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Self-Directed Personal Care**

**Provider Category:**

Individual

**Provider Type:**

Member-employed individual worker

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

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**Appendix C: Participant Services**

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

---

**Service Type: Other Service**

**Service Name: Self-Directed Personal Care**

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**Provider Category:**

Agency

**Provider Type:**

Agency-employed, member-directed workers

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

Wis. Admin. Code § DHS 105.17

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

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**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Skilled Nursing Services RN/LPN

**HCBS Taxonomy:**

**Category 1:**

05 Nursing

**Sub-Category 1:**

05020 skilled nursing

**Category 2:**

05 Nursing

**Sub-Category 2:**

05010 private duty nursing

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Skilled nursing is “professional nursing” as defined in Wisconsin’s Nurse Practice Act, Wis. Stat. Ch. 441. Nursing services are medically necessary, skilled nursing services that may only be provided safely and effectively by an advanced practice nurse, a registered nurse, or a licensed practical nurse who is working under the supervision of a registered nurse. The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act, consistent with the member-centered plan, authorized by the PIHP, and not otherwise available to the member under the Medicaid state plan or through Medicare. However, the lack of coverage under the State plan or through Medicare does not preclude the coverage of skilled nursing as a waiver service when services are within the scope of the Wisconsin Nurse Practice Act.

Under the Wisconsin Nurse Practice Act, professional nursing includes any of the following:

Professional skilled nursing means the observation or care of the ill, injured, or infirm, or for the maintenance of health or prevention of illness of others, that requires substantial nursing skill, knowledge, training, or application of nursing principles based on biological, physical, and social sciences. Professional skilled nursing includes any of the following:

- (a) The observation and recording of symptoms and reactions;
- (b) The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, podiatrist licensed under Wis. Stat. Ch. 448, dentist licensed under Wis. Stat. Ch. 447, or optometrist licensed under Wis. Stat. Ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry, or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state.
- (c) The execution of general nursing procedures and techniques.
- (d) The supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants in accordance with Wis. Stat. Ch. 441.

Nursing services may include periodic assessment of the member’s medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or monitor and/or modify the medical treatment services provided by non-professional care providers. Services may also include regular, ongoing monitoring of a member’s fragile or complex medical condition as well as the monitoring of a member who has a history of non-adherence with medication or other medical treatment needs.

Delegation of nursing tasks to less skilled personnel shall be in accordance with Wis. Stat. Ch. 441, Wis. Admin. Code Ch. N 6, and the Wisconsin Nurses Association’s Guidelines for Registered Nurse Delegation to Unlicensed Assistive Personnel.

These services are provided when nursing services identified as needed in a plan of care and furnished under the approved State plan limits are exhausted or when the nursing services are not covered under the Medicaid State Plan. For members enrolled in Medicare, this excludes services that are available through the Medicare program except for payment of Medicare cost share.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

For members enrolled in Medicare, excludes services available through the Medicare program except for payment of Medicare cost share.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Agency-directed registered nurse/LPN
Individual	Individual RN or LPN

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Skilled Nursing Services RN/LPN**

**Provider Category:**

Agency

**Provider Type:**

Agency-directed registered nurse/LPN

**Provider Qualifications**

**License (specify):**

Wis. Stats. Ch. 441

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Skilled Nursing Services RN/LPN**

**Provider Category:**

Individual

**Provider Type:**

Individual RN or LPN

**Provider Qualifications**

**License** (*specify*):

Wis. Stats. Ch. 441

**Certificate** (*specify*):

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Specialized Medical Equipment and Supplies

**HCBS Taxonomy:**

**Category 1:**

14 Equipment, Technology, and Modifications

**Sub-Category 1:**

14031 equipment and technology

**Category 2:**

14 Equipment, Technology, and Modifications

**Sub-Category 2:**

14032 supplies

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Specialized medical equipment, items, devices, and supplies are those items necessary to maintain the member’s health, manage a medical or physical condition, improve functioning, or enhance independence. Items or devices provided must be of direct medical or remedial benefit to the member. Allowable items, devices or supplies may include: incontinence supplies; wound dressings; IV or life support equipment; orthotics; enteral nutrition products and associated supplies and equipment not covered under the Medicaid state plan but needed for the member to obtain adequate nutrition; over the counter medications with a National Drug Code (NDC) if not covered under the state plan drug benefit and when prescribed by any licensed and authorized prescriber; medically necessary prescribed skin conditioning lotions/lubricants; and prescribed Vitamin D, a prescribed multivitamin and prescribed calcium supplements. (The SMA may add other prescribed vitamins or nutritional supplements in the future based on clear and convincing evidence substantiating their safety and effectiveness in maintaining health or treating or managing a medical condition.) Additionally, allowable items may include books and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, humidifiers, and water treatment systems may be allowable when needed to support a member’s health and safety outcomes.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Items or devices provided may be in excess of the quantity of medical equipment or supplies covered under the Medicaid state plan when coverage of the additional items or devices has been denied.

Excludes items considered as and regulated by the federal Food and Drug Administration (FDA) as nutritional supplements unless specifically covered under this definition or under the Medicaid state plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Other merchants
Agency	Authorized DME Vendors or Licensed Pharmacy

**Appendix C: Participant Services**

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

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**Service Type: Other Service**

**Service Name: Specialized Medical Equipment and Supplies**

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**Provider Category:**

Agency

**Provider Type:**

Other merchants

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Reputable merchant

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PHIP

**Frequency of Verification:**

At time of authorization/purchase

## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Specialized Medical Equipment and Supplies**

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**Provider Category:**

Agency

**Provider Type:**

Authorized DME Vendors or Licensed Pharmacy

**Provider Qualifications**

**License (specify):**

Wis. Admin Code § DHS 105.40 or Wis. Stat. Ch. 450

**Certificate (specify):**

**Other Standard (specify):**

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

At time of authorization/purchase

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Supported Employment - Small Group Employment Support

**HCBS Taxonomy:**

**Category 1:**

03 Supported Employment

**Sub-Category 1:**

03022 ongoing supported employment, group

**Category 2:**

03 Supported Employment

**Sub-Category 2:**

03010 job development

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Supported employment - small group employment support services are services and training activities provided in a regular business, industry, or community setting for groups of two to eight workers. Examples include mobile crews and other business-based workgroups who employ small groups of workers with disabilities in a community setting. Small group employment support must be provided in a manner that promotes integration into the workplace and integration between members and people without disabilities in those workplaces. The outcome of this service is sustained paid employment, work experience that leads to further career development, and individual integrated community-based employment for which a member is compensated at or above the minimum wage but not less than the customary wage level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Small group employment support services may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, work incentive benefits analysis and counseling, training and work planning, transportation, and career advancement services. This service also includes other workplace support services that are not specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Small group employment support does not include payment for supervision, training, support, or adaptations that are typically available to workers without disabilities who fill similar positions in the business. Employers may be reimbursed for supported employment services provided by co-workers or other job site personnel, when the services that are furnished are not part of the normal duties of the co-worker or other personnel, and when these individuals meet the qualifications established below for individual providers of the service.

Supported employment services do not include vocational services provided in facility-based work settings or other types of vocational services furnished in specialized facilities that are not part of general community work places. Supported employment services may not include volunteer work.

Members receiving small group employment support may also receive educational, pre-vocational, career planning, and day services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded by § 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. § 1401 et seq).

Coverage does not include incentive payments, subsidies, or unrelated vocational training expenses, like the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment or
2. Wages or other payments that are passed through to users of supported employment services.

The cost of transportation for a member to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider or may be reimbursed under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but it may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider or may be reimbursed under supportive home care or self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

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

When personal care/assistance, transportation, or both are a component of supported employment services, payment may not be made for such assistance or transport under another waiver service for the same period of time.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

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

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supported Employment - Small Group Employment Support**

**Provider Category:**

Individual

**Provider Type:**

On the job support person

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

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

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and, if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Supported Employment - Small Group Employment Support**

**Provider Category:**

Agency

**Provider Type:**

Supported Employment Agency

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

The PIHP shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

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

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and, if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Supportive Home Care

**HCBS Taxonomy:**

**Category 1:**

08 Home-Based Services

**Sub-Category 1:**

08030 personal care

**Category 2:**

08 Home-Based Services

**Sub-Category 2:**

08040 companion

**Category 3:**

08 Home-Based Services

**Sub-Category 3:**

08050 homemaker

**Category 4:**

**Sub-Category 4:**

08 Home-Based Services

08060 chore

*Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :*

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Supportive home care is the provision of services to directly assist people with daily living activities and personal needs and to assure adequate functioning and safety in their home and community. Services include the following:

1. Hands-on assistance with activities of daily living, such as dressing/undressing; bathing; feeding; managing medications and treatments that are normally self-administered; toileting; assistance with ambulation (including the use of a walker, cane, etc.); carrying out professional therapeutic treatment plans; and grooming, such as care of hair, teeth, or dentures. This may also include preparation and cleaning of areas that are used during provision of personal assistance, such as the bathroom and kitchen.
2. Direct assistance with instrumental activities of daily living, as well as observation or cueing of the member, to ensure that the member safely and appropriately completes activities of daily living and instrumental activities of daily living.
3. Providing supervision necessary for member safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, and arrangement and usage of transportation and personal assistance at a job site and in non-employment related community activities.
4. Routine housekeeping and cleaning activities performed for a member, consisting of tasks that take place on a daily, weekly, or other regular basis. These tasks may include washing dishes, doing laundry, dusting, vacuuming, cooking, shopping, and similar activities that do not involve hands-on care of the member.
5. Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event for reasons of health and safety or the need to assure the member's continued community living. These tasks may include outdoor activities, such as yard work and snow removal; indoor activities, such as window washing; cleaning of attics and basements; cleaning of carpets, rugs, and drapery; refrigerator/freezer defrosting; the necessary cleaning of vehicles, wheelchairs, and other adaptive equipment; bed bug inspection and extermination; and home modifications such as ramps. This also may include assistance with packing/unpacking and household cleaning/organizing when a member moves.

An unrelated live-in caregiver may provide any or all of the types of supportive home care services. Services by a related live-in caregiver are subject to the requirements in Appendix C-2-e. Payment of a live-in caregiver may be reduced by the value of room and board in accordance with any applicable wage and hour laws.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days when there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment or, if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

#### Medically- Related

- Hospitalization;
- Nursing home or ICF/IID admission;
- Receipt of medical or rehabilitative care entailing at least an overnight absence; and
- Participation in a therapeutic rehabilitative program as defined in Wis. Admin. Code § DHS 101.03(175)

There shall be no yearly limit on the number of medically-related episodes for which retainer payments may be made.

#### Non-Medically Related

- Planned vacation entailing at least an overnight absence and unaccompanied by the worker;
- Visit to relatives or friends entailing at least an overnight absence and unaccompanied by the worker;
- Obtaining education, employment or job, habilitative, or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; and
- Recreational activities unaccompanied by the worker entailing at least an overnight absence

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

PIHPs shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Excludes training provided to a member intended to improve the member's ability to independently perform routine daily living tasks, which may be provided as daily living skills training.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Individual	Individual workers
Agency	Agency-directed workers

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supportive Home Care**

**Provider Category:**

Individual

**Provider Type:**

Individual workers

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PHIP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Supportive Home Care**

**Provider Category:**

Agency

**Provider Type:**

Agency-directed workers

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Training and Documentation Standards for Supportive Home Care and In-Home Respite Care

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Training Services for Unpaid Caregivers

**HCBS Taxonomy:**

**Category 1:**

09 Caregiver Support

**Sub-Category 1:**

09020 caregiver counseling and/or training

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

This service is the provision of training services for individuals who provide uncompensated care, training, companionship, supervision, or other supports to members.

Training includes instruction about treatment regimens and other services that are included in the member-centered plan(MCP), use of equipment specified in the MCP, and guidance to safely maintain the member in the community. Training must be aimed at assisting the unpaid caregiver in meeting the needs of the member. All training for individuals who provide unpaid support to the member must be included in the MCP and must directly relate to the individual's role in supporting the member.

This service includes, but is not limited to, on-line or in-person training; conferences; or resource materials on the specific disabilities, illnesses, or conditions that affect the member. The purpose of the training is for the caregiver to learn more about member's condition, what to expect, and how to provide the best care for someone with that specific condition. For example, training could be provided on how to effectively care for a member with dementia.

Training includes registration costs and fees associated with formal instruction in areas that are relevant to the needs identified in the MCP.

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

This service may not be provided in order to train paid caregivers.

This service excludes payment for lodging and/or meal expenses incurred while attending a training event or conference.

This service does not cover teaching self-advocacy, which is covered under consumer education and training services.

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

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

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Training/Service Agency
Individual	Professional Services

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Training Services for Unpaid Caregivers**

**Provider Category:**

Agency

**Provider Type:**

Training/Service Agency

**Provider Qualifications**

**License** (specify):

This training must be provided by licensed, certified, or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals, or licensed therapists.

**Certificate** (specify):

This training must be provided by licensed, certified, or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals, or licensed therapists.

**Other Standard** (specify):

This training must be provided by accredited professionals who maintain current credentials in their field of practice.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Training Services for Unpaid Caregivers**

**Provider Category:**

Individual

**Provider Type:**

Professional Services

**Provider Qualifications**

**License** (*specify*):

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

**Certificate** (*specify*):

This training must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

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

This training must be provided by accredited professionals who maintain current credentials in their field of practice.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Transportation (Specialized Transportation) - Community Transportation

**HCBS Taxonomy:**

**Category 1:**

15 Non-Medical Transportation

**Sub-Category 1:**

15010 non-medical transportation

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Community transportation is the provision of transportation services or items that enable a member to gain access to waiver and other community services, activities, and resources, as specified in the member-centered plan. This service may consist of items such as tickets, fare cards, or other fare media or services where the common carrier, specialized medical vehicle, or other provider directly conveys a member and her or his attendant, if any, to destinations. Whenever possible, family, neighbors, friends or community agencies who can provide this service without charge will be utilized.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

Excludes transportation to receive non-emergency medical services which are covered under the Medicaid State plan transportation benefit, or in the case of a self-directing member with budget authority to purchase such services, under the Other Transportation service.

Excludes emergency (ambulance) medical transportation covered under the Medicaid State plan service.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Public mass transit
Agency	Taxi or common carrier

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Transportation (Specialized Transportation) - Community Transportation**

**Provider Category:**

Agency

**Provider Type:**

Public mass transit

**Provider Qualifications**

**License (specify):**

**Certificate (specify):**

**Other Standard (specify):**

Wis. Stat. § 85.20

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

Wisconsin Department of Transportation

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**Service Type: Other Service**

**Service Name: Transportation (Specialized Transportation) - Community Transportation**

**Provider Category:**

Agency

**Provider Type:**

Taxi or common carrier

**Provider Qualifications**

**License (specify):**

**Certificate** (specify):

**Other Standard** (specify):

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

**Frequency of Verification:**

## Appendix C: Participant Services

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

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

**Service Type:**

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

**HCBS Taxonomy:**

**Category 1:**

**Sub-Category 1:**

**Category 2:**

**Sub-Category 2:**

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition** (*Scope*):

Other Transportation consists of transportation to receive non-emergency, Medicaid-covered medical services. This service may include items such as tickets, fare cards or other fare media, reimbursement of mileage expenses, or payment for services where the provider directly conveys the member and her or his attendant, if any, by common carrier or specialized medical vehicle (SMV) as appropriate to and from receiving Medicaid-covered medical services.

Members eligible for this service must have decision-making authority over a budget for the purchase of such services. Such members (1) are not limited to providers in the PIHP's network, although the PIHP must verify credentials of specialized medical vehicle providers, (2) are not required to obtain prior authorization to purchase any transportation service from a qualified provider to any Medicaid-covered medical service if the member's budget is sufficient to pay for the service, and (3) are not required to schedule routine trips in advance if the member can obtain transport. Legally responsible persons, relatives, or legal guardians may be paid for providing this service if they meet the conditions under Appendix C-2 d & e of this waiver.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan. This service excludes ambulance transportation, which is available through the Medicaid State Plan.

This service excludes non-emergency medical transportation when authorized by the PIHP as a State Plan service for members without budget authority. It also excludes nonmedical transportation, which is provided under the sub-service of Community Transportation; however the same ride may be used to provide transport to medical appointments and community activities so long as there is not duplication of payment.

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Specialized Transportation Agency
Individual	Individuals (mileage reimbursed)

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## Appendix C: Participant Services

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

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**Service Type: Other Service**

**Service Name: Transportation (Specialized Transportation) - Other Transportation**

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**Provider Category:**

Agency

**Provider Type:**

Specialized Transportation Agency

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

Wis. Stat. § 85.21 and Wis. Admin. Code § DHS 61.45

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

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

**Appendix C: Participant Services**

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

**Service Type:** Other Service

**Service Name:** Transportation (Specialized Transportation) - Other Transportation

**Provider Category:**

Individual

**Provider Type:**

Individuals (mileage reimbursed)

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

Valid driver's license, liability insurance.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP - may delegate to member or member's representative

**Frequency of Verification:**

At the time of authorization/purchase

## Appendix C: Participant Services

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

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

**Service Type:**

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

**Service Title:**

Vocational Futures Planning and Support

**HCBS Taxonomy:**

**Category 1:**

03 Supported Employment

**Sub-Category 1:**

03021 ongoing supported employment, individual

**Category 2:**

03 Supported Employment

**Sub-Category 2:**

03010 job development

**Category 3:**

**Sub-Category 3:**

**Category 4:**

**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

**Service is included in approved waiver. There is no change in service specifications.**

**Service is included in approved waiver. The service specifications have been modified.**

**Service is not included in the approved waiver.**

**Service Definition (Scope):**

Vocational futures planning and support (VFPS) is a person-centered, team-based comprehensive employment planning and support service that provides assistance for members to obtain, maintain or advance in employment or self-employment/microenterprise. The agency providing VFPS services will ensure that the following service strategies are available as needed to the member:

- 1) Development of an employment plan based on an individualized determination of the member's strengths, needs, and interests; the barriers to work, including an assistive technology pre-screen or in-depth assessment; and identification of the assets that a member brings to employment;
- 2) Work Incentive Benefits analysis and support;
- 3) Resource team coordination;
- 4) Career exploration and employment goal validation;
- 5) Job seeking support; and
- 6) Job follow-up and long-term support.

VFPS must be provided by qualified professionals that include, for example, an employment specialist, a benefit specialist, and an assistive technology consultant. When this service is provided, the member record must contain activity reports, completed by the appropriate VFPS team member(s), within thirty (30) days of completing a particular service strategy. When ongoing support is provided, monthly ongoing support reports must be completed by the provider of the on-going support.

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

This service may not duplicate any service that is provided under another waiver service category or through the Medicaid State Plan.

VFPS excludes services that could be provided as prevocational or as supported employment. Such services may be used to supplement, but may not duplicate any VFPS services provided under the waiver.

VFPS excludes services funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401(16 and 17)).

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

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

**Provider managed**

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

**Legally Responsible Person**

**Relative**

**Legal Guardian**

**Provider Specifications:**

Provider Category	Provider Type Title
Agency	Vocational futures planning

**Appendix C: Participant Services**

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

**Service Type: Other Service**

**Service Name: Vocational Futures Planning and Support**

**Provider Category:**

Agency

**Provider Type:**

Vocational futures planning

**Provider Qualifications**

**License** (*specify*):

**Certificate** (*specify*):

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

All team members shall have skills and knowledge typically acquired through completion of an advanced degree in human services, or an equivalent combination of education and experience, with ongoing training and technical assistance appropriate to their specific specialty.

**Verification of Provider Qualifications**

**Entity Responsible for Verification:**

PIHP

**Frequency of Verification:**

Annually

## Appendix C: Participant Services

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

**b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*select one*):

**Not applicable** - Case management is not furnished as a distinct activity to waiver participants.

**Applicable** - Case management is furnished as a distinct activity to waiver participants.

*Check each that applies:*

**As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*

**As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

**As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

**As an administrative activity.** *Complete item C-1-c.*

**As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

**c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

## Appendix C: Participant Services

### C-2: General Service Specifications (1 of 3)

**a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

**No. Criminal history and/or background investigations are not required.**

**Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a) The SMA-PIHP contract requires the PIHP to comply with Wis. Stat. § 50.065 and Wis. Admin. Code Chs. DHS 12 and 13 which govern caregiver background checks and the reporting and investigation of caregiver misconduct. This authority defines a caregiver as:

- i. A person who is, or is expected to be, an employee or contractor of an entity, who is or is expected to be under the control of an entity, as defined by the department by rule, and who has, or is expected to have, regular, direct contact with clients of the entity; or
- ii. A person who has, or is seeking, a license, certification, registration, or certificate of approval issued or granted by the department to operate an entity.

The terms “entity,” “direct contact,” “regular contact,” and “under the control of an entity” are defined in Wis. Stat. § 50.065 and Wis. Admin. Code Chs. DHS 12 and 13.

The SMA-PIHP contract additionally requires PIHPs to require contracted co-employment agencies and fiscal employment agents to perform background checks that are substantially similar to those required to be conducted by entities under Wis. Stat. § 50.065 and Wis. Admin. Code Chs. DHS 12 and 13 on individuals providing services to self-directing members who have, or are expect to have, regular, direct contact with the member.

b) The scope of the required caregiver background checks is described under Wis. Stat. § 50.065(2).

c) Each PIHP is required by the SMA-PIHP contract to ensure that all persons working as caregivers as described above have had required background checks completed. The PIHP must perform, or ensure that its providers perform, these checks at the time of caregiver employment or contracting and at least every four years thereafter. During annual quality reviews and annual PIHP provider network reviews, the SMA and EQRO review a sample of member records and contracted provider agency records to verify that the required background checks have been completed.

Additionally, individuals providing support broker services are subject to criminal background checks as described above.

**b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

**No. The state does not conduct abuse registry screening.**

**Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

- a. The SMA, as required under Wis. Stat. § 146.40 and Wis. Admin. Code Ch. DHS 13, maintains a registry of caregivers as an official record of persons found to have abused or neglected a client or misappropriated a client's property. PIHPs, as well as all other entities that are licensed by, certified by, or registered with the SMA to provide direct care or treatment services to clients, are required to report to the SMA any allegation of abuse, neglect, or misappropriation committed by any person who is employed by or under contract with the entity if the person is under the control of the entity.
- b. Positions for which abuse registry screenings must be conducted include all caregivers as defined in C.2.a.
- c. Each PIHP is required by the SMA-PIHP contract to ensure that all persons working as caregivers, as described under C.2.a, have had the background checks described under Wis. Stat. § 50.065(2) completed. These background checks include screening the individual against the SMA's caregiver misconduct registry. The PIHP must perform, or ensure that its providers perform, these checks at the time of caregiver employment or contracting and at least every four years thereafter. During annual quality reviews and annual PIHP provider network care management reviews, the SMA and EQRO review a sample of member records and contracted provider agency records to verify that the required screens have been completed as a part of the background checking process.

## Appendix C: Participant Services

### C-2: General Service Specifications (2 of 3)

**c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

**No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

**Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

**i. Types of Facilities Subject to §1616(e).** Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
Adult family home - 3-4 beds	
Community-based residential facility (CBRF)	
Residential Care Apartment Complex (RCAC)	
Adult Residential Care - 1-2 Bed Adult Family Homes	

**ii. Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

A community character is maintained in such situations by requiring private rooms or independent apartments within the facility.

Regardless of facility size, state licensure and certification rules enforced by the SMA's Division of Quality Assurance require facilities to honor resident rights and act to promote integration and participation in the community. In addition, all existing residential facilities will be reviewed for compliance with the federal home and community based settings requirements. All new settings will be reviewed for compliance as part of the licensure or certification processes.

## Appendix C: Participant Services

## C-2: Facility Specifications

**Facility Type:**

Adult family home - 3-4 beds

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Assistive Technology/Communication aids	
Specialized Medical Equipment and Supplies	
Adaptive aids	
Adult Day Care Services	
Prevocational Services	
Personal Emergency Response Systems (PERS)	
Supportive Home Care	
Relocation services	
Daily Living Skills Training	
Financial Management Services	
Consultative Clinical and Therapeutic Services for Caregivers	
Transportation (Specialized Transportation) - Other Transportation	
Day Habilitation Services	
Housing Counseling	
Supported Employment - Individual Employment Support	
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	
Consumer Education and Training	
Environmental Accessibility Adaptations (Home Modifications)	
Home Delivered Meals	
Transportation (Specialized Transportation) - Community Transportation	
Skilled Nursing Services RN/LPN	
Care Management	
Self-Directed Personal Care	
Supported Employment - Small Group Employment Support	
Vocational Futures Planning and Support	
Adult Residential Care - 3-4 Bed Adult Family Homes	
Consumer Directed Supports (Self-Directed Supports) Broker	
Respite	
Counseling and Therapeutic Resources	
Adult residential care - 1-2 bed adult family homes	

Waiver Service	Provided in Facility
Adult Residential Care - Community-Based Residential Facilities (CBRF)	
Training Services for Unpaid Caregivers	

**Facility Capacity Limit:**

4 residents

**Scope of Facility Standards.** For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

**Appendix C: Participant Services**

**C-2: Facility Specifications**

**Facility Type:**

Community-based residential facility (CBRF)

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Assistive Technology/Communication aids	
Specialized Medical Equipment and Supplies	

<b>Waiver Service</b>	<b>Provided in Facility</b>
Adaptive aids	
Adult Day Care Services	
Prevocational Services	
Personal Emergency Response Systems (PERS)	
Supportive Home Care	
Relocation services	
Daily Living Skills Training	
Financial Management Services	
Consultative Clinical and Therapeutic Services for Caregivers	
Transportation (Specialized Transportation) - Other Transportation	
Day Habilitation Services	
Housing Counseling	
Supported Employment - Individual Employment Support	
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	
Consumer Education and Training	
Environmental Accessibility Adaptations (Home Modifications)	
Home Delivered Meals	
Transportation (Specialized Transportation) - Community Transportation	
Skilled Nursing Services RN/LPN	
Care Management	
Self-Directed Personal Care	
Supported Employment - Small Group Employment Support	
Vocational Futures Planning and Support	
Adult Residential Care - 3-4 Bed Adult Family Homes	
Consumer Directed Supports (Self-Directed Supports) Broker	
Respite	
Counseling and Therapeutic Resources	
Adult residential care - 1-2 bed adult family homes	
Adult Residential Care - Community-Based Residential Facilities (CBRF)	
Training Services for Unpaid Caregivers	

**Facility Capacity Limit:**

Members w/ an intellectual disability (ID) may only reside in a CBRF licensed for 8 or less residents, unless that member has been determined to require No Active Treatment (NAT) for her or his ID.

**Scope of Facility Standards.** For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Residential Care Apartment Complex (RCAC)

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Assistive Technology/Communication aids	
Specialized Medical Equipment and Supplies	
Adaptive aids	
Adult Day Care Services	
Prevocational Services	
Personal Emergency Response Systems (PERS)	
Supportive Home Care	
Relocation services	

Waiver Service	Provided in Facility
Daily Living Skills Training	
Financial Management Services	
Consultative Clinical and Therapeutic Services for Caregivers	
Transportation (Specialized Transportation) - Other Transportation	
Day Habilitation Services	
Housing Counseling	
Supported Employment - Individual Employment Support	
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	
Consumer Education and Training	
Environmental Accessibility Adaptations (Home Modifications)	
Home Delivered Meals	
Transportation (Specialized Transportation) - Community Transportation	
Skilled Nursing Services RN/LPN	
Care Management	
Self-Directed Personal Care	
Supported Employment - Small Group Employment Support	
Vocational Futures Planning and Support	
Adult Residential Care - 3-4 Bed Adult Family Homes	
Consumer Directed Supports (Self-Directed Supports) Broker	
Respite	
Counseling and Therapeutic Resources	
Adult residential care - 1-2 bed adult family homes	
Adult Residential Care - Community-Based Residential Facilities (CBRF)	
Training Services for Unpaid Caregivers	

**Facility Capacity Limit:**

No limit (See c.ii.)

**Scope of Facility Standards.** For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards	
Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	

Standard	Topic Addressed
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: Facility Specifications

**Facility Type:**

Adult Residential Care - 1-2 Bed Adult Family Homes

**Waiver Service(s) Provided in Facility:**

Waiver Service	Provided in Facility
Assistive Technology/Communication aids	
Specialized Medical Equipment and Supplies	
Adaptive aids	
Adult Day Care Services	
Prevocational Services	
Personal Emergency Response Systems (PERS)	
Supportive Home Care	
Relocation services	
Daily Living Skills Training	
Financial Management Services	
Consultative Clinical and Therapeutic Services for Caregivers	
Transportation (Specialized Transportation) - Other Transportation	
Day Habilitation Services	
Housing Counseling	
Supported Employment - Individual Employment Support	

Waiver Service	Provided in Facility
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	
Consumer Education and Training	
Environmental Accessibility Adaptations (Home Modifications)	
Home Delivered Meals	
Transportation (Specialized Transportation) - Community Transportation	
Skilled Nursing Services RN/LPN	
Care Management	
Self-Directed Personal Care	
Supported Employment - Small Group Employment Support	
Vocational Futures Planning and Support	
Adult Residential Care - 3-4 Bed Adult Family Homes	
Consumer Directed Supports (Self-Directed Supports) Broker	
Respite	
Counseling and Therapeutic Resources	
Adult residential care - 1-2 bed adult family homes	
Adult Residential Care - Community-Based Residential Facilities (CBRF)	
Training Services for Unpaid Caregivers	

**Facility Capacity Limit:**

1 or 2 residents

**Scope of Facility Standards.** For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

**Scope of State Facility Standards**

Standard	Topic Addressed
Admission policies	
Physical environment	
Sanitation	
Safety	
Staff : resident ratios	
Staff training and qualifications	
Staff supervision	
Resident rights	
Medication administration	
Use of restrictive interventions	
Incident reporting	
Provision of or arrangement for necessary health services	

**When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:**

## Appendix C: Participant Services

### C-2: General Service Specifications (3 of 3)

**d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

**No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

**Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

a. The parent (biological or adoptive) of a minor child, guardian of a minor child, or spouse of a member may be paid to provide personal care and/or supportive home care that the member's interdisciplinary team (IDT) identifies as necessary and is included in the member's member-centered plan (MCP) if: 1) the member's preference is for the parent or guardian of a minor child, or spouse to provide the service; 2) the parent or guardian of a minor child, or spouse meets the provider qualifications and standards for the service to be provided and there is a properly executed provider agreement between the PIHP and the parent or guardian of a minor child, or spouse; and 3) the parent or guardian of a minor child, or spouse will either i. provide an amount of service that exceeds the normal care giving responsibilities for a parent or guardian of a minor child, or spouse who does not have a disability, or ii. find it necessary to forego paid employment in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

b. The parent or guardian of a minor child, or spouse may be paid only for services that are above and beyond the usual parent, guardian, or spousal responsibilities for a person of the member's age. The IDT is responsible to ensure that the purchase of service meets all of the following criteria intended to ensure that the provision of services by a parent or guardian of a minor child, or spouse is in the best interest of the member: 1) the service to be provided meets identified needs and outcomes in the MCP and assures the health, safety, and welfare of the member; 2) purchase of services from the parent or guardian or a minor child, or spouse is cost-effective in comparison to purchase of services from another provider; and 3) potential conflicts of interest for the provider are identified and monitored by the IDT.

c. The IDT is responsible to monitor and document that the services purchased from the parent or guardian or a minor child, or spouse are actually delivered in accordance with the MCP. This may be accomplished through requiring signed timesheets and announced and unannounced visits or other strategies. The SMA and its contracted EQRO monitor PIHP oversight of all service providers including legally responsible caregivers.

**Self-directed**

**Agency-operated**

**e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

**The state does not make payment to relatives/legal guardians for furnishing waiver services.**

**The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Any relative or legal guardian of a member may be paid to provide personal care, supportive home care, specialized transportation, certified 1-2 bed adult family home services, education (daily living skills training), respite care services, skilled nursing services and supported employment services that the member's interdisciplinary team (IDT) identifies as necessary and are included in the member-centered plan (MCP) if: 1) the member's preference is for the relative or legal guardian to provide the service; 2) the relative or legal guardian meets the provider qualifications and standards for the service to be provided and there is a properly executed provider agreement between the PIHP and the relative or legal guardian; and 3) the relative or legal guardian will either i. provide an amount of service that exceeds the normal family caregiving responsibilities, if any, for a person in a similar family relationship who does not have a disability, or ii. find it necessary to forego paid employment in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

b. The relative or legal guardian may be paid only for services that are above and beyond the usual familial responsibilities, if any, for a person of the member's age. The IDT is responsible to ensure that the purchase of service meets all of the following criteria intended to ensure that the provision of services by a relative or legal guardian is in the best interest of the member: 1) the service to be provided meets identified needs and outcomes in the MCP and assures the health, safety, and welfare of the member; 2) purchase of services from the relative or legal guardian is cost effective in comparison to purchase of services from another provider; and, 3) potential conflicts of interest for the provider are identified and monitored by the IDT.

c. The IDT is responsible to monitor and document that the services purchased from the relative or legal guardian are actually delivered in accordance with the MCP. This may be accomplished through requiring signed timesheets and announced and unannounced visits or other strategies. The SMA and its contracted EQRO monitor PIHP oversight of all service providers including relative/legal guardian caregivers.

**Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

**Other policy.**

Specify:

**f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

This waiver is provided in conjunction with a § 1915(b) waiver that allows for the restriction of free choice of providers. However, for services that involve intimate personal care needs or require a provider to frequently enter a member’s home, the SMA-PIHP contract requires the PIHP to, upon a member’s request, purchase services from any qualified provider who will accept and meet the provisions of the PIHP’s subcontract.

Further, Wis. Stat. § 46.284(2)(c) requires that the SMA–PIHP contract specify that PIHPs must contract with any CBRF, residential care apartment complex, nursing home, intermediate care facility for individuals with intellectual disabilities, community rehabilitation program, home health agency, day service, or personal care provider that (1) agrees to accept the PIHP’s reimbursement rate for similar providers and (2) meets quality, utilization, or other standards.

## Appendix C: Participant Services

### Quality Improvement: Qualified Providers

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

**a. Methods for Discovery: Qualified Providers**

*The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.*

**i. Sub-Assurances:**

**a. Sub-Assurance:** *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

**Performance Measures**

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

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

**Performance Measure:**

**The SMA verifies that PIHPs assure that providers continually meet all licensure and/or certification standards that apply to them. Numerator: Number of providers reviewed annually through an SMA validation process that meet all licensure and/or certification standards that apply to them. Denominator: Number of providers reviewed annually through an SMA validation process.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
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<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% with +/- 5% margin of error</div>
<b>Other</b> Specify:  <div style="border: 1px solid black; padding: 2px; width: fit-content;">PIHP / EQRO data validation</div>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	

**Data Aggregation and Analysis:**

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis(check each that applies):</b>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify:  <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>

<b>Responsible Party for data aggregation and analysis</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.**

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

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

**Performance Measure:**

**The SMA verifies that PIHPs assure non-licensed/non-certified providers continually meet all the standards that apply to them. Numerator: Number of non-licensed/non-certified providers reviewed annually through an SMA validation process that meet all standards that apply to them. Denominator: Number of non-licensed/non-certified providers reviewed annually through an SMA validation process.**

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> ( <i>check each that applies</i> ):	<b>Frequency of data collection/generation</b> ( <i>check each that applies</i> ):	<b>Sampling Approach</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-top: 5px;">95% with +/- 5% margin of error</div>
<b>Other</b>	<b>Annually</b>	<b>Stratified</b>

Specify:  PIHP / EQRO data validation		Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

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

**c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

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

*For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the*

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

**Performance Measure:**

All providers of supportive home care and/or in-home respite have completed training per SMA standards. Numerator: Number of providers reviewed by the SMA who have completed training per the SMA standards. Denominator: Number of providers reviewed by the SMA.

**Data Source** (Select one):

**Training verification records**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  Confidence Interval = 95% with +/- 5% margin of error
<b>Other</b> Specify:  PIHP / EQRO data validation	<b>Annually</b>	<b>Stratified</b> Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

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

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

The SMA Oversight team is the primary resource for the discovery of problems/issues within the waiver program. However, other monitoring, quality improvement, and quality assurance processes may result in the discovery of problems/issues. The processes that could result in such discovery include the Annual Quality Review, conducted by the external quality review organization and the SMA; the review of PIHP or State level grievances and appeals, Family Care Ombudsman program reports, and critical incident reports; the evaluation of requests for the use of isolation, seclusion, or restrictive measures; and the provision of technical assistance or policy clarification.

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

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

SMA oversight teams direct the correction of individual problems. The SMA oversight team assigned to each PIHP discovers problems and issues through: reports from the EQRO related to individual member concerns; Family Care Ombudsman program reports; review of grievances and appeals; review of member incident reports; review of requests for use of isolation, seclusion, and restrictive measures; discovery of problems or issues when giving a PIHP policy clarification; complaints to the SMA; and from other sources. The oversight team also interacts with PIHP staff on a regular basis and may identify concerns through such communication and direct observation. As needed, the SMA oversight team directs remediation of individual member concerns, provider concerns, isolated operational concerns, and systemic problems or issues within the PIHP.

Each SMA oversight team documents issues and concerns and any resolution or remediation in a tracking system maintained by the SMA. An issue cannot be closed in the tracking system without approval of the SMA supervisor of the oversight team. The SMA has also developed policies and procedures for the EQRO and SMA oversight teams to report concerns that rise to a level where they require the immediate attention of the SMA.

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

<b>Responsible Party</b> ( <i>check each that applies</i> ):	<b>Frequency of data aggregation and analysis</b> ( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">EQRO</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

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

**No**

**Yes**

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

**Appendix C: Participant Services**

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**C-3: Waiver Services Specifications**

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

**Appendix C: Participant Services**

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**C-4: Additional Limits on Amount of Waiver Services**

**a. Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

**Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

**Applicable -** The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the

amount of the limit. (check each that applies)

**Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

*Furnish the information specified above.*

**Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

*Furnish the information specified above.*

**Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

*Furnish the information specified above.*

**Other Type of Limit.** The state employs another type of limit.

*Describe the limit and furnish the information specified above.*

## Appendix C: Participant Services

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### C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

*Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.*

- (1) The SMA has assessed and determined that the following settings meet the requirements of 42 CFR § 441.301(c)(4):
- (a) Member’s private residences; whether owned or rented, including when voluntarily shared with family, friends, or chosen residence mates; that are not regulated residential settings for persons with disabilities.
  - (b) Places of integrated, competitive employment.
  - (c) Community sites predominantly used by the general public for typical community activities, unless specifically prohibited by 42 CFR § 441.301(c)(5), 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; service establishments; streets; and other public accommodations.

The SMA has determined that these settings are not provider owned or controlled residential settings; are integrated in the greater community or, in the case of residences in rural settings, are the member’s choice and are consistent with the character of such communities; do not segregate or isolate members, except with respect to private residences in rural areas where such is the member’s preference; provide opportunities for regular interaction in daily activities with non-members; facilitate member choice in services, daily activities, and assumption of typical, age appropriate social roles; and support rights to dignity, respect, autonomy, and freedom from coercion.

- 2) To assure continuing compliance with setting requirements, the SMA has done the following:
- (a) Included requirements in the SMA-PIHP contract to ensure the ongoing assessment of settings in which waiver services are provided; and
  - (b) Informed members, through the Member Handbook, of the settings requirements and how to report any concerns in regard to the settings in which they receive services.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (1 of 8)

#### State Participant-Centered Service Plan Title:

Member-Centered Plan

**a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

**Registered nurse, licensed to practice in the state**

**Licensed practical or vocational nurse, acting within the scope of practice under state law**

**Licensed physician (M.D. or D.O)**

**Case Manager** (qualifications specified in Appendix C-1/C-3)

**Case Manager** (qualifications not specified in Appendix C-1/C-3).

*Specify qualifications:*

**Social Worker**

*Specify qualifications:*

Social Worker certificate requirements of the Social Worker Section of the Marriage and Family Therapy, Professional Counseling, and Social Work Examining Board:

1. Completion of a bachelor's degree from an accredited college or university in psychology, sociology, criminal justice, or other human service program approved by the Social Worker Section.
2. Completion of one of the following:
  - a. A 400 hour human services internship that involves direct practice with clients and that is supervised by a social worker certified under Wis. Stats. Chapter 457, who has a bachelor's or master's degree in social work.
  - b. One year of social work employment that involves at least 400 hours of face-to-face client contact in not less than 12 months and that is supervised by a social worker certified under Wis. Stats. Chapter 457, who has a bachelor's or master's degree in social work.
3. Successfully pass the State jurisprudence examination and national examination.

**Other**

*Specify the individuals and their qualifications:*

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (2 of 8)

**b. Service Plan Development Safeguards. *Select one:***

**Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Entities and/or individuals that have responsibility for member-centered plan development may not provide other direct waiver services to the member, with the exception of Indian Health Care Providers (IHCPs) providing services to Indian members and United Community Center (UCC) providing services to Hispanic members in Milwaukee County. For these exceptions, the following safeguards have been put in place:

The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist (TADRS) is responsible to inform the potential member and/or her/his legal representative about the available service and enrollment options, including managed long term care (Family Care or Family Care Partnership), institutional services, fee-for-service Medicaid card and self-directed supports waiver (IRIS) services. If the individual is an Indian, the ADRC or TADRS informs the potential member and/or her/his legal representative of 1) the option to choose between an Indian Health Care Provider (IHCP)(if available) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either the IHCP (if available) or PIHP network providers. If the individual is a Hispanic individual living in Milwaukee County, the ADRC informs the potential member and/or her/his legal representative of 1) the option to choose between UCC (if the selected PIHP has a care management contract with UCC) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either UCC (if available) or PIHP network providers.

IHCPs who provide care management to Indian members are required, via the SMA-PIHP-IHCP Agreement, to educate members about the full range of waiver services available to them – not just those services provided by the IHCP. The IHCP is also required to educate members that they have a right to free choice of providers and can access services through the IHCP (if the IHCP has the capacity) or a PIHP network provider. The IHCP provider is required to ask the member to sign an attestation which will be attached to the member care plan (MCP) indicating that IHCP has provided him/her with this information every twelve (12) months as part of the annual comprehensive assessment. If the member refuses to sign the attestation, the IHCP will document that refusal in the MCP. The State's EQRO will, as part of its annual review, sample the MCPs of Indian members receiving care management from an IHCP to assure this process has occurred.

If UCC provides care management to Hispanic members UCC is required, via the PIHP-UCC contract, to educate members about the full range of waiver services available to them – not just those services provided by UCC. UCC is also required to educate members that they have a right to free choice of providers and can access services through UCC (if available and UCC has the capacity) or a PIHP network provider. UCC is required to ask the member to sign an attestation which will be attached to the member care plan (MCP) indicating that UCC has provided him/her with this information every twelve (12) months as part of the annual comprehensive assessment. If the member refuses to sign the attestation, UCC will document that refusal in the MCP. The State's EQRO will, as part of its annual review, sample the MCPs of Hispanic members receiving care management from UCC to assure this process has occurred.

## **Appendix D: Participant-Centered Planning and Service Delivery**

### **D-1: Service Plan Development (3 of 8)**

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a. The Aging and Disability Resource Center (ADRC) informs members of the member-centered care planning process prior to enrollment. Upon enrollment, members are provided with an SMA-approved member handbook that is specific to the PIHP that describes the care planning, care management, and service authorization processes that the PIHP is required to use; the role members and their families play in these processes; and the grievance and appeal rights and procedures. In addition, the SMA-approved member handbook explains a member's rights and responsibilities as a member in the PIHP. For Indian members who choose to receive Indian Health Care Provider (IHCP) care management, the member handbook will include an insert specific to the IHCP. Likewise, members are informed by the ADRC – prior to enrollment – and by the PIHP – immediately following enrollment – of the option to self-direct supports and services. This option is also explained in the member handbook. This information and support, as with all aspects of the member-centered planning process, is communicated to the member in plain language; in a manner that reflects his or her cultural considerations; and in a way that is accessible to members with disabilities, through the provision of auxiliary aids and services at no cost to the member, and to members who are limited English proficient, through the provision of language services at no cost to the member. This process provides the necessary information and support to ensure that the member leads and directs the member-centered care planning process to the maximum extent possible and that the member is enabled to make informed choices and decisions. Information specific to Indian members receiving care management from an IHCP can be found in the SMA-IHCP-PIHP Agreement.

b. Each member has the right to include anyone he or she chooses in the care planning process. This right is explained in the PIHP's member handbook.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (4 of 8)

**d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a. Upon enrollment, the PIHP is responsible for providing all services in the benefit package that are needed by the member. The PIHP must contact the member within three calendar days of enrollment to welcome the member to the PIHP; review the stability of current supports to identify the services necessary to sustain the member in his/her living arrangement; make certain that any services needed to assure the member's health, safety, and wellbeing are authorized; provide the member with immediate information about how to contact the PIHP for needed services; and schedule a face-to-face contact at a time and location convenient to the member.

Initial service authorizations must be developed and implemented within five calendar days of enrollment and signed by the member or the member's legal decision maker within 10 calendar days of enrollment. An initial assessment must be completed within 10 calendar days of enrollment. A comprehensive assessment must be completed within 30 calendar days of enrollment. A fully developed member-centered plan (MCP) shall be finalized and signed by the member or the member's legal decision maker within 60 calendar days of enrollment.

The assessment and MCP are developed by the interdisciplinary team (IDT). The IDT always consists of the member, the member's guardian, any other persons requested by the member, a registered nurse, and a social service coordinator assigned by the PIHP. The IDT may also include, as needed, any other appropriate professionals (e.g., therapist, behavioral specialist).

The Indian Health Care Provider (IHCP) has the same requirements as the PIHP. Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the State-IHCP-PIHP Agreement.

PIHPs must obtain the signature of all individuals and essential providers responsible for the MCP implementation. Essential providers will be defined under program policy. For non-essential providers, the PIHP will attach a copy of the provider's signed service contract, agreement, or authorization to the MCP. The PIHP will distribute a copy of the MCP to the member or the member's legal decision maker, and essential provider(s) that are responsible for the MCP's implementation, according to program policy. For non-essential providers, the PIHP will attach a copy of the provider's signed service contract, agreement, or authorization to the MCP.

b. Assessments include a face-to-face interview between the IDT and the member that comprehensively assesses and identifies the member's needs and strengths, preferences, informal supports, personal experience outcomes, and long-term care outcomes and identifies any ongoing member conditions that require a course of treatment or regular care monitoring.

The assessment must include a review of the member's functional screen, available member medical records, and any other available background information. It must also include documentation of:

- i. A full nursing assessment, including but not limited to risk assessments for falls, skin integrity, nutrition, pain, and an evaluation of the member's ability to set up, administer, and monitor their own medication;
- ii. The member's medications and understanding of the desired responses, potential benefits, and side effects, and rationale for use and a detailed description of the behaviors indicating the need for any complex medication regime or behavior modifying medication; any examples of inappropriate use of, side effects caused by, or any use contrary to the intended use of any complex medication regime or behavior modifying medication;
- iii. Clarification and correction of any discrepancies between medications prescribed and taken;
- iv. An exploration of self-directed supports and the member's desire to self-direct;
- v. The member's preferences regarding privacy, services, caregivers, and daily routine;
- vi. Mental health, alcohol, and substance use issues;
- vii. The availability and stability of natural and community supports, and assessing how to sustain, maintain, and/or enhance existing supports;
- viii. The member's preferred living situation and the stability of housing and finances to sustain housing;
- ix. The member's preferences for educational and vocational activities, including supported employment;
- x. The member's available financial resources;
- xi. The member's understanding of his or her rights, preferences for executing advance directives and whether the member has a guardian, durable power of attorney, activated power of attorney for health care, or a supported decision-making agreement; and
- xii. The member's vulnerability and risk of abuse or neglect.

The IHCP is required to use the PIHP's assessment protocol.

c. Members are first informed about the services available in the Family Care program by the Aging and Disability Resource Center (ADRC) before enrolling. Upon enrollment, members are also provided with an SMA-approved member handbook, which describes the services available.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the State-IHCP-PIHP Agreement.

d. The MCP is developed using a member-centered process that identifies and documents the member's long-term care personal experience outcomes; the services and supports, consistent with the assessment, that will be sufficient to assure the member's health, safety, and well-being and which are satisfactory to the member in supporting his or her outcomes; and will encourage the active involvement of the member and his or her natural and community supports.

To ensure that the MCP is understandable to the member and the individuals important in supporting the member, it is written in plain language and in a manner that is accessible to members with disabilities (through the provision of auxiliary aids and services at no cost to the member) and members with limited English proficiency (through the provision of language services at no cost to the member).

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the State-IHCP-PIHP Agreement.

e. The IDT is responsible for coordinating waiver services with other services and service providers that also support the member. Managed long-term care includes all Medicaid-funded long-term care services. The coordination efforts are primarily with Medicare and Medicaid acute and primary health care providers. Most coordination efforts are conducted by the registered nurse on the IDT.

f. The IDT, which includes the member, is responsible for development of the MCP. The MCP results in service authorizations for providers that the IDT processes. The IDT is responsible for monitoring the delivery of those services and supports. The IDT is also responsible for monitoring the member's health and welfare. The IDT is required to conduct a face-to-face visit with the member each quarter of the calendar year.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the State-IHCP-PIHP Agreement.

g. The member and IDT must review and update the MCP periodically, but no later than the sixth month after the month in which the previous comprehensive assessment was completed. MCPs must also be reviewed and updated whenever the member's preferences change, there is a significant change in the member's situation or condition, the MCP fails to meet the member's needs or support the planned outcomes, or at the member's, the member's legal decision maker's, or the member's primary medical provider's request.

## Appendix D: Participant-Centered Planning and Service Delivery

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### D-1: Service Plan Development (5 of 8)

**e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The PIHP is responsible to assure member health, safety, and well-being; and it must implement a policy that expressly prohibits all forms of abuse, neglect, exploitation, and mistreatment of members by PIHP employees and providers. Each PIHP is required to create a safety and risk policy that must be approved by the SMA.

The safety and risk policy must include the following: guidelines for how interdisciplinary teams assess and respond to risk factors; directions for identifying abuse and neglect; procedures for reporting suspected abuse or neglect; policies that address decision-making about care as it relates to members' safety and risk, including standards and methods for determining acceptable risk for members; identification of members' right to freedom from unnecessary physical or chemical restraint; and identification of specific mechanisms to balance member needs for safety, protection, good physical health, and freedom from accidents with overall quality of life and individual choice. Indian Health Care Providers (IHCPs) providing care management are required to comply with the PIHP's safety and risk policy.

The PIHP's safety and risk policy reduces risk to members by making the interdisciplinary teams responsible for preventing unnecessary risk. PIHP procedures provide teams with appropriate tools for working with each member to identify risks and assess the level of risk that the member is willing to accept in order to allow for personal freedom.

The interdisciplinary team monitors the effectiveness of backup plans. It ensures that provider contracts include arrangements for backup for direct care providers or that a member's self-directed supports plan includes backup arrangements. Specific arrangements vary but a typical arrangement might include a designated alternate for each care worker and/or a pool of "on-call" providers available to provide services in the event a regularly scheduled provider is unable to furnish services.

Each PIHP is required to have a mechanism to monitor, evaluate, and improve its performance in the area of safety and risk issues to ensure that there are individualized supports in place to facilitate a safe environment for each member and that its performance is consistent with the understanding of the desired member outcomes and preferences. If it is consistent with the member's preferences, family members and other informal supports are included when addressing safety concerns.

The PIHP and its subcontracted providers must comply with Wis. Stat. § 51.61(1)(i) and Wis. Admin. Code § DHS 94.10 in the use of isolation, seclusion, and restrictive measures, which require specific case-by-case approval from the SMA.

The PIHP is responsible for providing members with access to services in the benefit package, coordinating services outside the benefit package, and linking to adult protective services 24 hours a day, seven days a week. This responsibility includes maintaining a 24-hour, seven days a week coverage/on-call system through which members can address access to urgent and emergency services needed immediately to protect health and safety.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (6 of 8)

**f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Freedom of choice of providers is generally restricted under the companion s. 1915 (b) waiver to the PIHP's network providers.

For services involving intimate personal care or when a provider frequently comes into the member's home, the PIHP shall, upon request of the member, purchase services from any qualified provider who will accept and meet the provisions of the PIHP's contract for providers of the same service.

Member handbooks are provided to every member and describe the process for requesting an out-of-network provider if the PIHP's network providers are unable to meet the member's needs or support the member's outcomes. PIHPs must develop and maintain up-to-date provider directories which are provided to members upon enrollment and upon request. When significant changes occur in their provider network, PIHPs must provide members with an updated directory, an addendum to the directory, or other written notification of the change. PIHPs must also make provider directories available on the PIHP's website and provide them to each Aging and Disability Resource Center (ADRC) in the PIHP's service area.

Prior to enrollment, if an applicant is an Indian, the ADRC or Tribal Aging and Disability Resource Specialist (TADRS) informs the potential member and/or her/his legal representative of 1) the option to choose between an Indian Health Care Provider (IHCP) (if available) and the PIHP for care management services, and 2) the option to choose to receive benefit package services from either the IHCP (if available) or PIHP network providers.

IHCPs who provide care management to Indian members are required, via the SMA-IHCP-PIHP Agreement, to educate members that they can access services through the IHCP, assuming it has the capacity to provide it, or a PIHP network provider.

The PIHP is required to allow members to change interdisciplinary teams (IDT) up to two times per calendar year if additional IDTs are available. If an Indian member chooses to receive care management through the PIHP, and wants to change IDTs, they must be given the choice between selecting a different IDT within the PIHP (up to two times per year, within the same PIHP), or accessing care management through an Indian Health Care Provider (IHCP)(if available).

## **Appendix D: Participant-Centered Planning and Service Delivery**

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### **D-1: Service Plan Development (7 of 8)**

**g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Member-centered plan (MCP) reviews are conducted on an ongoing basis and carried out concurrently as the PIHP develops and implements the member's individual MCP. For each PIHP, a sample of members is selected at least annually. Wisconsin's long-term care functional screen data and the PIHP's encounter data are used to effectively identify populations of members for review based on pre-established targeting criteria. Systematic, random sampling techniques are employed to ensure that the MCP review provides valid and reliable information on the quality of care provided.

The MCP for each individual in the sample is made available to the SMA-designated reviewers, either onsite at the PIHP or off-site at the SMA. MCPs are reviewed by individuals who are knowledgeable about waiver target groups, services, eligibility requirements, and the service delivery system. The MCP may also be reviewed in consultation with other professionals within the SMA, including nurse consultants, therapy consultants, and others who have knowledge of services and member needs.

When a MCP identifies and addresses each of the member's needs adequately, the MCP is approved. If the reviewer finds, after collecting all relevant information, that services in a MCP do not address the member's disabilities and needs in critical areas, or if basic member needs are overlooked in the assessment, an immediate referral will be made to the SMA and the PIHP will be contacted. If after further investigation the SMA determines that the effect on the member is serious, the PIHP will be directed to take immediate corrective action to ensure that the essential needs of the member are adequately addressed. In this circumstance, the MCP will not be approved until the identified problems are corrected. The SMA will track and review findings, identify trends, and provide a periodic report to the PIHP. If a PIHP is found to have an unfavorable trend towards non-approved MCPs, the frequency of review may be increased.

In addition to the review of a statistical sample of MCPs, the SMA establishes criteria for and implements targeted reviews of additional MCPs, based on the results of the sample reviews and other quality monitoring activities. Such reviews may be targeted to situations where quality monitoring results indicate additional review is needed, for example, specific PIHPs, specific interdisciplinary teams, specific target populations, or members with specific conditions.

These procedures also apply to MCPs developed by an IHCP providing case management. A statistical sample of those MCPs will also be reviewed.

## Appendix D: Participant-Centered Planning and Service Delivery

### D-1: Service Plan Development (8 of 8)

**h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

**Every three months or more frequently when necessary**

**Every six months or more frequently when necessary**

**Every twelve months or more frequently when necessary**

**Other schedule**

*Specify the other schedule:*

**i. Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

**Medicaid agency**

**Operating agency**

**Case manager**

**Other**

Specify:

## Appendix D: Participant-Centered Planning and Service Delivery

### D-2: Service Plan Implementation and Monitoring

**a. Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a. The member's interdisciplinary team (IDT) is responsible for monitoring the implementation of the member-centered plan (MCP) and of the member's health and welfare.

b. As required by the SMA-PIHP contract, the IDT regularly contacts members, face-to-face and by telephone, to monitor the implementation of the MCP as well as the member's health and welfare. Further, the IDT may review provider timesheets, provider agency reports, or member contact records.

When the IDT contacts the member, it is required to document all aspects of service monitoring to ensure that the member receives services and supports as authorized, the natural and community services and supports are being provided as identified in the MCP, and the quality of services and supports received is adequate and necessary.

c. The frequency with which monitoring is performed is established by the SMA-PIHP contract. The contract indicates that the IDT must establish a schedule of face-to-face contacts based on the complexity of the member's needs and the member's potential vulnerability/risk.

The SMA-PIHP contract requires, at a minimum, the IDT to conduct a face-to-face visit with a member every three months. Both the social services coordinator and registered nurse are required to conduct a face-to-face visit in the member's residence, at a minimum, every twelve months as part of the annual comprehensive assessment.

**b. Monitoring Safeguards.** *Select one:*

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

**Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

Entities and/or individuals that have responsibility for member-centered plan monitoring and implementation may not provide other direct waiver services to the member, with the exception of Indian Health Care Providers (IHCPs) providing services to Indian members. For this exception, the following safeguards have been put in place:

The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialist (TADRS) is responsible to inform the potential member and/or his or her legal representative about the available service and enrollment options. If the individual is an Indian, the ADRC or TADRS informs the potential member and/or his or her legal representative of 1) the option to choose between IHCP, if available, and the PIHP for care management services and 2) the option to choose to receive benefit package services from the IHCP, if available, or PIHP network providers.

IHCPs that provide care management to Indian members are required, via the SMA-PIHP-IHCP Agreement, to educate members that they can access services through the IHCP, assuming it has the capacity to provide it, or a PIHP network provider.

## Appendix D: Participant-Centered Planning and Service Delivery

### Quality Improvement: Service Plan

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

#### a. Methods for Discovery: Service Plan Assurance/Sub-assurances

*The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.*

##### i. Sub-Assurances:

- a. *Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

##### Performance Measures

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

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

##### Performance Measure:

**Member-centered plans address members' assessed needs and personal goals.**

**Numerator: Number of member-centered plans reviewed by the EQRO that were determined to be comprehensive per criteria by the SMA. Denominator: Number of member centered plans reviewed by the EQRO.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

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

		Confidence Interval = 95% with +/- 5% margin of error
<b>Other</b> Specify:  EQRO	<b>Annually</b>	<b>Stratified</b> Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

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

**b. Sub-assurance: The State monitors service plan development in accordance with its policies and**

*procedures.*

**Performance Measures**

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

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

- c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.**

**Performance Measures**

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

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

**Performance Measure:**

**Member-centered plans are updated at least annually. Numerator: Number of member-centered plans reviewed by the EQRO that were updated at least annually. Denominator: Number of member-centered plans reviewed by EQRO.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-left: 20px;">95% with +/- 5% margin of error</div>

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

**Data Aggregation and Analysis:**

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

**d. Sub-assurance:** *Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

**Performance Measures**

*For each performance measure the State will use to assess compliance with the statutory assurance (or*

sub-assurance), complete the following. Where possible, include numerator/denominator.

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

**Performance Measure:**

**Services identified in the member-centered plan are implemented. Numerator:**  
**Number of member-centered plans reviewed by the EQRO that were implemented consistent with the plan. Denominator: Number of member-centered plans reviewed by the EQRO.**

**Data Source** (Select one):

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  95% with +/- 5% margin of error
<b>Other</b> Specify:  EQRO	<b>Annually</b>	<b>Stratified</b> Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis ( <i>check each that applies</i> ):	Frequency of data aggregation and analysis( <i>check each that applies</i> ):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>

e. *Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.*

**Performance Measures**

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

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

**Performance Measure:**

**Members verify they were given a choice of services and providers through signature on the member-centered plan. Numerator: Number of member-centered plans reviewed by the EQRO with appropriate signature verifying choice of services and providers. Denominator: Number of member-centered plans reviewed by the EQRO.**

**Data Source (Select one):**

**Record reviews, off-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> <i>(check each that applies):</i>	<b>Frequency of data collection/generation</b> <i>(check each that applies):</i>	<b>Sampling Approach</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval =  95% with +/- 5% margin of error
<b>Other</b> Specify:  EQRO	<b>Annually</b>	<b>Stratified</b> Describe Group:  
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  
	<b>Other</b> Specify:  	

**Data Aggregation and Analysis:**

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

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

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

For a member-centered plan to be comprehensive, all needs that are identified in the health and care management assessment by the PIHP as needing some level of assistance (not independent) must have a related intervention or identification of how the need is being met. For members who choose not to receive an outside intervention for an assessed need, this could be identified in the assessment or the plan. DME and DMS utilized by the member is expected to be on the MCP.

Additional components of comprehensive assessment include:

- The frequency of IDT face-to-face visits; and
- LTC outcomes are identified in the record.

If any item is missing, the MCP would be scored as ‘not comprehensive.’”

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

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

In general, SMA oversight teams direct the correction of individual problems. The oversight team assigned to each PIHP discovers problems and issues through reports from the external quality review organization (EQRO) related to individual member concerns; review of Family Care Ombudsman program reports, grievances and appeals, and member incident reports; assessment of requests for use of isolation, seclusion, and restrictive measures; discovery of problems or issues when providing policy clarification to PIHPs; complaints to the SMA; and from other sources. The team also regularly interacts with the PIHP and may identify concerns through these interactions. As needed, the oversight team directs remediation of individual member concerns as well as isolated operational concerns. The oversight team also uses information gathered through direct interaction with the PIHP, and from many available sources, to identify and direct remediation of systemic problems or issues within the PIHP. Oversight teams have the ability to respond quickly to any issue that affects member health or safety.

Each oversight team documents issues and concerns as well as any resolution or remediation in the SMA’s oversight team tracking system. An issue cannot be cleared in the tracking system without approval from the supervisor of the oversight team. The SMA has also developed policies and procedures for the EQRO and oversight teams to report concerns that require the SMA’s immediate attention.

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

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix E: Participant Direction of Services**

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**Applicability** (*from Application Section 3, Components of the Waiver Request*):

**Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

**No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

*CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.*

**Indicate whether Independence Plus designation is requested** (*select one*):

**Yes. The state requests that this waiver be considered for Independence Plus designation.**

**No. Independence Plus designation is not requested.**

**Appendix E: Participant Direction of Services**

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## E-1: Overview (1 of 13)

**a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

All waiver services, except care management and community residential care services, may be self-directed. In regard to the services that may be self-directed, every member is offered the opportunity to direct some or all of the services that he or she receives. PIHPs and Indian Health Care Providers (IHCPs) performing case management are required to identify the support an individual member may need in order to exercise this option and to provide training opportunities or other assistance as needed.

b. Members may exercise employer authority or budget authority or both. Members may choose to employ a support broker to assist in exercising self-directed supports (SDS) options.

c. Fiscal agents are available to members to pay member-selected providers, using funds that the PIHP or IHCP authorized for the member's use. Fiscal agents withhold taxes and other required or optional payroll deductions. When using fiscal agent services, the member is the common law employer. The cost of fiscal agent services is provided and reported as financial management services. Co-employment agency services are also available to members. Co-employment agencies function as the common law employer while the member directs the worker. The cost of co-employment services is provided and reported as part of the individual service for which the co-employment agency hired the provider, e.g., supportive home care. Service brokers may be hired by a member to assist in the direction of services and supports. The cost of a service broker is assumed by the member and reported under the service entitled consumer-directed services – support broker.

d. SDS is the provision of a flexible array of services provided to members that includes member direction of a specified portion of the member's authorized services. Each PIHP must have an SMA-approved SDS plan, which the IHCP must also use. An approved SDS plan will ensure that SDS is implemented through processes characterized by the following:

- Support for the member and those who are close to the member to assist in identifying the member's desired outcomes and the means of achieving those outcomes in a manner that reflects member preferences as closely as possible;
- Planning that occurs within the limits of an individualized budget based on a standardized method to identify typical service costs for waiver members with similar needs in similar situations;
- Emphasis on identifying and strengthening networks of informal supports and on making use of community resources to the extent possible; and
- Identification of how members will be supported in service planning and implementation and how the member's SDS plan will be monitored to ensure member health and welfare, including ensuring that SDS services are provided by individuals or entities that are qualified to meet the member's unique needs and preferences.

## Appendix E: Participant Direction of Services

### E-1: Overview (2 of 13)

**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

**Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

**Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

**Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*.

Supports and protections are available for participants who exercise these authorities.

**c. Availability of Participant Direction by Type of Living Arrangement.** *Check each that applies:*

**Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

**Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

**The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Member direction opportunities are available to members who live in any allowable living arrangement. Services included in a residential facility's rate cannot be member directed, but other waiver services received may be directed by the member.

## Appendix E: Participant Direction of Services

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### E-1: Overview (3 of 13)

**d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

**Waiver is designed to support only individuals who want to direct their services.**

**The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**

**The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

*Specify the criteria*

Members can choose to direct some of the services as identified in Appendix E-1 g.

## Appendix E: Participant Direction of Services

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### E-1: Overview (4 of 13)

**e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a. Information about member self-direction services (SDS) opportunities (e.g. the benefits of SDS, member responsibilities, and potential liabilities) is provided in the PIHP member handbooks. As part of the comprehensive assessment and member-centered care planning process, IDT staff are required to explain that SDS is voluntary and the member's choice, the choices available within SDS, the supports and resources available to assist members with SDS, and an overview of the conditions in which the PIHP or IHCP may limit or terminate SDS for a member. The IDT must also address which specific services a member chooses to self-direct, what level of participation a member chooses to exercise, whether the member will need assistance or support to participate in SDS, resources (including natural supports) available to assist members participate in SDS, whether any potential health or safety issues exist related to SDS and how to address them, development of a budget and the extent to which the member has chosen to participate in the budgeting and payment, the manner in which payroll and benefits will be administered, and the need for training legal decision makers or self-advocacy training. The IDT must also ensure mechanisms are in place to ensure the member's expenditures are consistent with their budget, identify any changes needed to the member's budget or related supports, exercise oversight over potential health and safety issues, exercise oversight regarding potential conflicts of interest, and validate the completion of appropriate provider training.

Annually, members must also affirm their IDT explained the SDS option to them and affirmatively accept or deny the SDS option by choosing the appropriate option on their member-centered plan.

b. PIHPs or IHCPs are responsible for providing the information described above.

c. PIHPs and IHCPs must distribute member handbooks to members within ten (10) business days of their initial enrollment notification, within five (5) business days of a member's request, and an addendum or other written notification at least thirty (30) calendar days in advance of the effective date when significant changes occur. Additional information is provided to members on an ongoing basis throughout the member-centered planning process.

## Appendix E: Participant Direction of Services

### E-1: Overview (5 of 13)

**f. Participant Direction by a Representative.** Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

**The state does not provide for the direction of waiver services by a representative.**

**The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

**Waiver services may be directed by a legal representative of the participant.**

**Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

## Appendix E: Participant Direction of Services

### E-1: Overview (6 of 13)

**g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Assistive Technology/Communication aids		
Specialized Medical Equipment and Supplies		
Adaptive aids		
Adult Day Care Services		
Prevocational Services		
Personal Emergency Response Systems (PERS)		
Supportive Home Care		
Relocation services		
Daily Living Skills Training		
Financial Management Services		
Consultative Clinical and Therapeutic Services for Caregivers		
Transportation (Specialized Transportation) - Other Transportation		
Day Habilitation Services		
Housing Counseling		
Supported Employment - Individual Employment Support		
Consumer Education and Training		
Environmental Accessibility Adaptations (Home Modifications)		
Home Delivered Meals		
Transportation (Specialized Transportation) - Community Transportation		
Skilled Nursing Services RN/LPN		
Self-Directed Personal Care		
Supported Employment - Small Group Employment Support		
Vocational Futures Planning and Support		
Consumer Directed Supports (Self-Directed Supports) Broker		
Respite		
Counseling and Therapeutic Resources		
Training Services for Unpaid Caregivers		

## Appendix E: Participant Direction of Services

### E-1: Overview (7 of 13)

**h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

**Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

**Governmental entities**

**Private entities**

**No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.**

## Appendix E: Participant Direction of Services

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### E-1: Overview (8 of 13)

**i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

**FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:**

Financial Management Services

**FMS are provided as an administrative activity.**

**Provide the following information**

**i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Financial Management Services may be provided by:

1. Private, for profit accounting agencies;
2. Private profit or not-for-profit financial management agencies; or
3. Individual FMS providers.

These services may be procured through Request for Proposal procedures. Prospective providers may also register on a website.

A new vendor may begin providing support at any time after meeting the required qualifications as indicated in the service contract proposed by the PIHP and completing a Provider Agreement with the SMA.

There may be more than one FMS providing services to Family Care members under contract with any PIHP. Members may choose alternate FMS agencies on an individual basis.

**ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FMS entities are paid by PIHPs according to the terms specified in the contract between the PIHP and the FMS entity.

**iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

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Supports furnished when the participant is the employer of direct support workers:

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**Assist participant in verifying support worker citizenship status**

**Collect and process timesheets of support workers**

**Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

**Other**

*Specify:*

Perform provider background checks as specified in Appendix C service provider requirements.

---

Supports furnished when the participant exercises budget authority:

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**Maintain a separate account for each participant's participant-directed budget**

**Track and report participant funds, disbursements and the balance of participant funds**

**Process and pay invoices for goods and services approved in the service plan**

**Provide participant with periodic reports of expenditures and the status of the participant-directed budget**

**Other services and supports**

*Specify:*

---

Additional functions/activities:

---

**Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**

**Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**

**Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**

**Other**

*Specify:*

The FMS entity may act as the Representative Payee.

**iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

1. Fiscal Management Services of the Self-Directed Support payment system:

a. This program is designed to provide a conduit for individual service funds to be held by the FMS until accessed by members and their support brokers.

b. The FMS will issue monthly statements to the member, PIHP or IHCP, and support broker, indicating all disbursements made on the member's behalf and balances remaining in the member's account.

2. Content of Report: For this program, the FMS shall submit, at a minimum, and within fifteen (15) days of the end of each period (whether monthly or quarterly), the following reports to the PIHP or IHCP that is responsible for completing all encounter reporting to the SMA:

a. Monthly, the number of financial transactions made.

b. Monthly and quarterly statements indicating all disbursements made on the member's behalf, including vendor paid, categories of payments, and amount paid to each vendor.

c. Monthly and quarterly statements indicating balance of funds in each member account.

d. Quarterly statements indicating aggregate amounts paid by vendor and payment categories and aggregate amounts held in reserve.

3. Other Features and Requirements:

a. The FMS shall maintain all individual service funds in a separate interest bearing bank account and will maintain a separate internal member account for each member.

b. The FMS shall not commingle individual service funds with any other funds that the agency holds.

c. The FMS shall not request or transfer funds from the individual services funds to any other program that it provides.

d. The FMS shall not influence the member or support broker in selecting, contracting with or terminating agreements with support brokers, service providers, FMS providers, or independent contractors.

e. The FMS and PIHP staff agree to meet quarterly to review program goals, and progress and barriers encountered in reaching those goals.

f. The FMS agrees that during the terms of the agreement the contract may be renegotiated to address changes in utilization, service delivery, or other provisions required by law, policy, or funding sources.

g. An audit of the funds held in trust may be performed as part of the FMS audit and included in the audit report submitted by the FMS. The audit of funds held in trust shall be performed on the cash basis of accounting.

4. The FMS shall submit to the PIHP by January 31 of the contract year the following:

a. Legal Name of the Organization;

b. Current street address and telephone number;

c. Chief Operating Officer/Executive Director;

d. Legal Status (Private, Not-for Profit Corporation; Private, For-Profit Corporation, LLC, etc.);

- e. Number of board meetings the governing body or board of directors scheduled for the contract year (if applicable);
- f. A list of the board officers and their role (President/Chair, Vice President/Chair, Treasurer, Secretary) (if applicable);
- g. The address and telephone numbers of all board members, including the board officers (if applicable);
- h. Listing of all hours/days and dates the fiscal management agency anticipates to be closed (holidays); and
- i. Appropriate Medicaid provider registration forms.

Information regarding FMS when an IHCP is providing case management is detailed in the State- IHCP-PIHP Agreement.

## Appendix E: Participant Direction of Services

### E-1: Overview (9 of 13)

**j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

**Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

*Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*

The member's interdisciplinary team (IDT) is responsible to assess the needs of each member who elects self-direction and to provide support to the member. Examples of support provided include training, sharing information, and assistance in locating resources. The IDT has access to the SMA's best practice guide, Self-Directed Supports in Family Care, Family Care Partnership, and PACE: A Best Practice Manual of Interdisciplinary Team Staff, which has best practice strategies to assure member health and safety while supporting members' ability to self-direct some of their services.

#### **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Assistive Technology/Communication aids	
Specialized Medical Equipment and Supplies	
Adaptive aids	
Adult Day Care Services	
Prevocational Services	
Personal Emergency Response Systems (PERS)	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Supportive Home Care	
Relocation services	
Daily Living Skills Training	
Financial Management Services	
Consultative Clinical and Therapeutic Services for Caregivers	
Transportation (Specialized Transportation) - Other Transportation	
Day Habilitation Services	
Housing Counseling	
Supported Employment - Individual Employment Support	
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	
Consumer Education and Training	
Environmental Accessibility Adaptations (Home Modifications)	
Home Delivered Meals	
Transportation (Specialized Transportation) - Community Transportation	
Skilled Nursing Services RN/LPN	
Care Management	
Self-Directed Personal Care	
Supported Employment - Small Group Employment Support	
Vocational Futures Planning and Support	
Adult Residential Care - 3-4 Bed Adult Family Homes	
Consumer Directed Supports (Self-Directed Supports) Broker	
Respite	
Counseling and Therapeutic Resources	
Adult residential care - 1-2 bed adult family homes	
Adult Residential Care - Community-Based Residential Facilities (CBRF)	
Training Services for Unpaid Caregivers	

**Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

*Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c)*

describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

## Appendix E: Participant Direction of Services

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### E-1: Overview (10 of 13)

#### k. Independent Advocacy (select one).

**No. Arrangements have not been made for independent advocacy.**

**Yes. Independent advocacy is available to participants who direct their services.**

*Describe the nature of this independent advocacy and how participants may access this advocacy:*

The ombudsman programs offer independent advocacy to members or potential members. The ombudsman program for individuals under age 60 is operated by Disability Rights Wisconsin, the state's Protection and Advocacy Agency. For elders, the ombudsman program is operated by the Board on Aging and Long Term Care, which also operates the ombudsman program for nursing home residents.

Advocacy services provided by these ombudsman agencies vary and are tailored to members' individual needs and preferences. The scope of assistance ranges from a single information and assistance discussion with a member to individualized, step-by-step advocacy through the appeals process including representation at fair hearings and judicial proceedings.

PIHPs are required to inform members of the existence of these agencies and how to contact them via the member handbook (Family Care) and evidence of coverage document (Family Care-Partnership) that are provided to members upon enrollment. PIHPs are also required to use SMA templates (e.g. notice of adverse benefit determination, notice of change in level of care, etc.). The templates include contact information for the ombudsman agencies and describe the services they provide. This information is also included on SMA-issued notices of disenrollment. PIHPs are required to assist members to obtain access to ombudsman services upon member request.

In addition to the ombudsman programs, individuals who are receiving services for mental illness, a developmental disability, substance abuse, or who have been protectively placed by a court have access to an additional independent advocacy resource, a state-operated grievance system. This system is prescribed by state statute and is operated by the Client Rights Office of the Division of Mental Health and Substance Abuse Services. Individuals covered by this program are required to be informed of its existence, their rights under statute and rule and must be assisted in accessing this program if they request it.

## Appendix E: Participant Direction of Services

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### E-1: Overview (11 of 13)

**I. Voluntary Termination of Participant Direction.** Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A member transitioning from self-direction to an alternate service delivery method is not terminating Family Care services or disenrolling from the program; the member is only changing how he or she obtains his or her Family Care services.

When the member decides that she or he no longer wants to self-direct services, the member notifies the IDT. This notification can occur at any time, or the member may communicate the decision during a member-centered plan (MCP) review. As part of the MCP review, the IDT is required to ask the member whether he or she prefers to continue self-directing services. Based on the member's MCP, the IDT is aware of the types and amounts of services that the member receives. The IDT meets with the member to select PIHP network providers to replace the self-directed providers. The IDT ensures that there will be no gaps in services by assuring that authorizations end, for self-directed services, and start, for contracted network providers, without interruption, according to the schedule in the MCP. The PIHP or Indian Health Care Provider (IHCP) transmits this information to the network providers and sends written notice along with a revised MCP to the member. Further, the PIHP or IHCP informs the financial management services (FMS) provider that the member will no longer receive fiscal agent services. The member is advised to inform the IDT of any problems during the transition. Reported gaps in essential services will trigger PIHP or IHCP contingency plans for use of backup providers.

The member may use any of the external member resources available for advocacy, including, but not limited to, the Family Care Ombudsman Program, the external quality review organization, and the benefit specialist programs available through Aging and Disability Resource Centers. See Appendix A:3.

## Appendix E: Participant Direction of Services

### E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The PIHP or IHCP is authorized to involuntarily terminate member self direction if the member's health and safety is jeopardized, purchasing authority is mismanaged, or the member refuses to report information necessary for the PIHP or IHCP to adequately monitor the situation. This action is appealable. If member direction is involuntarily terminated for a member, the member's IDT resumes full responsibility for authorization of services and for assuring continuity of services and, as appropriate, providers.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement.

## Appendix E: Participant Direction of Services

### E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	10759
Year 2	<input type="text"/>	11125
Year 3	<input type="text"/>	11483
Year 4	<input type="text"/>	11834

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 5	<input type="text"/>	<input type="text" value="12186"/>

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant Direction (1 of 6)

**a. Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

**i. Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

**Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

**Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

**ii. Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

**Recruit staff**

**Refer staff to agency for hiring (co-employer)**

**Select staff from worker registry**

**Hire staff common law employer**

**Verify staff qualifications**

**Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

**Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

**Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

**Determine staff wages and benefits subject to state limits**

**Schedule staff**

**Orient and instruct staff in duties**

**Supervise staff**

**Evaluate staff performance**

**Verify time worked by staff and approve time sheets**

**Discharge staff (common law employer)**

**Discharge staff from providing services (co-employer)**

**Other**

Specify:

## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (2 of 6)

**b. Participant - Budget Authority** *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

**i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

**Reallocate funds among services included in the budget**

**Determine the amount paid for services within the state's established limits**

**Substitute service providers**

**Schedule the provision of services**

**Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

**Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

**Identify service providers and refer for provider enrollment**

**Authorize payment for waiver goods and services**

**Review and approve provider invoices for services rendered**

**Other**

Specify:

## Appendix E: Participant Direction of Services

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### E-2: Opportunities for Participant-Direction (3 of 6)

**b. Participant - Budget Authority**

**ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

To determine budgets for self-directed services (SDS), PIHPs and the Indian Health Care Providers (IHCP) estimate what it would cost the PIHP to fund the member-centered plan (MCP), or the part of the MCP to be self-directed, in the absence of self-direction. The estimated cost is the basis for the self-directed budget. Usually, the estimate involves determining what the same services and supports, in the authorized amounts, would cost if the PIHP purchased them for the member or for a similarly situated member who does not self-direct. In some situations where, in the absence of self-direction, the member would likely move into community residential care with a daily rate or his or her care would otherwise be paid at a daily rate, such as live-in home care, that rate may be used as the basis for calculating the member's budget. In all circumstances, the member selects the needs and outcomes for which he or she wants to self-direct supports. Within this overall approach, PIHPs have some flexibility in the methods that they use. IHCPs providing case management to Indian members will use the PIHP's SMA-approved policy and procedure for setting budgets.

These variations can be categorized as follows:

- **Establishing an Overall Rate**

This approach starts with an established rate that is determined by the PIHP for the cost of the authorized goods or services to be self-directed. PIHPs use an average rate based on their contracted providers that offer the same or similar waiver services multiplied by the authorized amount. Using the established rate, the PIHP creates the member's overall budget. Within that budget, the member has some flexibility to determine wages.

- **Zero-based Budget**

In this variation, the process starts with the amount of services needed and the cost of goods or services to purchase through an FMS provider (e.g., special medical equipment, assistive technology, or home modification). For direct care services, the IDT then works with the member to establish possible employee wage levels for the amount of services authorized. The PIHP adds additional costs to the wage baseline for fringe benefit costs. The budget is set for a specific time period, such as one month, six months, or one year.

- **Daily rate**

For members who choose to direct many or all of their services, a PIHP can use a member's current or projected MCP to establish a daily rate for the goods or services that the member will receive. This works well for members who need a significant amount of daily home care, up to 24 hours, especially when workers may not be providing hands-on care but need to be on the premises or when the provider lives with the member. It also can be used for members who, in the absence of self-directed supports, would be in community residential care, with the daily SDS rate based on the daily facility rate plus a daily rate for any waiver services outside of the facility rate. The daily rate is set to be sufficient to comply with applicable wage and hour requirements for member-employed home care workers.

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (4 of 6)

#### b. Participant - Budget Authority

**iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

IDT staff use an assessment tool to estimate the number of hours needed to meet a member's stated outcomes. As a part of the individualized planning process, members receive a document showing them estimated monthly costs. The process of applying an assessment tool and completing that tool with the member ensures consistency and transparency. Fairness is ensured through the Resource Allocation Decision (RAD) making process and discussion, as well as through the availability of appeal options should a member not be satisfied with his/her member-centered plan (MCP).

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (5 of 6)

#### b. Participant - Budget Authority

##### iv. Participant Exercise of Budget Flexibility. *Select one:*

**Modifications to the participant directed budget must be preceded by a change in the service plan.**

**The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

## Appendix E: Participant Direction of Services

### E-2: Opportunities for Participant-Direction (6 of 6)

#### b. Participant - Budget Authority

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The interdisciplinary team (IDT) retains responsibility for oversight of the member's implementation of his or her member-centered plan (MCP) and use of his or her self-directed supports (SDS) budget. Some PIHPs' contracts for fiscal agent services require regular budget authority utilization reports for the IDT. If there is significant under-utilization or over-utilization of services and budget authority, the IDT reviews the MCP, budget, and member's circumstances. The SMA does not prescribe protocols for PIHPs to follow in carrying out these reviews.

Moreover, an SMA Member Care Quality Specialist reviews a sample of member charts for each PIHP on a rotating basis. For members who self-direct, special attention is paid to plans and associated budgets.

## Appendix F: Participant Rights

### Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

**Procedures for Offering Opportunity to Request a Fair Hearing.** Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to

offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Members are informed of the right to a fair hearing in multiple ways and at multiple times, including prior to enrollment, at the time of enrollment, and while enrolled. The Aging and Disability Resource Center (ADRC) or Tribal Aging and Disability Resource Specialists (TADRS) inform potential members of the right to a fair hearing prior to enrollment. This information is contained in the “Being a Full Partner” booklet produced by the SMA, which ADRCs give to all potential members. The regional income maintenance (IM) consortium determines eligibility for Medicaid and all managed long-term care programs, and processes enrollments. The IM agencies use standardized eligibility notification forms that include information about the right to a fair hearing. Once a member is enrolled, the member handbook (Family Care) or evidence of coverage document (Family Care-Partnership), given to every member by the PIHP’s inter-disciplinary team (IDT), contains information about the right to a fair hearing and how to request one. PIHPs are also required to use SMA templates (e.g. notice of adverse benefit determination, notice of change in level of care, etc.). The templates include information about the right to a fair hearing and how to request one. This information is also included on SMA-issued notices of disenrollment. Copies of these notices are maintained in the member-centered plan (MCP). The member handbook/evidence of coverage and the above referenced notices describe the member’s right to continuation of services pending the outcome of an appeal at the PIHP and State fair hearing levels.

The SMA requires PIHPs to assist members in filing a request for fair hearing. Both the member’s IDT and the PIHP’s member rights specialist (a position required by the SMA) are available to assist members. In addition, the ombudsman programs the SMA contracts with or has an MOU for are available to assist members in filing a request for fair hearing and to assist the member at the hearing.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement.

## Appendix F: Participant-Rights

### Appendix F-2: Additional Dispute Resolution Process

**a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates an additional dispute resolution process**

**b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

- a. The SMA operates a dispute resolution process called Department of Health Services (DHS) review. It contracts with the external quality review organization (EQRO) to administer the process.
- b. The process is primarily an attempt to negotiate an informal resolution that is mutually acceptable to the member and the PIHP. The EQRO reviews the disagreement with both sides and facilitates discussion to seek to informally resolve the issue/complaint. This is not a formal appeal process in that the SMA does not issue an order as a result of this process unless it finds a PIHP has breached a contractual obligation. A member may elect DHS review at any time for dissatisfaction with any action or omission of a PIHP, or for concerns about quality or any other issue. The DHS review process is also automatically initiated when a member requests a fair hearing. This is called concurrent review. A request for DHS review must be made within 45 days of the event that precipitates the request. Wisconsin Administrative Code § DHS 10.54 requires that a DHS review must be completed within twenty (20) business days of receiving a request. The SMA must mail or hand deliver to the member in writing the result of the DHS review within 5 business days of the completion of the review.
- c. While members are encouraged to use the informal DHS review process to resolve their concerns, the use of this process is not required for, nor does it limit, the opportunity to request a fair hearing. A member is not required to first undergo DHS review in order to request a fair hearing. If a member requests DHS review, that request and its outcome does not limit the member's right to additionally request a fair hearing. However, if a member elects not to request DHS review and go directly to a fair hearing for resolution of his or her issue, he or she cannot request DHS review following the fair hearing decision. The member will still undergo the DHS review process ("concurrent review" discussed above) which occurs automatically whenever a member requests a fair hearing. If concurrent review does not result in an informal resolution prior to the fair hearing, the member is precluded from requesting DHS review following the fair hearing decision.

The SMA oversight teams use the grievance and appeal data base to monitor trends for each PIHP. In addition, the SMA uses the grievance and appeal database to monitor trends overall.

The EQRO tracks all grievances in a database that the SMA has access to. This database includes all timeline information. In addition, the SMA receives a monthly report from the EQRO detailing the grievances and efforts to mediate a resolution. This report is reviewed by the SMA contract administrators for consistency in practices.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement.

## Appendix F: Participant-Rights

### Appendix F-3: State Grievance/Complaint System

**a. Operation of Grievance/Complaint System.** *Select one:*

**No. This Appendix does not apply**

**Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

**b. Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

The SMA operates a grievance resolution process called Department of Health Services (DHS) review. The SMA contracts with the external quality review organization (EQRO) to administer the process. The EQRO tracks all grievances in a database that the SMA has access to. This database includes all timeline information. In addition, the SMA receives a monthly report from the EQRO, detailing the grievances and efforts to mediate a resolution. This report is reviewed by the SMA for consistency. The SMA uses the grievance and appeal database to monitor trends for each PIHP and trends overall.

**c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available

to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a. The SMA uses the dispute resolution process described under F-2b, DHS review, to address grievances.

In distinguishing the types of member issues addressed under F-2 and the types of member issues addressed under F-3, it is necessary to distinguish between an appeal and a grievance.

An appeal is a request for a review of an “action.” Actions are defined in the SMA-PIHP contract as a (1) denial of or a reduction in functional eligibility, (2) a denial or limited authorization of a requested service in the benefit package, (3) the reduction, suspension or termination of a previously authorized service, (4) the denial, in whole or in part, of payment for a service in the benefit package, (5) the failure to provide services and support items included in the member-centered plan (MCP) in a timely manner, (6) the failure of the PIHP to act within the timeframes for resolution of grievances and appeals, (7) the development of an MCP that is unacceptable to the member because any of the following apply: a) the plan is contrary to a member’s wishes insofar as it requires the member to live in a place that is unacceptable to the member or b) the plan does not provide sufficient care, treatment or support to meet the member’s needs and support the member’s outcomes or c) the plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member, or (8) notification by the PIHP of a decision that was made in response to a member’s appeal that is entirely or partially adverse to the member.

A grievance is an expression of a member’s dissatisfaction about any matter other than an “action.” Common examples of grievable issues are changes in providers, concerns about the quality of care or services, and personal care workers arriving late.

Actions can be pursued through the PIHP appeals process, DHS review and the state fair hearing process.

Grievances can be pursued through the PIHP grievance process, DHS review and the state fair hearing process.

b. The processes and timelines for addressing grievances are the same as those described under F-2b.

c. The mechanisms for resolving grievances are the same as those described under F-2b.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement.

## Appendix G: Participant Safeguards

### Appendix G-1: Response to Critical Events or Incidents

**a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

**Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

**No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

**b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

The incident types that the SMA requires to be reported for review and follow-up action are:

1. Abuse (physical, sexual, emotional, treatment without consent, unreasonable confinement or restraint);
2. Neglect and self-neglect;
3. Financial exploitation;
4. Any unplanned or unapproved use of restraints or restrictive measures;
5. Any unplanned or unapproved use of isolation/seclusion;
6. Death due to member abuse, neglect, self-neglect, exploitation, accident, restraint, seclusion, suicide, psychotropic medication(s), medication error(s), falls; unexplained, unusual, or suspicious circumstances;
7. Missing person;
8. Any unplanned (e.g. emergency) or unapproved involvement of law enforcement and/or criminal justice system (e.g. not addressed in a restrictive measures or behavior support plan);
9. Medication errors (med omission, wrong med, wrong dose, wrong time, wrong person, wrong route of administration, wrong technique); and
10. Falls

Incidents must be reported to designated PIHP staff by contracted providers or by PIHP staff no later than one (1) business day after the incident was discovered. Incidents may be reported by phone, paper form, or use of the respective PIHP's web-based incident reporting system.

The requirements described above also apply to Indian Health Care Providers (IHCP) performing case management for Indian members. Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the SMA-IHCP-PIHP Agreement.

**c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Referencing the member handbook and/or instructional pamphlet, the Interdisciplinary Teams (IDT) provide training regarding abuse, neglect, and exploitation to PIHP members, families, legal representatives, and/or unpaid direct caregivers. This training occurs at the time of the initial face-to-face assessment, which takes place within 10 days of enrollment, or at the time of the initial comprehensive assessment, which takes place within 30 days of enrollment, and, again, at each annual reassessment. The requirements described for PIHP IDTs also apply to Indian Health Care Providers (IHCP) performing case management for Indian members.

**d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Each PIHP is responsible for evaluating the reports. Reports are evaluated by designated PIHP managers who initiate incident investigations. Each PIHP has an incident review committee to evaluate all incidents and monitor for trends and quality improvement opportunities. The frequency of committee meetings varies by PIHP (weekly, biweekly, monthly, or quarterly).

PIHPs initiate an incident investigation to determine the cause of all incidents.

Designated PIHP staff or the provider complete an investigation of the incident and related events to determine and document whether the reported incident occurred and if it did:

- a) The facts of the reported incident (including the date and location of occurrence), the type and extent of harm experienced by the member, any actions that were taken immediately to protect the member and to halt or ameliorate the harm;
- b) The cause(s) of the incident;
- c) Whether reasonable actions by the provider or others with responsibility for the well-being of the member would have prevented the incident; and
- d) Whether any changes in the PIHP's or provider's policies or practices might prevent occurrence of similar incidents in the future.

Investigations are to be completed within thirty (30) calendar days of incident discovery. If information or findings necessary for completion of the investigation cannot be obtained within 30 calendar days for reasons beyond the PIHP's control, the investigation is to be completed as promptly as possible.

Within five (5) business days of completion of each incident investigation, the PIHP is to provide notification of the results of the investigation to the member or the member's legal representative. This notification will be documented in the member's care management record.

Indian Health Care Providers (IHCP) performing case management are required to complete the incident reports and send them to the PIHP who proceeds with the above process.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The SMA is responsible for overseeing the integrity of the incident management system that is operated by the PIHPs. In a monthly report, in a format specified by the SMA, the PIHPs must report all specified incident types.

Individual member/incident data elements are collected monthly. Data is aggregated and compiled into a monthly SMA incident report and disseminated to Oversight Teams and SMA management. Each Oversight Team reviews its respective PIHP's monthly report to monitor for incident trends and any member care-related quality issues/concerns relevant to PIHP incident management. Each SMA oversight team conducts monthly follow-up reviews with its PIHP or with the Indian Health Care provider. Remedial or corrective action is determined, as needed, by the oversight team. All findings and/or follow-up by the SMA oversight team are documented. Additional follow-up may include, but is not limited to, examination of individual member data (as provided in the PIHP's monthly report) and/or individual member record reviews, depending on the trends or concerns identified.

Annually, the EQRO will conduct a Quality Compliance Review for performance validation of each PIHP's incident management system. The SMA may also request targeted quality reviews when necessary.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

**The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

**The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Unless specifically indicated otherwise, all of the information provided applies to restraints, restrictive interventions, and seclusion.

The Restrictive Measures Guidelines and Standards are available at:

<https://www.dhs.wisconsin.gov/waivermanual/appndx-r1.pdf>

The PIHP is responsible for investigating unauthorized or emergency use of restraints in the context of incident management system investigations. Actions taken with provider deficiencies may include, but are not limited to, mandated training or re-training and additional monitoring by the member's interdisciplinary team (IDT) and/or the PIHP's Provider Network (IHCP's if applicable) staff. In egregious situations, provider suspension may occur. Further, the Restrictive Measures Guidelines and Standards specify that if the same or a similar emergency occurs more than twice in a six month period, it is no longer an emergency and the restrictive measures planning process for an approved restrictive measure is initiated.

Each request for use of a restraint must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request for the restrictive measure.

Any use of restraint that is not within the scope of the state Restrictive Measures Guidelines and Standards is prohibited under any circumstance.

Each PIHP's restrictive measures committee reviews and approves each request prior to submission for state level review and approval.

Once submitted to the SMA, review and approval of restraint requests is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. The review will be completed within 45 business days of receipt of the request.

Each Division of Medicaid Services Restrictive Measures Review Panel is comprised of the State Restrictive Measures Coordinator and 1-2 additional staff from any of the following teams:

- Best Practice Integration Resources
- Member Care Quality Specialist
- DHS Division of Quality Assurance (if the residence is licensed)
- Area Administration
- IRIS (Self-Directed Supports program)
- Children's Long Term Supports

Documentation requirements related to restraint use are specified in the Restrictive Measures Guidelines and Standards. Each restraint application must specify the monitoring and documentation plan as well as the reduction/elimination plan.

Providers are required to report the use of each approved restraint to the applicable PIHP as indicated in the application.

Quarterly each PIHP reports restrictive measures member utilization data to the SMA in accordance with the SMA's data reporting specifications.

All individuals involved in the administration of restraints/seclusion must be trained by the SMA, a restrictive measures training expert and/or designated competent PIHP (or IHCP if applicable) staff.

Assurance of training of all individuals involved in the administration of restraints/seclusion is the responsibility of the PIHP/IHCP within their contracts/care coordination agreement with respective providers in accordance with SMA-PIHP Contract or SMA-IHCP-PIHP Agreement as applicable.

Restraints may be approved for less than but no more than one year; a renewal request, review, and approval is required prior to expiration of the previous approval.

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of

restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Quarterly, the SMA will collect data on approved restrictive measures from each PIHP in a standardized file format via the Restrictive Measures database. This data is loaded into a data warehouse environment. The SMA will extract aggregated data from the warehouse environment for analysis, tracking, and trending to identify potential patterns and outcomes for monitoring and possible quality improvement efforts.

The SMA is responsible for review of each PIHP's monthly incident reports. Upon request for renewal of restrictive measures approval, the member's restrictive measures utilization report will be reviewed to monitor restraint/seclusion trends and to verify the effectiveness of approved restraints/seclusion. At a minimum, follow-up consists of a review of the report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data as provided in the PIHP's monthly incident report and/or individual member record reviews, depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the SMA Oversight Team are documented.

Potential patterns concerning the unauthorized use of restraints associated with certain providers will be obtainable via analysis of the incident management system data. Unauthorized use of restraints (any type), isolation, or seclusion is captured as a member incident within the Incident Management System.

Use of approved restrictive measures is monitored and accounted for by each PIHP's restrictive measures lead. Thus, whether restraints have been approved can be readily assessed. In the context of member-centered care, PIHP IDT oversight includes ongoing risk assessment and harm reduction management. If there are any concerns, the IDT will increase monitoring of the member or situation, which can result in daily member contact.

Member record reviews could include the member-centered plan (MCP), approved restrictive measures request, PIHP tracking data concerning behavioral incidents, antecedent behavior tracking, use of restrictive measure(s), and related training documentation. The SMA would also review any appeal and grievance issues related to a restrictive measure.

During the annual external quality organization (EQRO) review process, the individual PIHP's restrictive measures tracking tool is reviewed to ensure timeliness of initial approval and annual renewal. If EQRO discovery indicates out-of-compliance timelines for initial or annual renewal approval, remediation of the identified individual or systems issues takes place with follow-up from the SMA's PIHP Oversight Team. It may or may not need a corrective action plan, but the SMA's PIHP Oversight Team would follow-up in its regular meetings with the PIHP.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

#### b. Use of Restrictive Interventions. *(Select one):*

**The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

**The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

**i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Unless specifically indicated otherwise, all of the information provided applies to restraints, restrictive interventions, and seclusion.

Each request for a restrictive intervention must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request.

Any use of a restrictive intervention that is not within the scope of the state Restrictive Measures Guidelines and Standards is prohibited under any circumstance.

Unauthorized and /or emergency use of restrictive interventions is to be reported as an incident by any person who observes such use or to whom such use is reported by the member. Any report is to be investigated as a member incident.

Review and approval of all restrictive intervention requests is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. Each PIHP's restrictive measures committee reviews and approves each request prior to submission for state level review and approval.

Documentation requirements related to restrictive interventions are specified in the Restrictive Measures Guidelines and Standards. Each restrictive intervention application must specify the monitoring and documentation plan.

Providers are required to report the use of each approved restrictive intervention to the applicable PIHP as indicated in the application.

Quarterly each PIHP reports member data (which includes IHCP data) to the SMA in accordance with the SMA's data reporting specifications.

All individuals involved in the administration of restrictive interventions must be trained by the SMA, a restrictive measures training expert and/or designated competent PIHP/IHCP staff. Restrictive interventions may be approved for less than but no more than one year; a renewal request and review and approval is required prior to the expiration of the previous approval.

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The SMA is responsible for review of each PIHP's monthly incident reports. Upon request for renewal of restrictive measures approval, the member's restrictive measure utilization report will be reviewed to monitor restraint/seclusion trends and to verify the use and effectiveness of approved restraints/seclusion. At a minimum, follow-up consists of a review of the report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data as provided in the PIHP's monthly incident report and/or individual member record reviews, depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the SMA Oversight Team are documented.

PIHPs are required to report any unauthorized use of restraints/seclusion within their member incident management systems.

Data are aggregated to enable comparative analysis of trends/patterns across the PIHPs and data variables. Any concerning trends are examined for quality improvement opportunities.

## Appendix G: Participant Safeguards

### Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

**c. Use of Seclusion.** *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

**The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

**The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

**i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Unless specifically indicated otherwise, all of the information provided applies to restraints, restrictive interventions, and seclusion.

Each application for seclusion must indicate any support strategies or interventions which evidence methods/approaches attempted prior to the request. Any use of seclusion that is not within the scope of the state Guidelines and Standards is prohibited under any circumstance.

Unauthorized and /or emergency use of seclusion is to be reported as an incident by any person who observes such use or to whom such use is reported by the member. Any report is to be investigated as a member incident.

Review and approval of each seclusion request is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel.

Each PIHP's restrictive measures committee reviews and approves each request prior to submission for state level review and approval.

Documentation requirements related to seclusion use are specified in the Restrictive Measures Guidelines and Standards. Each seclusion application must specify the monitoring and documentation plan.

Providers are required to report the use of each approved use of seclusion to the applicable PIHP as indicated in the application.

Quarterly each PIHP reports member data (which includes IHCP data) to the SMA in accordance with the SMA's data reporting specifications.

All individuals involved in the administration of seclusion must be trained by the SMA, a restrictive measures training expert and/or designated competent PIHP/IHCP staff. Seclusion may be approved for less than but no more than one year; a renewal request and review and approval is required prior to the expiration of the previous approval.

**ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is

conducted and its frequency:

The SMA is responsible for review of each PIHP's monthly incident report. Upon request for renewal of restrictive measures approval, the member's restrictive measures utilization report will be reviewed to monitor restraint/seclusion trends and to verify the use and effectiveness of approved restraints/seclusion. At a minimum, follow-up consists of a review of the report with the PIHP. Additional follow-up may include, but is not limited to, examination of individual member data as provided in the PIHP's monthly incident report and/or individual member record reviews, depending on the trends or concerns identified. Remedial or corrective action is determined, as needed, by the Oversight Team. All findings and/or follow-up by the SMA Oversight Team are documented.

PIHPs are required to report any unauthorized use of restraints/seclusion within their member incident management system.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (1 of 2)

*This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.*

**a. Applicability.** Select one:

**No. This Appendix is not applicable** (*do not complete the remaining items*)

**Yes. This Appendix applies** (*complete the remaining items*)

**b. Medication Management and Follow-Up**

**i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

The PIHP interdisciplinary team (IDT) is responsible for monitoring members' medication regimens. The IDT assesses the medication regimens of all members, regardless of residential setting, as part of routine reassessments – at minimum, every six months or whenever there is a significant change in the member's health or functional status. This monitoring is part of the nursing assessment and includes an evaluation of a member's ability to set-up, administer, and monitor their own medication.

When there is a discrepancy between medications prescribed and medications being taken, the IDT nurse is responsible, in accordance with state and professional nursing standards, for clarifying and reinforcing with the member the correct medication regimen.

When a complex medication regimen and /or behavior modifying medication is/are prescribed for a member, the IDT nurse or other appropriately licensed medical professional ensures the member is reassessed, as needed, but at least every six months for the desired responses and possible side effects of the medication, and ensures that all care staff understand the potential benefits and side effects of the medication and that all assessment results and follow-up have been completed and documented in the assessment.

**ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

PIHP nursing staff or other appropriately licensed medical professional is responsible for monitoring the member's medication regimens as part of regular reassessment, at least every six months or more often when there is a significant change in health or functional status. This activity is part of the member's nursing assessment. It includes identifying harmful medication practices such as contraindicated medications, identifying failures to comply with medication regimens, and follow-up with the member, provider staff, prescribers, and other relevant health care providers, as needed.

The PIHP must review, document, and report any medication errors that come to its attention. SMA reviews monthly PIHP incident reports for medication errors, trends, and/or concerns. Identifying insufficient responses to medication errors requires a review and corrective action plan.

When medication errors are the result of nurse error, the Department of Safety and Professional Services (DSPS) completes the oversight and any sanctions. The DSPS communicates its oversight activities related to errors made by nurses to PIHPs via:

- A letter to the nurse's employer(s)
- Posting of Board of Nursing disciplinary actions in the Wisconsin Board of Nursing newsletter

Wisconsin RNs are also required to self-report to DSPS.

PIHPs are contractually required to assure all RNs are duly and fully licensed upon and throughout employment. RNs are to report any licensure changes to the PIHP; failure to do so may be cause for termination.

When specifically directed by the SMA, the EQRO will evaluate PIHP performance related to medication management.

## Appendix G: Participant Safeguards

### Appendix G-3: Medication Management and Administration (2 of 2)

#### c. Medication Administration by Waiver Providers

##### i. Provider Administration of Medications. *Select one:*

**Not applicable.** *(do not complete the remaining items)*

**Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

**ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Providers are required to assess medications a member takes and the member's ability to control and self-administer medications. Providers administer medications to members who have been found incompetent or lack the physical or mental capacity to self-administer as determined by the member's physician, or to members who request in writing that the provider manage and administer medication.

When a service provider is responsible for the administration of medications to a member, there must be a written order from a physician and a properly labeled prescription, including the dosage. Medications given on an as needed basis require a clear definition of the circumstances under which the medication is given. A registered nurse affiliated with or employed by the provider is responsible to assure that staff who assist with the administration of medications are appropriately trained in administration of the medications that are specific to each member. Staff document each medication administration at the time of administration. Documentation of errors takes place as soon as discovered.

Members that have the capacity to self-administer medications do so and their medications remain under their control. The provider makes available a secure place for the storage of medications in the member's room. A member with the mental and physical capacity to develop increased independence in medication administration shall receive self-administration instruction.

**iii. Medication Error Reporting.** *Select one of the following:*

**Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**

*Complete the following three items:*

(a) Specify state agency (or agencies) to which errors are reported:

Providers are required to report medication errors affecting Family Care members to the PIHP. The PIHP must report errors to the Department of Health Services, Division of Medicaid Services.

In addition, providers licensed by the Department of Health Services, Division of Quality Assurance (DQA) have reporting requirements related to the terms of their licensure. The DQA regulates licensed and certified residential facilities including annual onsite monitoring and investigation of complaints and incidents with those facilities.

Providers in a licensed profession may also have license-related reporting requirements enforced by the Department of Safety and Professional Services (DSPS). The DSPS regulates licensed professional nurses, such as LPN, RN, APNP, as well as investigation of complaints for professional misconduct.

(b) Specify the types of medication errors that providers are required to *record*:

PIHPs monitor the performance of contracted providers, including identification of potentially harmful practices. All medication errors (medication omission, wrong medication, wrong dose, wrong time, wrong person, wrong technique, and wrong route) must be recorded by providers at the time of incident discovery.

(c) Specify the types of medication errors that providers must *report* to the state:

PIHPs monitor the performance of contracted providers, including identification of potentially harmful practices. All medication errors (medication omission, wrong medication, wrong dose, wrong time, wrong person, wrong technique, and wrong route) discovered by providers must be reported to the PIHP at the time of incident discovery. Therefore providers do not report medication errors directly to the SMA; incident reports to the SMA are provided monthly by the PIHPs. Any necessary corrective action will be taken by the PIHPs per medication administration standards of practice for each particular type of provider.

The DQA and DSPS have standards for reporting specific to categories of licensure. DQA provides ongoing oversight of provider medication administration practices in regulated facilities and takes appropriate regulatory actions if a pattern of errors are discovered.

**Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

**iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

PIHPs monitor the performance of contracted providers, including identification of potentially harmful practices. All medication errors discovered by providers must be reported to the PIHP at the time of incident discovery. Therefore providers do not report medication errors directly to the SMA. Any necessary corrective action will be taken by the PIHP per medication administration standards of practice for each particular type of provider. In addition, the SMA's Division of Quality Assurance provides ongoing oversight of provider medication administration practices in regulated facilities and takes appropriate regulatory actions if a pattern of errors are discovered.

Incident data reports are provided monthly to the SMA by the PIHP. Incident data is reviewed to identify trends and patterns and support improvement strategies.

The external quality review organization (EQRO) evaluates the performance of PIHPs for appropriate medication management as part of annual quality reviews.

## Appendix G: Participant Safeguards

### Quality Improvement: Health and Welfare

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

#### **a. Methods for Discovery: Health and Welfare**

***The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")***

##### **i. Sub-Assurances:**

***a. Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)***

**Performance Measures**

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

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

**Performance Measure:**

**PIHPs will remediate all substantiated instances of abuse, neglect and/or exploitation.**

**Numerator: Number of substantiated cases of abuse, neglect and/or exploitation for which actions to protect health and welfare were implemented as verified by the SMA.**

**Denominator: Number of substantiated cases of abuse, neglect and/or exploitation reported through the incident management system.**

**Data Source** (Select one):

**Critical events and incident reports**

If 'Other' is selected, specify:

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

	<input style="width: 80%; height: 30px;" type="text"/>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input style="width: 100%; height: 30px;" type="text"/>

**b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

**Performance Measures**

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

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

**Performance Measure:**

**The required investigations of all incidents are completed within required timeframes as specified in the approved waiver. Numerator: Number of incidents that are investigated within required timeframes. Denominator: Number of all incidents that are reported in the incident management system.**

**Data Source (Select one):**

**Critical events and incident reports**

If 'Other' is selected, specify:

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

**Data Aggregation and Analysis:**

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

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

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

**Performance Measures**

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

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

**Performance Measure:**

All SMA approved restrictive interventions are implemented by the PIHP and provider(s) as approved. **Numerator:** Number of properly implemented restrictive interventions based on SMA review. **Denominator:** Number of approved restrictive interventions.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample Confidence</b>

		Interval = <input type="text"/>
<b>Other</b> Specify:  <input type="text" value="PIHP"/>	<b>Annually</b>	<b>Stratified</b> Describe Group:  <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:  <input type="text"/>
	<b>Other</b> Specify:  <input type="text"/>	

**Data Aggregation and Analysis:**

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

**d. Sub-assurance:** *The state establishes overall health care standards and monitors those standards based*

on the responsibility of the service provider as stated in the approved waiver.

**Performance Measures**

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

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

**Performance Measure:**

**PIHPs ensure members 65 and older receive a pneumococcal immunization.**

**Numerator:** Number of members age 65 and older continuously enrolled during the measurement period who have ever received a pneumococcal immunization.

**Denominator:** All members age 65 and older continuously enrolled during the measurement period.

**Data Source** (Select one):

**Record reviews, on-site**

If 'Other' is selected, specify:

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

	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	
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**Data Aggregation and Analysis:**

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">EQRO data validation</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

**Performance Measure:**

**PIHPs ensure members receive influenza immunizations. Numerator: Number of members during the measurement period who receive an influenza immunization. Denominator: All members continuously enrolled during the measurement period.**

**Data Source (Select one):**

**Record reviews, on-site**

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative</b>

		<b>Sample</b> Confidence Interval = <input type="text"/>
<b>Other</b> Specify: <input type="text" value="PIHP"/>	<b>Annually</b>	<b>Stratified</b> Describe Group: <input type="text"/>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify: <input type="text"/>
	<b>Other</b> Specify: <input type="text"/>	

**Data Aggregation and Analysis:**

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the

State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Additional information for the Performance Measure listed under sub-assurance (c) above:

SMA oversight staff will review individual case files at the PIHP to determine if restrictive interventions are being monitored by the PIHP and that the monitoring shows that the interventions are being implemented as approved. This review applies to all waiver populations.

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

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

Providers, members, guardians, and family members are charged with reporting individual problems to the PIHP. This includes the reporting of incidents (including unapproved use of restraints, restrictive interventions, and seclusion); the use of approved restraints, restrictive interventions, and seclusion; and medication errors (these are a subset of incidents).

PIHPs are charged with investigating and remediating individual problems related to incidents; restraints, restrictive interventions, and seclusion; and medication errors as they are discovered. PIHPs are expected to remediate problems based on the nature of the incident and the potential for additional harm or reoccurrence of the problems, with rapid remediation expected in instances carrying the highest risk of harm.

As part of routine oversight, the SMA reviews the incident reports (including medication errors) and reports of incorrect use of approved restraints, restrictive interventions and seclusion submitted by PIHPs and reviews the PIHPs' response to these problems. The SMA reviews any instances discovered by the EQRO during the review process, problems identified in the annual restraints, restrictive interventions, and seclusion review and approval process and any on-site observations made by SMA staff or other potential reporters. If issues with the substance or timeliness of remediation is determined to be deficient, the SMA will review requirements and procedures with the PIHP and may request corrective action if warranted.

**ii. Remediation Data Aggregation**

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

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of data aggregation and analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify:

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

**c. Timelines**

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

**No**

**Yes**

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

**Appendix H: Quality Improvement Strategy (1 of 3)**

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Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

**Quality Improvement Strategy: Minimum Components**

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may

provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

## **Appendix H: Quality Improvement Strategy (2 of 3)**

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### **H-1: Systems Improvement**

#### **a. System Improvements**

- i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The SMA's processes for trending, prioritizing and implementing system improvements that are prompted as a result of analysis of discovery and remediation involve the steps outlined below.

#### 1. Issues at the Individual Issue Level

PIHPs are charged with the day-to-day identification and remediation of individual issues. When the SMA identifies single issues that require remediation, additional action, or oversight, SMA oversight teams review those issues with PIHP staff and managers and develop plans for remediation. If quality concerns are identified, those are addressed with the PIHP and may be elevated to SMA regional or central office managers. Individual issues may be identified through the review of reports submitted by PIHPs, the findings of the external quality review organization (EQRO), and other sources. This process occurs on a continuous basis. Health and safety issues are given priority. Issues that require corrective action are identified in writing by the SMA to the PIHP and the SMA oversight team tracks and documents implementation of the corrective action until the issue is resolved.

#### 2. System Issues at the PIHP Level

When systemic issues are identified within a PIHP, the SMA oversight teams work with the PIHP to develop systemic plans for system improvements at the PIHP. These issues may be identified through the review of reports submitted by PIHPs, the findings of the EQRO as identified above, the receipt of complaints, as well as during annual certification, financial auditing, and review of encounter submissions. This process occurs on a continuous basis in addition to the regularly scheduled reviews and audits. An issue may be identified when multiple records during a review indicate an issue or when similar issues are identified over time during regular reviews of PIHP information.

#### 3. Systemic Issues at the Statewide or Regional Level or Among Multiple PIHPs

When issues that cross multiple PIHPs are identified during the discovery process, the systems improvement activities described above are implemented as appropriate. In addition, the SMA uses a variety of processes to identify trends that require more far-reaching SMA systems improvement activities. The SMA issues technical assistance and policy documents as well as contract changes to address some issues that have been identified among multiple PIHPs.

#### 4. Systemic Issues

Systemic issues that could affect member health and safety or that involve members with high risk due to complex needs are given priority, but issues that address service gaps, affect financial accountability and could impact SMA compliance with waiver assurances are also prioritized for remediation. Issues that require corrective action are identified in writing by the SMA to the PIHP and the SMA oversight team tracks and documents implementation of the corrective action. Significant issues of concern are also addressed by SMA managers with PIHP managers to ensure they are addressed adequately and promptly. Systemic issues may require changes in PIHP policies and procedures, such as additional staff and provider training or the implementation of performance improvement projects.

##### a. Oversight

##### i. SMA PIHP oversight process

The SMA oversight teams for multiple PIHPs are supervised by regional managers who can identify trends across the PIHPs for which they have responsibility. All of the SMA oversight teams meet on a periodic basis to share information about PIHP performance and best practices in relation to PIHP oversight. The SMA regional managers meet regularly with other regional and SMA managers and discuss issues they are seeing that may cross PIHPs or suggest changes to SMA policies and procedures. SMA managers coordinate with managers in the SMA's Bureau of Financial Management and with information systems staff to share information about issues identified in those areas.

##### ii. SMA review of EQRO discovery

The SMA reviews all reports of discovery by the EQRO to identify issues that cross PIHPs and systems. SMA Quality staff identify and analyze issues that affect the overall waiver systems and recommend potential quality improvement strategies. Strategies are prioritized based on the impact of the issue on 1) health and safety; 2) compliance with waiver assurances and other Medicaid requirements; and 3) other SMA quality priorities.

b. Policy

SMA policy staff work with SMA oversight teams and PIHPs regarding interpretation of policy and issues related to policy. Recurring questions or issues brought to these staff are documented, discussed within the unit and brought to management as appropriate. Issues that require an immediate response may be addressed through written policy clarifications, technical assistance documents, or contract amendments. Other issues may require more in-depth analysis and discussion within the SMA and may result in amendments or changes to future contracts.

c. Quality

i. Trending and analysis of performance metrics

The SMA has identified a number of performance metrics that it is tracking and trending over time. Those metrics are available to PIHPs and SMA oversight teams for prompt discussion and to identify successes and areas that need improvement. The metrics are also used by the SMA to compare PIHP performance and to identify program-wide issues. These metrics are relatively new and may be modified over time. The performance metrics are not specified as such in the SMA-PIHP contract although many of them are based on reporting requirements found in the contract, such as influenza and pneumococcal vaccination rates, member survey results and financial reporting. Another group of metrics include the results of reviews conducted by the External Quality Review Organization. They are compiled from various sources into a report for each PIHP.

ii. Analysis of waiver performance measures

Trends and opportunities to improve CMS-reported measures are identified annually when preparing the 372 report and the waiver renewal evidence-based report. Performance indicators yielding below-standard outcomes are identified for process improvement.

iii. Adult Long Term Care Dashboard

The SMA developed a digital Adult Long Term Care Dashboard in 2018 that tracks data such as program enrollment, member living situation, incidents, admissions to institutions of mental disease, use of self-directed services, PIHP staff turnover, continuing skills scores for functional screeners, and ombudsman cases. Data in the dashboard is available to program managers and is updated on a monthly, quarterly, or annual basis as appropriate. Following the creation of the dashboard, implementation of a system for monitoring and identifying quality improvement opportunities based on the trended dashboard data will become part of the overall Quality Improvement Strategy as a tool for identifying real-time concerns requiring further investigation.

iv. Implementation of Medicaid Managed Care Quality Strategy

On June 28, 2018, the SMA submitted the Medicaid Managed Care Quality Strategy to CMS. The strategy includes a three year plan for overall quality improvement efforts that prioritizes projects to address long term care opportunities including and beyond CMS-reported measures. The strategy outlines five goals with corresponding quality measures. These goals address four domains of quality improvement: 1) access to care and member choice, 2) cost-effectiveness, 3) person-centered care and member experience, and 4) health outcomes and reducing disparities. Measures presented in the strategy include and extend beyond regulatory requirements and are operationally defined and collected through the appropriate measurement mechanisms. Enabled by health information technology and data infrastructure innovation, strategies including payment reform, delivery system transformation, and member engagement are employed to reach quality goals. The strategy will be revised and submitted to CMS every three years.

5. Methods of Implementing Quality Improvement Strategies

Quality improvement strategies can be implemented in a variety of ways including:

a. Oversight

- i. Review process for certification and business plan: Some issues may be addressed by modifying SMA criteria for the annual review of certification documentation or the annual PIHP business plans.
- ii. Modification of EQRO review instructions: The periodic reviews conducted by the EQRO can be customized to address a particular issue of concern, both as a vehicle for discovery and as a way to emphasize a particular improvement strategy.
- iii. Focused EQRO reviews: The SMA has the option to assign the EQRO to conduct focused reviews based on discovery of individual or systematic concerns and work with the PIHP(s) on remediation strategies.

b. Policy

- i. Modifications to the contract between the SMA and each PIHP: The contract reflects the requirements and expectations of the SMA for the operation of the waiver. If the nature of the quality issue is one that warrants a contract modification, it can be done by amendment or as part of the next annual contract cycle, depending on the urgency.
- ii. Issuance or modification of technical assistance and policy documents: The SMA issues technical assistance and policy documents on an ongoing basis, as needed, to address a range of issues including improving quality. These documents are sent to the PIHPs and are available to members and providers on the SMA’s website.
- iii. Modification of RFP criteria: The SMA must periodically re-procure for PIHPs. The request for proposal (RFP) process allows the SMA to establish criteria that reinforce quality standards.

c. Quality

- i. Statewide performance improvement projects: The SMA-PIHP contract includes a provision allowing the SMA to mandate a statewide performance improvement project to address an issue that is of program-wide concern. The SMA has not required a statewide improvement project in a number of years, but it remains an option if an area of concern is identified by the SMA.
- ii. Specialized reporting requirements: The SMA can require the PIHPs to submit materials to monitor progress related to a quality issues.

Information specific to Indian members receiving care management from an Indian Health Care Provider (IHCP) can be found in the State-IHCP-PIHP Agreement. The State will utilize corrective action procedures specified in that Agreement for any systems issues identified.

**ii. System Improvement Activities**

<b>Responsible Party</b> <i>(check each that applies):</i>	<b>Frequency of Monitoring and Analysis</b> <i>(check each that applies):</i>
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Quality Improvement Committee</b>	<b>Annually</b>
<b>Other</b> Specify:  <input type="text"/>	<b>Other</b> Specify:  <input type="text"/>

**b. System Design Changes**

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The SMA uses a “Plan, Do, Study, Act” process for quality improvement. Changes that are precipitated by analysis of data collected as a result of discovery activities are monitored using the various discovery methods described elsewhere in this document. These changes undergo the same scrutiny as the processes or policies they are replacing. The SMA staff that monitors and assesses a particular system design change varies with the nature of the change. Fiscal oversight staff monitor and assess changes related to fiscal policies or practices. Contract specialists monitor compliance with contract requirements. Clinical staff (e.g. RN, behavioral health specialist) monitor changes within their scope of practice and expertise. Member care quality specialists monitor changes that directly impact members. Some changes may precipitate a change in the tools used by the EQRO to ensure the data needed to assess a change is being collected.

A change of particular significance may be assessed through a focused review by the EQRO or SMA oversight staff. Because staff work within a team under the direction of leadership within the SMA, they are able to communicate their observations to other members of the team and to SMA managers. The SMA also meets regularly with the EQRO and receives updates on results of any changes as the information is being gathered. The processes for monitoring and assessing systems improvement vary. A major guiding principle is that the same measurement or observation by which the need for improvement was identified should be repeated. For example, the success of a systems improvement change, developed in response to a care plan review finding that identified insufficient documentation of offers of self-direction, is confirmed by another care plan review. The EQRO annual quality reviews routinely include repeat measurements of any indicators that were observed to be less than satisfactory in the previous year.

When systems improvements are implemented with organized performance improvement projects (PIPs), the specifications for monitoring and assessing the implemented change are developed and adopted in compliance with the standards set forth in the CMS protocol for PIPs. When a PIP is undertaken by a single PIHP, the PIHP develops the process and measures for monitoring and assessing system design changes, which are approved by the SMA and annually validated by the EQRO. If the PIP is a statewide project, the process and measures for monitoring and assessing system design changes are selected by the SMA, with the consultation of the EQRO and the PIHPs.

Changes to systems or processes are communicated to the PIHPs through official SMA transmittals such as technical assistance documents or contract amendments. PIHP leaders are alerted to coming changes at regular meetings. The SMA also maintains several electronic sharing mechanisms by which staff in various PIHP functional areas (e.g., provider network, quality, care management) are alerted to changes. The SMA maintains a website that provides information about the Family Care program to the general public, including stakeholders, such as families, providers, agencies and other interested parties. The website includes: general information; program monitoring and evaluation, including Family Care reports; program operations including the PIHP contract, and Family Care requirements.

The results of changes are communicated in many of the same ways. The communication method and frequency depend on the change. Some changes, although precipitated by discovery, are relatively routine (e.g., a change in elements in a fiscal report). The contract between the SMA and PIHPs may include biannual changes, in conjunction with contract review processes. The SMA shares results of such a change internally and with the PIHPs to determine if the change had the desired results. As necessary, the results of more significant changes (e.g., implementation of an automated system for target group identification during the functional screen process) are communicated more broadly. For example, results are presented to the Wisconsin Long Term Care Advisory Council and other interested stakeholder groups.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy is evaluated by the SMA's Quality Strategy Steering Committee on an annual basis to review performance on waiver measures and revisit high level goals linked to the SMA vision, mission, and values of adult long term care programs. The Quality Strategy Steering Committee includes representation from the quality, oversight, and compliance teams, who shape the SMA's direction of continuous improvement and operationalization of processes to measure, analyze, and improve outcomes. The Steering Committee evaluates progress on meeting performance goals, decides a course of action to meet goals not met, and monitors high-level effects of system-wide changes.

EQRO Annual Quality Reviews and activities are periodically reviewed as they relate to the overall Quality Improvement Strategy.

## Appendix H: Quality Improvement Strategy (3 of 3)

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### H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

## Appendix I: Financial Accountability

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### I-1: Financial Integrity and Accountability

**Financial Integrity.** Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a. Each PIHP is required by the SMA contract to submit a financial audit conducted by an external independent CPA to the SMA by June 1 of each year for the prior calendar year ending December 31. The audit must be in accordance with the Generally Accepted Auditing Standards and GAAP (accrual accounting). It must also include compliance testing of program and financial requirements outlined in the SMA Family Care Audit Guide, which includes sampling and testing of payments made for contracted waiver services. The independent CPA audit report requirements include “Letters to Management,” management response/corrective action plan for issues identified in the audit report and/or Letter to Management, and a report on the PIHP internal control environment over financial reporting. The SMA conducts a comprehensive review of the audited financial results and audit report(s) and follows up with the PIHP on identified audit reports and findings, including internal controls and results of compliance testing. Follow up with the PIHP on audit findings requiring corrective action includes additional communications and reporting to the SMA and, as required, steps to show implementation of changes to correct identified deficiencies.

The annual PIHP external independent CPA audits are used as a part of the ongoing SMA fiscal oversight conducted by CPAs staffing that function. The external independent audits are one of many inputs to support the full oversight function.

b. Capitated payments to PIHPs are made through the SMA’s CMS certified MMIS rather than as provider billings, and are prorated based on member actual enrollment dates. The SMA conducts ongoing fiscal oversight of the PIHPs to monitor PIHP reporting of payments made for waiver services. Oversight begins with the annual review and certification of PIHP policies and procedures for claims payments. The criterion established in the SMA review tool includes a description of the PIHP’s process for internal audit of claims payments, whether paid through an in-house claims system or through a Third Party Administrator. Annual review and certification of each PIHP’s policies and procedures is followed by a quarterly review of reported claims payments against PIHP quarterly financial reporting results. Identified issues in either the policy and procedure submission or the quarterly reconciliation of claims payments against financial reporting may result in an audit of claims payments on-site at the PIHP offices. SMA audit procedures include system walkthroughs, sample and tracing of service payments against service authorizations, provider contracts, member eligibility, and actual payment for services received. Findings are identified in an SMA report to the PIHP with SMA-identified corrective action outlined and followed up on to ensure corrective measures are satisfactory and fully implemented. Heightened fiscal and program monitoring is established and continued by the SMA until there is assurance that PIHP payments for services are accurate.

i. At least every three years, each PIHP has an on-site comprehensive financial audit conducted by SMA independent auditors with health care and waiver program expertise staffed by the Wisconsin Office of the Commissioner of Insurance. The audit includes sampling and testing of payments made to contracted providers for waiver services to ensure payments are accurate and for eligible, enrolled members.

ii. PIHP annual independent CPA audits include a requirement for sample and testing of claims payments to ensure systems are in place to accurately pay only contracted providers for waiver services for eligible, enrollment members. Annual audit report submissions by PIHPs to the SMA must include a report of the claim audit results against the SMA defined criteria. Follow up on failure to satisfy the criteria is conducted by the SMA fiscal oversight CPAs to ensure corrective action plans are identified and implemented.

iii. The need for off-cycle audit is identified through comprehensive SMA fiscal oversight and includes review of PIHP financial reporting and system concerns identified through communications related to quality, program operations, internal controls, failure to meet solvency and reserve requirements, and contracted service provider issues. Financial reporting is used to identify solvency concerns, identify financial trend issues, understand unresolved discrepancies, and potential PIHP fiscal operational system concerns. Review of balance sheet changes, payment for member service expense claims payment development, aging of receivables and payables and notes to the financial reporting may be the underlying source used to conduct a targeted or comprehensive audit. In addition, follow up on findings from annual independent CPA audits and findings identified in the established 3-year cycle audits may be followed up on by the SMA through an audit to evidence correction of the finding prior to the next 3-year cycle audit if warranted.

iv. Fiscal corrective action plans are developed by the Division of Medicaid Services within the SMA specific to the identified fiscal deficiency. Development and SMA approval of new procedures to correct a service provider claims processing issue or an internal control deficiency not immediately corrected upon identification. Satisfaction of corrective action plans are evidenced through both required submissions and documentation from the PIHP to the SMA fiscal oversight CPAs and site visits to observe the actual correction based on the specific fiscal finding. Heightened monitoring of PIHP required fiscal submissions are ongoing until the SMA is confident the finding has been satisfied.

v. PIHPs are required to maintain a robust program integrity plan that includes review and audit of provider claims to establish accuracy and to assure procedures are in place to identify potential fraud, waste, and abuse in provider claims. The SMA reviews PIHP program integrity plans as part of the annual certification for contracting and identifies gaps and required corrections in PIHP procedures. Audit of actual service payments occurs as follows: during the annual compliance testing by the independent CPA auditors; during the SMA independent audits conducted on the three year cycle; through required follow-up audits conducted due to identified deficiencies during annual review of the PIHP policies and procedures; and through comparison of financial reporting submissions to reported claims payments submitted to the SMA encounter reporting system.

c. The SMA defines audit requirements and the program-specific audit program is conducted by all auditors in addition to required standard audit procedures that meet the Generally Accepted Audit Standards for the entity. In place are: the three year examination (audit) cycle; targeted audits as required; and annual independent CPA audits that include program compliance audit requirements developed by the SMA. This may include qualified CPAs with expertise in the waiver program compliance requirements, such as staff from the Office of the Commissioner of Insurance, using the SMA-defined audit program requirements. Standard audit procedures and sampling methods specific to the health insurance industry are used with modifications specific to PIHP program operations and contract requirements. The SMA also uses standard sampling and audit procedures for compliance testing of claims payment systems with verification specific to PIHP program operations and contract requirements. Audit sampling uses a combination of traditional random sampling methods used in audit and auditor selection to ensure samples are representative of the area of testing.

Sampling instructions and the required template for the claims audit reporting and completion for external independent CPAs are outlined in the SMA Managed Long-Term Care Audit Guide available on the SMA's website:  
<http://www.dhs.wisconsin.gov/LTCare/ProgramOps/fiscal/index.htm>

The SMA has currently contracted with the OCI to conduct the 3-year cycle audits and the SMA has CPA auditors with specific industry and program expertise to conduct off-cycle and targeted audits.

For services provided by IHCPs, IHCPs submit claims to PIHPs that are included in the approved encounter reporting process and used by the SMA to ensure the integrity of provider billings for Medicaid payment of waiver services. The SMA monitors the costs for waiver services, including self-directed services, in encounter reporting against statewide program experience for similar services to evaluate whether costs are reasonable and to identify areas of concern. The IHCPs submit a comprehensive annual financial audit conducted by an independent CPA firm. IHCPs are required to submit a cost allocation methodology for the SMA's approval prior to the submission of cost reporting. IHCPs submit cost reports to the SMA to demonstrate the IHCP's full costs for providing waiver services to members. The SMA's Office of Inspector General (OIG) and the SMA fiscal oversight CPAs review the annual cost report to validate that: 1) the total costs are consistent with the costs reported on the tribe's comprehensive annual audit; 2) the cost report was developed using the cost allocation methodology approved by the SMA; and 3) that costs reported on the waiver cost report are removed from the IHCP's Federally Qualified Health Center (FQHC) cost report. The SMA requests additional information and/or conducts additional audit sampling and testing work as required to evaluate cost allocation and to further establish compliance with the requirements. Annually, the SMA contracts for an external quality review organization (EQRO) which includes review of a sample of IHCP care plans. The SMA provides a sample of encounter reporting records for the IHCP care plans selected for validation against services rendered and documented in the IHCP care plan notes.

## **Appendix I: Financial Accountability**

### **Quality Improvement: Financial Accountability**

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

#### **a. Methods for Discovery: Financial Accountability Assurance:**

**The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.** (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

##### **i. Sub-Assurances:**

- a. **Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.**  
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

**Performance Measures**

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

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

**Performance Measure:**

**Claims reviewed by independent auditors during required annual audits are in compliance with claims standards. Numerator: Number of claim payments that are found in compliance with claims standards. Denominator: Number of claims payments reviewed by auditors.**

**Data Source (Select one):**

**Financial audits**

If 'Other' is selected, specify:

<b>Responsible Party for data collection/generation</b> (check each that applies):	<b>Frequency of data collection/generation</b> (check each that applies):	<b>Sampling Approach</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>	<b>100% Review</b>
<b>Operating Agency</b>	<b>Monthly</b>	<b>Less than 100% Review</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>	<b>Representative Sample</b> Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">95% with +/- 5% margin of error</div>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">Independent Auditor</div>	<b>Annually</b>	<b>Stratified</b> Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	<b>Continuously and Ongoing</b>	<b>Other</b> Specify:

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

**Data Aggregation and Analysis:**

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

**b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

**Performance Measures**

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

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

**Performance Measure:**

**Capitation payments to PIHPs are made in accordance with CMS approved actuarially sound rate methodology. Numerator: Capitation payments made to PIHPs at the**

**approved rate through the CMS certified MMIS. Denominator: All capitation payments made to PIHPs through the CMS certified MMIS.**

**Data Source (Select one):**

**Other**

*If 'Other' is selected, specify:*

**Monthly Capitation Payment Data**

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

**Data Aggregation and Analysis:**

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

<b>Responsible Party for data aggregation and analysis (check each that applies):</b>	<b>Frequency of data aggregation and analysis (check each that applies):</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <input type="text"/>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <input type="text" value="Biannually (twice per year)"/>

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

The SMA pays a monthly capitation to the PIHP for each member, based on Family Care eligibility criteria. Functional eligibility is documented by using the SMA's automated long-term care functional screen. Financial eligibility is verified and documented by a county income maintenance worker using the SMA's Client Assistance for Re- Employment and Economic Support (CARES) system. The information about functional and financial eligibility is stored in the SMA's CMS-certified MMIS. The SMA's Fiscal Agent makes the monthly capitation payment based on the level of care, eligibility, and enrollment of members as documented in MMIS. No payment can be made for a member who does not have Medicaid eligibility and a level of care assessment that shows that functional eligibility is documented in MMIS for the program. The MMIS system ensures proper coding and payment of PIHP claims through system logic that is reviewed and tested annually and includes retroactive changes to either increase or decrease a capitation payment to reflect changes in eligibility and/or level of care. The system will not provide payment for a member who has lost eligibility or has been terminated from the program for any reason, and will automatically generate retroactive payments and/or recoupment to accommodate lags in information transfer.

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

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

The PIHP is contractually required to perform monthly reconciliation of actual capitation payments received against the PIHP's internal enrollment systems and to perform a "back end" reconciliation of capitation payments against information obtained from the CARES and CMS certified MMIS data systems. The PIHP and SMA work together to identify the cause of and remedy any discrepancies. Manual override of MMIS claims may only be made through the SMA's Fiscal Agent, which requires hard copy documentation to support a change and authorization by designated SMA MMIS representatives. Manual changes may not be made without documentation demonstrating accuracy of the change and authorization by designated SMA Family Care program management. PIHPs reconcile payments received against their records and provide audit and communication of expected vs. paid capitations through a monthly reconciliation process that is contractually required. Unresolved issues requiring manual intervention by the SMA are reported monthly by PIHPs. Review of the PIHP capitation reconciliations and issue resolutions are part of the PIHP compliance audit requirements as outlined in the SMA Managed Long Term Care Audit Guide.

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

<b>Responsible Party</b> (check each that applies):	<b>Frequency of data aggregation and analysis</b> (check each that applies):
<b>State Medicaid Agency</b>	<b>Weekly</b>
<b>Operating Agency</b>	<b>Monthly</b>
<b>Sub-State Entity</b>	<b>Quarterly</b>
<b>Other</b> Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">PIHP</div>	<b>Annually</b>
	<b>Continuously and Ongoing</b>
	<b>Other</b> Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

**c. Timelines**

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

**No**

**Yes**

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

**Appendix I: Financial Accountability**

**I-2: Rates, Billing and Claims (1 of 3)**

**a. Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

*The payment method to reimburse the PIHPs is a per member per month (PMPM) capitation developed by the SMA's contracted actuary to be actuarially sound and submission rate methodology with the CMS managed care rate setting checklist are approved by CMS. Therefore, payment requirements identified in the SMA contract for the provision of member services are incorporated into the above rate development process. The PIHP is responsible for establishing service provider rates for waiver services for which it contracts. The incentive to negotiate and establish competitive rates that result in cost effective services to meet identified member outcomes is critical to the financial viability of the PIHP. The SMA contract with the PIHP outlines the payment requirements for the PIHP with their contracted service providers. In addition, analyses to assess the level of provider rate increases from one year to the next are conducted. The level of provider rate increases allowed to flow into the base costs during the rate setting process has been limited, by policy decision, in prior years to support the development of the trend (this process is described in Section IV of the 2014 capitation rate report: <https://www.dhs.wisconsin.gov/non-dhs/dms/fcratereport2014.pdf>). This analysis and limitation, in conjunction with the contract requirement listed above, represent the SMA's primary oversight mechanisms of the provider rate setting process for waiver services.*

*The SMA's contract with PIHPs contains provisions with respect to the appropriate payment of providers. Given that Family Care is a managed care program, a PIHP has some flexibility in the establishment of its provider fee schedule, as long as it is in compliance with these contract provisions. The SMA works closely with its contracted actuarial firm during the annual capitation rate development process to analyze the full set of encounter data that is submitted by the PIHPs.*

*Analyses are carried out to ensure that the Medicaid fee schedule is being employed where required, per the SMA contract and the CMS managed care rate setting checklist. In addition, analyses to assess the level of provider rate increases from one year to the next are conducted. The level of provider rate increases allowed to flow into the base costs during the rate setting process has been limited, by policy decision, in prior years to support the development of the trend (this process is described in Section IV of the 2014 capitation rate report: <https://www.dhs.wisconsin.gov/non-dhs/dms/fcratereport2014.pdf>). This analysis and limitation, in conjunction with the contract requirement listed above, represent the SMA's primary oversight mechanisms of the provider rate setting process for waiver services.*

*The SMA approves care management rates for care management services provided directly by the PIHP. Care management is a significant and distinct service under the program model. SMA review of the rates is based on PIHP submission of direct costs and allocated costs and include a description of the allocated cost methodology to achieve the proposed unit rate. Total annual projected costs are divided by projected annual units of service to derive a unit cost. In addition, the review and approval includes benchmarking against other PIHP rates and program experience over time for the same internally provided services. PIHP unit rates reflect the PIHP costs associated with the provision of this service based on the SMA contractual requirements. PIHP unit rates for care management are incorporated into the actuarially sound capitation rate methodology.*

*The annual audit process is used to verify actual costs and cost allocation to those services.*

*Indian Health Care Providers (IHCPs) of waiver services receive an initial payment from the PIHP at a rate negotiated between the PIHP and the IHCP. The SMA makes a wraparound payment/recoupment to/from the IHCP for waiver services to Indian members so that the total of the payments the IHCP received from PIHPs, the member, Medicare, third party payers, and the SMA equals the IHCP's full cost of providing waiver services to Indian members. The IHCP's costs for providing waiver services to Indian members will be determined based on cost reports the IHCP submits to the SMA. The SMA will determine the amount of the wraparound payment/recoupment by comparing the IHCP's costs from the cost report to revenue the IHCP received from members, Medicare, third party payers, and the payments the PIHPs made to the IHCP based on Indian member encounter records. The list of Indian members will come from the IHCP and will be cross-referenced against the SMA's Medicaid eligibility files.*

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

PIHPs' authorized waiver services and provider claims are submitted to a contracted third party administrator (TPA) or the PIHP if processing claims in-house. Claims are processed against the PIHP service authorization and against the contracted provider rates.

Each contracted PIHP must develop a compliant TPA process as outlined in the SMA contract with the PIHP. The PIHP is required to have an internal audit process to sample and verify the TPA processes claims in accordance with the authorization and the contracted rates. The SMA validates that this has been done through annual review of PIHP policies and procedures for claims processing and the process is tested during the sampling and audit of services paid during the independent annual audit, 3-year cycle audits, and periodic SMA audits of the PIHP.

Indian Health Care Providers (IHCPs) of waiver services submit claims to the PIHP or the PIHP's contracted TPA to receive payment at the rate negotiated between the PIHP and the IHCP. The IHCP separately submits a cost report to the SMA for the SMA's wraparound payment/recoupment to/from the IHCP.

DHS's Medicaid Management Information System (MMIS) fiscal agent has selected an EVV vendor for Wisconsin. This arrangement allows DHS to maximize integration between the MMIS and EVV system. A general implementation timeline is as follows:

- o Fall 2019 - Provider, payer, member, and participant trainings.
- o Early 2020 - DHS requires providers to utilize EVV for personal care services.
- o Late 2020 - Claims may be denied if EVV is not completed.

## Appendix I: Financial Accountability

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### I-2: Rates, Billing and Claims (2 of 3)

#### c. Certifying Public Expenditures (select one):

**No. state or local government agencies do not certify expenditures for waiver services.**

**Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

#### **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

#### **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

## *I-2: Rates, Billing and Claims (3 of 3)*

**d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Capitated payments to PIHPs are made through the SMA's CMS certified MMIS system, which assures that payments are made only for eligible individuals by validating against the enrollment record for managed care members. The PIHPs authorize services through a member-centered plan and the interdisciplinary team assures that services were delivered. Both the annual financial audit by independent CPA firms and financial audits conducted by independent State auditors include sampling and testing claims payments, as well as verification of eligibility, authorization, and provision of services.

Wraparound payments the SMA makes to Indian Health Care Providers (IHCPs) are eligible for 100% federal financial participation. The wraparound payments/recoupments are limited to those Indian members the IHCP identifies and to services provided to the Indian member while the Indian member was eligible for and enrolled in the Medicaid waiver program.

Annually, the SMA contracts for an external quality review organization (EQRO) review which includes review of a sample of IHCP care plans. Outcome-based care plans identify the service needs that result in service authorizations and encounter records for billed services. The SMA provides a sample of rendered and billed services from the SMA encounter reporting records for validation against individual IHCP service plans.

**e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

## **Appendix I: Financial Accountability**

### *I-3: Payment (1 of 7)*

**a. Method of payments -- MMIS (select one):**

**Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**

**Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

**Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

The SMA's Fiscal Agent maintains eligibility and enrollment information for each member who is enrolled in a PIHP. A capitation payment is made each month by the SMA's Fiscal Agent to the PIHP for each member. Payments are adjusted for partial months of enrollment on a prorated basis.

## Appendix I: Financial Accountability

### I-3: Payment (2 of 7)

**b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

**The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**

**The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

**The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

**Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Not applicable. All waiver services are included in the SMA's contract with the PIHP.

## Appendix I: Financial Accountability

### I-3: Payment (3 of 7)

**c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

**No. The state does not make supplemental or enhanced payments for waiver services.**

**Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

## Appendix I: Financial Accountability

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### I-3: Payment (4 of 7)

**d. Payments to state or Local Government Providers.** Specify whether state or local government providers receive payment for the provision of waiver services.

**No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.

**Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

PIHPs can be departments within a county government, government districts, public entities, private for-profit entities, or private non-profit entities. PIHPs are direct providers of care management services. Therefore, payments for care management services can be made to government, public, and private (for profit and non-profit) providers for care management services.

The underlying entity type differs but there is no difference in the operation of the program contracted by the SMA or the contract requirements for the PIHPs. A county government PIHP would be operated by a single county but structured as a separate department of the county and operated as a separate enterprise. Although the county has taxing authority, the contracted PIHP would be at risk for the program operated by the county. There is currently not a county government PIHP under contract with the SMA.

Districts were created through statute by groups of counties with the specific purpose of operating the SMA contracted program. Districts do not have taxing authority and the counties that formed the districts do not bear financial risk at the county level. PIHPs operated under a district are risk bearing and operated as private enterprises. There are currently no districts operating PIHPs under contract with the SMA.

The public entity PIHP, a private for-profit entity, the private non-profit 501(c)(3), and the private non-profit 501(c)(4) are operated no differently from the county or district PIHPs. Regardless of entity type, all contracted PIHPs are risk bearing and required by contract to keep funds and accounting segregated from other operations, whether county, district, public, or private.

The SMA fiscal oversight function includes review of required financial reporting submissions to include both contracted PIHP operations and other operations to support the review and validation that capitation payments are segregated and used to support payments for waiver members' contracted Medicaid services and the infrastructure required to support those services.

## Appendix I: Financial Accountability

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### I-3: Payment (5 of 7)

**e. Amount of Payment to State or Local Government Providers.**

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

**The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.**

*The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.*

*The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.*

Describe the recoupment process:

## **Appendix I: Financial Accountability**

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### **I-3: Payment (6 of 7)**

**f. Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

*Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.*

*Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.*

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

*The monthly capitated payment to PIHPs is not reduced or returned in part to the SMA in any way that results in a disparity between the amount that is claimed to CMS and the amounts actually paid to PIHPs.*

## **Appendix I: Financial Accountability**

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### **I-3: Payment (7 of 7)**

**g. Additional Payment Arrangements**

**i. Voluntary Reassignment of Payments to a Governmental Agency.** Select one:

*No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.*

*Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).*

Specify the governmental agency (or agencies) to which reassignment may be made.

**ii. Organized Health Care Delivery System.** Select one:

*No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.*

*Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under*

*the provisions of 42 CFR §447.10.*

*Specify the following: (a) the entities that are designated as an OHCDs and how these entities qualify for designation as an OHCDs; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:*

**iii. Contracts with MCOs, PIHPs or PAHPs.**

***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

*Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.*

***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

## **Appendix I: Financial Accountability**

### **I-4: Non-Federal Matching Funds (1 of 3)**

**a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

***Appropriation of State Tax Revenues to the State Medicaid agency***

***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

*If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:*

**Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

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**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (2 of 3)**

**b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

*Not Applicable.* There are no local government level sources of funds utilized as the non-federal share.

**Applicable**

Check each that applies:

**Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

**Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

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**Appendix I: Financial Accountability**

**I-4: Non-Federal Matching Funds (3 of 3)**

**c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

*None of the specified sources of funds contribute to the non-federal share of computable waiver costs*

**The following source(s) are used**

Check each that applies:

**Health care-related taxes or fees**

**Provider-related donations**

**Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

## **Appendix I: Financial Accountability**

### **I-5: Exclusion of Medicaid Payment for Room and Board**

**a. Services Furnished in Residential Settings. Select one:**

**No services under this waiver are furnished in residential settings other than the private residence of the individual.**

**As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

**b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:**

*PIHPs are required to exclude room and board from the cost of allowable waiver services. Payments to providers for room and board are not processed through the Medicaid system and are, therefore, not included in any Medicaid cost reports. The waiver member pays the room and board obligation from the waiver member's funds.*

*The waiver member's room and board obligation is the lesser of:*

- HUD FMR rental amounts based on residential type plus the maximum Supplemental Nutrition Assistance Allocation for one person; or*
- SSI-E benefit amount less \$100 personal needs allowance; or*
- The amount of funds the PIHP has determined the waiver member has available using procedures specified by the SMA.*

## **Appendix I: Financial Accountability**

### **I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver**

**Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:**

**No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**

**Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

*The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method*

used to reimburse these costs:

**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)**

**a. Co-Payment Requirements.** Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:

**No.** The state does not impose a co-payment or similar charge upon participants for waiver services.

**Yes.** The state imposes a co-payment or similar charge upon participants for one or more waiver services.

**i. Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

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**Charges Associated with the Provision of Waiver Services** (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

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*Nominal deductible*

*Coinsurance*

*Co-Payment*

*Other charge*

Specify:

**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)**

**a. Co-Payment Requirements.**

**ii. Participants Subject to Co-pay Charges for Waiver Services.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**

**a. Co-Payment Requirements.**

**iii. Amount of Co-Pay Charges for Waiver Services.**

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**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

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**Appendix I: Financial Accountability**

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**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)**

**a. Co-Payment Requirements.**

**iv. Cumulative Maximum Charges.**

**Answers provided in Appendix I-7-a indicate that you do not need to complete this section.**

**Appendix I: Financial Accountability**

**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)**

**b. Other State Requirement for Cost Sharing.** Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

**No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**

**Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

**Appendix J: Cost Neutrality Demonstration**

**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

**Composite Overview.** Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

**Level(s) of Care: Nursing Facility, ICF/IID**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	27018.64	9674.22	36692.86	75282.21	3941.75	79223.96	42531.10
2	27500.76	9905.59	37406.35	76782.13	4036.02	80818.15	43411.80
3	28091.66	10177.39	38269.05	78581.40	4146.76	82728.16	44459.11
4	28684.08	10453.83	39137.91	80401.19	4259.40	84660.59	45522.68
5	29363.18	10763.83	40127.01	82462.65	4385.71	86848.36	46721.35

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (1 of 9)**

**a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

*Table: J-2-a: Unduplicated Participants*

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	ICF/IID
Year 1	65311	45456	19855
Year 2	67531	46738	20793
Year 3	69707	47990	21717
Year 4	71840	49212	22628
Year 5	73973	50440	23533

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (2 of 9)**

**b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average Length of Stay is calculated by dividing the total number of projected enrollment days for the year by the number of projected unduplicated participants served during the year.

The total number of enrollment days for the year is calculated by summing the product of each month's projected enrollment multiplied by the number of calendar days in each month. Monthly projected enrollment is generally based on historical enrollment experience in the Family Care and Partnership programs. Additional capacity is added to ensure Factor C is not exceeded in the event of unforeseen enrollment spikes. The Family Care waiver is available statewide as of 7/1/2018; however, there are eight counties that have not reached entitlement yet. Some of these counties have waitlists from the legacy waivers. In counties that have people on a waitlist, projected enrollment is based on the number of people remaining on the legacy waiver waitlist multiplied by the proportion of eligible individuals that have chosen to enroll in the Family Care waiver.

Persons on a waitlist are assumed to be enrolled evenly over 36 months. The State has enrolled persons from waitlists in expanding counties evenly over 36 months since May 2009. Counties are required to submit a transition plan for State approval, which includes a requirement that the waitlist population be enrolled evenly over 36 months. The Department has communicated to ADRCs the current number of individuals previously enrolled in the waivers or on the waitlist to provide an estimate of the total number of individuals who will receive enrollment counseling at the ADRC by the end of the 36 month period.

The number of unduplicated participants served during the year is calculated by adding the number of members expected to disenroll during the year to the projected participant count at the end of the year. A churn factor based on the waiver's historical monthly disenrollment rate is applied to the projected monthly member count to calculate the number of members projected to disenroll each month. The sum of the monthly disenrollments is then added to the projected member count at year end to arrive at the total number of unduplicated participants served during the year.

**Appendix J: Cost Neutrality Demonstration**

**J-2: Derivation of Estimates (3 of 9)**

**c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

**i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

*The Factor D estimate is generally based on actual 10/1/2017 - 9/30/2018 Family Care service costs from encounter data for members at the Nursing Home level of care, which includes costs for both the ICF-IID and Nursing Facility populations. This is the most recent 12 month period of complete encounter data. The term "Nursing Home level of care" used here is defined as a broader term referring to waiver eligibility determined by the State's Long-Term Care Functional Screen. It does not refer to a specific type of facility or target group. This is a different definition than the term used to describe "level of care" in the 1915(c) waiver.*

*Housing Counseling is based on 10/1/2018 - 12/31/2018 encounters. This is an infrequently utilized and low cost service. No encounters were reported for this service during the base period, so a different period had to be used.*

*The 10/1/2017 - 9/30/2018 encounter data includes data for members in all counties, which gives a more complete picture of the Family Care waiver cost structure compared with the CY2013 encounter data used as the source for the previous waiver renewal, when the program was not yet operating statewide.*

*All service costs are trended forward at average annual rates of 0.8% in CY2018, 4.3% in CY2019, and 2.0% in CY2020 (Year 1) - CY2024 (Year 5) based on costs and trends in the Family Care rate setting model and the State budget. Actual CY2018 and CY2019 trends are included, so projections can be tracked back to the source data. The unduplicated participant count in the derivation is projected using the same method to derive Average Length of Stay as described above. The Family Care benefit package also includes services covered under the State Medicaid plan. These costs are included in the calculation of Factor D'.*

*The number of users for each service is calculated by multiplying the user percentage for each service by the projected unduplicated participants for each waiver year. The user percentage is based on the number of users for each service in the 10/1/2017 - 9/30/2018 base period encounter data divided by the number of unduplicated participants in the base period. User percentages are held constant for the projected waiver years as utilization patterns are not expected to change.*

*Total costs and total units are pulled from the 10/1/2017 - 9/30/2018 base period encounter data and grouped by service. The total costs and units for each service are divided by member days in the base period to arrive at the baseline average service cost per member per day and average units per member per day.*

*To calculate projected total cost for each waiver year, the base period daily service costs per member are trended forward using the trend factors found in the Family Care rate setting model and State budget and then multiplied by the projected member days for each waiver year.*

*Average cost per unit is calculated by dividing projected total costs for each waiver year as described above by the projected total units each year for each service. To calculate total units, the average units per member per day for each service from the base data are multiplied by the projected member days for each year. No trend factors are applied to average units per member per day as utilization patterns are assumed to remain constant.*

*Average units per user for each service is calculated by dividing the projected units for each service by the number of users for each service. Derivations for total units and number of service users are described above.*

- ii. **Factor D' Derivation.** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*Factor D' is based on actual 10/1/2017 - 9/30/2018 service costs paid by the State Medicaid plan for Family Care members at the Nursing Home Level of Care. State plan service costs in Factor D' that are not included in the capitation payment are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. The portion of Factor D' related to State plan services included in the capitation payment is from encounter data certified by PIHPs. The cost of prescribed drugs furnished to Medicare / Medicaid dual eligible members under the provisions of Part D are not included in the estimate. Costs for both the ICF-IID and Nursing Facility populations are included.*

*The term "Nursing Home level of care" used here is defined as a broader term which refers to waiver eligibility determined by the State's Long-Term Care Functional Screen. It does not refer to a specific type of facility or target group. This is a different definition than the term used to describe "level of care" in the 1915(c) waiver.*

*Average cost per member is trended forward at an annual rate of 2.6% using the Consumer Price Index for Medical Care. The trend for each factor is applied consistently in all five years.*

*The unduplicated participant count used in the derivation is projected using the same method to derive Average Length of Stay as described above.*

iii. **Factor G Derivation.** *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*Factor G is based on a blend of 10/1/2017 - 9/30/2018 Medicaid institutional costs for individuals residing in ICFs-IID, State Centers, and Nursing Facilities to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS.*

*Costs are trended forward at an annual rate of 2.2% using the Consumer Price Index for All Items. The trend for each factor is applied consistently in all five years.*

*The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay between the institutional populations versus the Family Care waiver population. The average length of stay (ALOS) in the institutional population base data is 253 days. The ALOS for the waiver population is 301.9 days in CY2020 (Year 1), 301.3 days in CY2021 (Year 2), 301.7 days in CY2022 (Year 3), 302.1 days in CY2023 (Year 4), and 303.1 in CY2024 (Year 5). With the institutional population having a lower ALOS, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional population are adjusted by the ratio of the institutional ALOS to the waiver ALOS. This has the effect of increasing Factors G and G' by 19% to 20% depending on the ALOS in the waiver population for the year. **Factor G is higher by \$12,192 in Year 1; \$12,303 in Year 2; \$12,684 in Year 3; \$13,054 in Year 4; and \$13,634 in Year 5 than it would be without the adjustment for ALOS.***

iv. **Factor G' Derivation.** *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

*Factor G' is based on a blend of 10/1/2017 - 9/30/2018 Medicaid non-institutional costs for individuals residing in ICFs-IID, State Centers, and Nursing Facilities to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS.*

*Costs are trended forward at an annual rate of 2.6% using the Consumer Price Index for Medical Care. The trend for each factor is applied consistently in all five years.*

*The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay between the institutional populations versus the Family Care waiver population. The average length of stay (ALOS) in the institutional population base data is 253 days. The ALOS for the wavier population is 301.9 days in CY2020 (Year 1), 301.3 days in CY2021 (Year 2), 301.7 days in CY2022 (Year 3), 302.1 days in CY2023 (Year 4), and 303.1 in CY2024 (Year 5). With the institutional population having a lower ALOS, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional population are adjusted by the ratio of the institutional ALOS to the wavier ALOS. This has the effect of increasing Factors G and G' by 19% to 20% depending on the ALOS in the waiver population for the year. Factor G' is higher by \$638 in Year 1, \$647 in Year 2, \$669 in Year 3, \$692 in Year 4, and \$725 in Year 5 than it would be without the adjustment for ALOS.*

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (4 of 9)

**Component management for waiver services.** If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Adult Day Care Services	
Care Management	
Daily Living Skills Training	
Day Habilitation Services	
Prevocational Services	
Respite	
Supported Employment - Individual Employment Support	
Consumer Directed Supports (Self-Directed Supports) Broker	
Financial Management Services	
Adaptive aids	
Adult residential care - 1-2 bed adult family homes	
Adult Residential Care - 3-4 Bed Adult Family Homes	
Adult Residential Care - Community-Based Residential Facilities (CBRF)	
Adult Residential Care - Residential Care Apartment Complexes (RCAC)	
Assistive Technology/Communication aids	
Consultative Clinical and Therapeutic Services for Caregivers	
Consumer Education and Training	
Counseling and Therapeutic Resources	
Environmental Accessibility Adaptations (Home Modifications)	
Home Delivered Meals	
Housing Counseling	
Personal Emergency Response Systems (PERS)	
Relocation services	
Self-Directed Personal Care	

Waiver Services	
Skilled Nursing Services RN/LPN	
Specialized Medical Equipment and Supplies	
Supported Employment - Small Group Employment Support	
Supportive Home Care	
Training Services for Unpaid Caregivers	
Transportation (Specialized Transportation) - Community Transportation	
Transportation (Specialized Transportation) - Other Transportation	
Vocational Futures Planning and Support	

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (5 of 9)

#### d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 1

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Care Services Total:</b>							16136228.58
Adult Day Care Services		Hours	2252	688.97	10.40	16136228.58	
<b>Care Management Total:</b>							194228221.11
Care Management		Hours	50621	49.83	77.00	194228221.11	
<b>Daily Living Skills Training Total:</b>							3853745.75
Daily Living Skills Training		Hours	841	201.51	22.74	3853745.75	
<b>Day Habilitation Services Total:</b>							77835806.79
Day Habilitation Services		Hours	7309	800.70	13.30	77835806.79	
<b>Prevocational Services Total:</b>							42566575.12
Prevocational Services		Hours	6239	604.31	11.29	42566575.12	
<b>Respite Total:</b>							9156418.58
Respite		Hours	2017	316.35	14.35	9156418.58	
<b>GRAND TOTAL:</b>							1764614524.96
Total: Services included in capitation:							1764614524.96
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							65311
Factor D (Divide total by number of participants):							27018.64
Services included in capitation:							27018.64
Services not included in capitation:							
Average Length of Stay on the Waiver:							302

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Supported Employment - Individual Employment Support Total:</b>							10791221.66
Supported Employment - Individual Employment Support		Hours	2453	189.05	23.27	10791221.66	
<b>Consumer Directed Supports (Self-Directed Supports) Broker Total:</b>							393016.78
Consumer Directed Supports (Self-Directed Supports) Broker		Hours	610	18.19	35.42	393016.78	
<b>Financial Management Services Total:</b>							14550946.85
Financial Management Services		Hours	22764	14.17	45.11	14550946.85	
<b>Adaptive aids Total:</b>							1341762.52
Adaptive aids		Items	3412	6.91	56.91	1341762.52	
<b>Adult residential care - 1-2 bed adult family homes Total:</b>							147699848.27
Adult residential care - 1-2 bed adult family homes		Days	2701	264.58	206.68	147699848.27	
<b>Adult Residential Care - 3-4 Bed Adult Family Homes Total:</b>							368075753.16
Adult Residential Care - 3-4 Bed Adult Family Homes		Days	7375	301.69	165.43	368075753.16	
<b>Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:</b>							414923445.63
Adult Residential Care - Community-Based Residential Facilities (CBRF)		Days	15826	260.33	100.71	414923445.63	
<b>Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:</b>							49883649.53
Adult Residential Care - Residential Care Apartment Complexes (RCAC)		Days	3294	241.22	62.78	49883649.53	
<b>Assistive Technology/Communication aids Total:</b>							145908.67
Assistive Technology/Communication aids		Items	375	28.38	13.71	145908.68	
<b>Consultative Clinical and Therapeutic Services for Caregivers Total:</b>							36989.89
Consultative Clinical and Therapeutic Services for		Hours	49	41.73	18.09	36989.89	
<b>GRAND TOTAL:</b>							1764614524.96
Total: Services included in capitation:							1764614524.96
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							65311
Factor D (Divide total by number of participants):							27018.64
Services included in capitation:							27018.64
Services not included in capitation:							
Average Length of Stay on the Waiver:							302

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregivers							
<b>Consumer Education and Training Total:</b>							677087.95
Consumer Education and Training		Hours	143	153.68	30.81	677087.95	
<b>Counseling and Therapeutic Resources Total:</b>							1134642.17
Counseling and Therapeutic Resources		Hours	1320	29.94	28.71	1134642.17	
<b>Environmental Accessibility Adaptations (Home Modifications) Total:</b>							1771366.15
Environmental Accessibility Adaptations (Home Modifications)		Projects	786	3.55	634.83	1771366.15	
<b>Home Delivered Meals Total:</b>							5896684.49
Home Delivered Meals		Meals	4381	158.91	8.47	5896684.49	
<b>Housing Counseling Total:</b>							1573.96
Housing Counseling		Hours	1	26.36	59.71	1573.96	
<b>Personal Emergency Response Systems (PERS) Total:</b>							1942436.45
Personal Emergency Response Systems (PERS)		Month	7904	8.93	27.52	1942436.45	
<b>Relocation services Total:</b>							231046.66
Relocation services		Projects	359	1.20	536.32	231046.66	
<b>Self-Directed Personal Care Total:</b>							322755.77
Self-Directed Personal Care		Hours	25	975.83	13.23	322755.77	
<b>Skilled Nursing Services RN/LPN Total:</b>							4326255.15
Skilled Nursing Services RN/LPN		Hours	193	688.87	32.54	4326255.15	
<b>Specialized Medical Equipment and Supplies Total:</b>							2050814.49
Specialized Medical Equipment and Supplies		Items	10409	386.32	0.51	2050814.49	
<b>Supported Employment - Small Group Employment Support Total:</b>							2010063.10
Supported Employment - Small Group Employment Support		Hours	501	334.90	11.98	2010063.10	
<b>GRAND TOTAL:</b>							1764614524.96
Total: Services included in capitation:							1764614524.96
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							65311
Factor D (Divide total by number of participants):							27018.64
Services included in capitation:							27018.64
Services not included in capitation:							
Average Length of Stay on the Waiver:							302

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Supportive Home Care Total:</b>							<b>353589056.59</b>
Supportive Home Care	<input type="checkbox"/>	Hours	27736	783.07	16.28	353589056.59	
<b>Training Services for Unpaid Caregivers Total:</b>							<b>158853.83</b>
Training Services for Unpaid Caregivers	<input type="checkbox"/>	Hours	812	10.34	18.92	158853.83	
<b>Transportation (Specialized Transportation) - Community Transportation Total:</b>							<b>38312461.59</b>
Community Transportation	<input type="checkbox"/>	Trips	17955	162.39	13.14	38312461.59	
<b>Transportation (Specialized Transportation) - Other Transportation Total:</b>							<b>530512.78</b>
Transportation (Specialized Transportation) - Other Transportation	<input type="checkbox"/>	Trips	1018	19.71	26.44	530512.78	
<b>Vocational Futures Planning and Support Total:</b>							<b>39374.93</b>
Vocational Futures Planning and Support	<input type="checkbox"/>	Hours	27	23.27	62.67	39374.93	
<b>GRAND TOTAL:</b>							<b>1764614524.96</b>
Total: Services included in capitation:							1764614524.96
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							65311
Factor D (Divide total by number of participants):							27018.64
Services included in capitation:							27018.64
Services not included in capitation:							
Average Length of Stay on the Waiver:							<input type="text" value="302"/>

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (6 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 2

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Care Services Total:</b>							<b>16983034.01</b>
<b>GRAND TOTAL:</b>							<b>1857153728.64</b>
Total: Services included in capitation:							1857153728.64
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							67531
Factor D (Divide total by number of participants):							27500.76
Services included in capitation:							27500.76
Services not included in capitation:							
Average Length of Stay on the Waiver:							<input type="text" value="301"/>

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Services		Hours	2328	687.57	10.61	16983034.01	
<b>Care Management Total:</b>							204437080.02
Care Management		Hours	52342	49.73	78.54	204437080.02	
<b>Daily Living Skills Training Total:</b>							4059002.40
Daily Living Skills Training		Hours	870	201.10	23.20	4059002.40	
<b>Day Habilitation Services Total:</b>							81943421.90
Day Habilitation Services		Hours	7557	799.07	13.57	81943421.90	
<b>Prevocational Services Total:</b>							44818203.80
Prevocational Services		Hours	6451	603.08	11.52	44818203.80	
<b>Respite Total:</b>							9641480.32
Respite		Hours	2086	315.71	14.64	9641480.32	
<b>Supported Employment - Individual Employment Support Total:</b>							11358501.90
Supported Employment - Individual Employment Support		Hours	2537	188.67	23.73	11358501.90	
<b>Consumer Directed Supports (Self-Directed Supports) Broker Total:</b>							413784.24
Consumer Directed Supports (Self-Directed Supports) Broker		Hours	631	18.15	36.13	413784.24	
<b>Financial Management Services Total:</b>							15313384.99
Financial Management Services		Hours	23538	14.14	46.01	15313384.99	
<b>Adaptive aids Total:</b>							1413122.76
Adaptive aids		Items	3528	6.90	58.05	1413122.76	
<b>Adult residential care - 1-2 bed adult family homes Total:</b>							155409064.54
Adult residential care - 1-2 bed adult family homes		Days	2792	264.04	210.81	155409064.54	
<b>Adult Residential Care - 3-4 Bed Adult Family Homes Total:</b>							387420260.03
Adult Residential Care - 3-4						387420260.03	

**GRAND TOTAL:**

1857153728.64

Total: Services included in capitation:

1857153728.64

Total: Services not included in capitation:

Total Estimated Unduplicated Participants:

67531

Factor D (Divide total by number of participants):

27500.76

Services included in capitation:

27500.76

Services not included in capitation:

Average Length of Stay on the Waiver:

301

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Bed Adult Family Homes		Days	7626	301.07	168.74		
<b>Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:</b>							436673752.13
Adult Residential Care - Community-Based Residential Facilities (CBRF)		Days	16363	259.80	102.72	436673752.13	
<b>Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:</b>							52499886.11
Adult Residential Care - Residential Care Apartment Complexes (RCAC)		Days	3406	240.73	64.03	52499886.11	
<b>Assistive Technology/Communication aids Total:</b>							153218.56
Assistive Technology/Communication aids		Items	387	28.32	13.98	153218.56	
<b>Consultative Clinical and Therapeutic Services for Caregivers Total:</b>							39181.16
Consultative Clinical and Therapeutic Services for Caregivers		Hours	51	41.64	18.45	39181.16	
<b>Consumer Education and Training Total:</b>							708555.41
Consumer Education and Training		Hours	147	153.36	31.43	708555.41	
<b>Counseling and Therapeutic Resources Total:</b>							1194219.94
Counseling and Therapeutic Resources		Hours	1365	29.88	29.28	1194219.94	
<b>Environmental Accessibility Adaptations (Home Modifications) Total:</b>							1863604.29
Environmental Accessibility Adaptations (Home Modifications)		Projects	813	3.54	647.53	1863604.29	
<b>Home Delivered Meals Total:</b>							6199901.60
Home Delivered Meals		Meals	4530	158.59	8.63	6199901.60	
<b>Housing Counseling Total:</b>							1602.54
Housing Counseling		Hours	1	26.31	60.91	1602.54	
<b>Personal Emergency Response Systems (PERS) Total:</b>							2046391.70
Personal Emergency Response Systems (PERS)		Month	8173	8.92	28.07	2046391.70	
<b>GRAND TOTAL:</b>							1857153728.64
Total: Services included in capitation:							1857153728.64
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							67531
Factor D (Divide total by number of participants):							27500.76
Services included in capitation:							27500.76
Services not included in capitation:							
Average Length of Stay on the Waiver:							301

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Relocation services Total:</b>							244203.12
Relocation services		Projects	372	1.20	547.05	244203.12	
<b>Self-Directed Personal Care Total:</b>							341568.15
Self-Directed Personal Care		Hours	26	973.85	13.49	341568.15	
<b>Skilled Nursing Services RN/LPN Total:</b>							4563425.86
Skilled Nursing Services RN/LPN		Hours	200	687.47	33.19	4563425.86	
<b>Specialized Medical Equipment and Supplies Total:</b>							2157774.85
Specialized Medical Equipment and Supplies		Items	10763	385.54	0.52	2157774.85	
<b>Supported Employment - Small Group Employment Support Total:</b>							2115599.23
Supported Employment - Small Group Employment Support		Hours	518	334.22	12.22	2115599.23	
<b>Supportive Home Care Total:</b>							372027305.10
Supportive Home Care		Hours	28678	781.48	16.60	372027305.10	
<b>Training Services for Unpaid Caregivers Total:</b>							167108.66
Training Services for Unpaid Caregivers		Hours	839	10.32	19.30	167108.66	
<b>Transportation (Specialized Transportation) - Community Transportation Total:</b>							40345914.70
Community Transportation		Trips	18565	162.06	13.41	40345914.70	
<b>Transportation (Specialized Transportation) - Other Transportation Total:</b>							558616.39
Transportation (Specialized Transportation) - Other Transportation		Trips	1053	19.67	26.97	558616.39	
<b>Vocational Futures Planning and Support Total:</b>							41558.23
Vocational Futures Planning and Support		Hours	28	23.22	63.92	41558.23	
<b>GRAND TOTAL:</b>							1857153728.64
Total: Services included in capitation:							1857153728.64
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							67531
Factor D (Divide total by number of participants):							27500.76
Services included in capitation:							27500.76
Services not included in capitation:							
Average Length of Stay on the Waiver:							301

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (7 of 9)

**d. Estimate of Factor D.**

**ii. Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 3**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Care Services Total:</b>							17902096.72
Adult Day Care Services		Hours	2403	688.53	10.82	17902096.72	
<b>Care Management Total:</b>							215547506.86
Care Management		Hours	54029	49.80	80.11	215547506.86	
<b>Daily Living Skills Training Total:</b>							4278868.89
Daily Living Skills Training		Hours	898	201.39	23.66	4278868.89	
<b>Day Habilitation Services Total:</b>							86393185.51
Day Habilitation Services		Hours	7801	800.19	13.84	86393185.51	
<b>Prevocational Services Total:</b>							47252663.54
Prevocational Services		Hours	6659	603.92	11.75	47252663.54	
<b>Respite Total:</b>							10162417.28
Respite		Hours	2153	316.15	14.93	10162417.28	
<b>Supported Employment - Individual Employment Support Total:</b>							11974719.70
Supported Employment - Individual Employment Support		Hours	2618	188.93	24.21	11974719.70	
<b>Consumer Directed Supports (Self-Directed Supports) Broker Total:</b>							436126.38
Consumer Directed Supports (Self-Directed Supports) Broker		Hours	651	18.18	36.85	436126.38	
<b>Financial Management Services Total:</b>							16146056.25
Financial Management Services		Hours	24297	14.16	46.93	16146056.25	
<b>GRAND TOTAL:</b>							1958185490.65
Total: Services included in capitation:							1958185490.65
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							69707
Factor D (Divide total by number of participants):							28091.66
Services included in capitation:							28091.66
Services not included in capitation:							
Average Length of Stay on the Waiver:							302

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adaptive aids Total:</b>							1490091.89
Adaptive aids		Items	3642	6.91	59.21	1490091.89	
<b>Adult residential care - 1-2 bed adult family homes Total:</b>							163859229.19
Adult residential care - 1-2 bed adult family homes		Days	2882	264.41	215.03	163859229.19	
<b>Adult Residential Care - 3-4 Bed Adult Family Homes Total:</b>							408435359.71
Adult Residential Care - 3-4 Bed Adult Family Homes		Days	7871	301.50	172.11	408435359.72	
<b>Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:</b>							460415062.11
Adult Residential Care - Community-Based Residential Facilities (CBRF)		Days	16891	260.17	104.77	460415062.11	
<b>Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:</b>							55356894.46
Adult Residential Care - Residential Care Apartment Complexes (RCAC)		Days	3516	241.07	65.31	55356894.46	
<b>Assistive Technology/Communication aids Total:</b>							161765.44
Assistive Technology/Communication aids		Items	400	28.36	14.26	161765.44	
<b>Consultative Clinical and Therapeutic Services for Caregivers Total:</b>							41594.08
Consultative Clinical and Therapeutic Services for Caregivers		Hours	53	41.70	18.82	41594.08	
<b>Consumer Education and Training Total:</b>							748413.77
Consumer Education and Training		Hours	152	153.58	32.06	748413.77	
<b>Counseling and Therapeutic Resources Total:</b>							1258816.38
Counseling and Therapeutic Resources		Hours	1409	29.92	29.86	1258816.38	
<b>Environmental Accessibility Adaptations (Home Modifications) Total:</b>							1967206.66
Environmental Accessibility Adaptations (Home Modifications)		Projects	839	3.55	660.48	1967206.66	
<b>GRAND TOTAL:</b>							1958185490.65
Total: Services included in capitation:							1958185490.65
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							69707
Factor D (Divide total by number of participants):							28091.66
Services included in capitation:							28091.66
Services not included in capitation:							
Average Length of Stay on the Waiver:							302

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Home Delivered Meals Total:</b>							6542266.88
Home Delivered Meals		Meals	4676	158.81	8.81	6542266.88	
<b>Housing Counseling Total:</b>							1636.24
Housing Counseling		Hours	1	26.34	62.12	1636.24	
<b>Personal Emergency Response Systems (PERS) Total:</b>							2156797.53
Personal Emergency Response Systems (PERS)		Month	8436	8.93	28.63	2156797.53	
<b>Relocation services Total:</b>							257121.79
Relocation services		Projects	384	1.20	557.99	257121.79	
<b>Self-Directed Personal Care Total:</b>							348891.13
Self-Directed Personal Care		Hours	26	975.21	13.76	348891.13	
<b>Skilled Nursing Services RN/LPN Total:</b>							4801979.15
Skilled Nursing Services RN/LPN		Hours	206	688.44	33.86	4801979.15	
<b>Specialized Medical Equipment and Supplies Total:</b>							2273354.86
Specialized Medical Equipment and Supplies		Items	11110	386.08	0.53	2273354.86	
<b>Supported Employment - Small Group Employment Support Total:</b>							2226906.77
Supported Employment - Small Group Employment Support		Hours	534	334.69	12.46	2226906.77	
<b>Supportive Home Care Total:</b>							392425893.15
Supportive Home Care		Hours	29602	782.57	16.94	392425893.15	
<b>Training Services for Unpaid Caregivers Total:</b>							176312.92
Training Services for Unpaid Caregivers		Hours	866	10.34	19.69	176312.92	
<b>Transportation (Specialized Transportation) - Community Transportation Total:</b>							42513197.90
Community Transportation		Trips	19163	162.29	13.67	42513197.90	
<b>Transportation (Specialized Transportation) - Other</b>							589096.39
<b>GRAND TOTAL:</b>							1958185490.65
Total: Services included in capitation:							1958185490.65
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							69707
Factor D (Divide total by number of participants):							28091.66
Services included in capitation:							28091.66
Services not included in capitation:							
Average Length of Stay on the Waiver:							302

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost	
<b>Transportation Total:</b>								
Transportation (Specialized Transportation) - Other Transportation		Trips	1087	19.70	27.51	589096.39		
<b>Vocational Futures Planning and Support Total:</b>							43961.10	
Vocational Futures Planning and Support		Hours	29	23.25	65.20	43961.10		
<b>GRAND TOTAL:</b>							1958185490.65	
Total: Services included in capitation:							1958185490.65	
Total: Services not included in capitation:								
Total Estimated Unduplicated Participants:							69707	
Factor D (Divide total by number of participants):							28091.66	
Services included in capitation:							28091.66	
Services not included in capitation:								
Average Length of Stay on the Waiver:								302

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (8 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

#### Waiver Year: Year 4

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost	
<b>Adult Day Care Services Total:</b>							18849926.40	
Adult Day Care Services		Hours	2477	689.31	11.04	18849926.40		
<b>Care Management Total:</b>							226806344.57	
Care Management		Hours	55682	49.85	81.71	226806344.57		
<b>Daily Living Skills Training Total:</b>							4500208.80	
Daily Living Skills Training		Hours	925	201.62	24.13	4500208.80		
<b>Day Habilitation Services Total:</b>							90944717.28	
Day Habilitation Services		Hours	8040	801.10	14.12	90944717.28		
<b>GRAND TOTAL:</b>							2060664589.64	
Total: Services included in capitation:							2060664589.64	
Total: Services not included in capitation:								
Total Estimated Unduplicated Participants:							71840	
Factor D (Divide total by number of participants):							28684.08	
Services included in capitation:							28684.08	
Services not included in capitation:								
Average Length of Stay on the Waiver:								302

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Prevocational Services Total:</b>							49710272.39
Prevocational Services		Hours	6863	604.61	11.98	49710272.39	
<b>Respite Total:</b>							10696572.56
Respite		Hours	2219	316.51	15.23	10696572.56	
<b>Supported Employment - Individual Employment Support Total:</b>							12599300.09
Supported Employment - Individual Employment Support		Hours	2698	189.14	24.69	12599300.09	
<b>Consumer Directed Supports (Self-Directed Supports) Broker Total:</b>							459056.60
Consumer Directed Supports (Self-Directed Supports) Broker		Hours	671	18.20	37.59	459056.60	
<b>Financial Management Services Total:</b>							16985080.22
Financial Management Services		Hours	25040	14.17	47.87	16985080.22	
<b>Adaptive aids Total:</b>							1566107.76
Adaptive aids		Items	3753	6.91	60.39	1566107.76	
<b>Adult residential care - 1-2 bed adult family homes Total:</b>							172492826.42
Adult residential care - 1-2 bed adult family homes		Days	2971	264.71	219.33	172492826.42	
<b>Adult Residential Care - 3-4 Bed Adult Family Homes Total:</b>							429838753.34
Adult Residential Care - 3-4 Bed Adult Family Homes		Days	8112	301.84	175.55	429838753.34	
<b>Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:</b>							484557950.36
Adult Residential Care - Community-Based Residential Facilities (CBRF)		Days	17408	260.46	106.87	484557950.36	
<b>Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:</b>							58266928.58
Adult Residential Care - Residential Care Apartment Complexes (RCAC)		Days	3624	241.34	66.62	58266928.58	
<b>Assistive Technology/Communication</b>							170246.64
<b>GRAND TOTAL:</b>							2060664589.64
Total: Services included in capitation:							2060664589.64
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							71840
Factor D (Divide total by number of participants):							28684.08
Services included in capitation:							28684.08
Services not included in capitation:							
Average Length of Stay on the Waiver:							302

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>aids Total:</b>							
Assistive Technology/Communication aids		Items	412	28.40	14.55	170246.64	
<b>Consultative Clinical and Therapeutic Services for Caregivers Total:</b>							
Consultative Clinical and Therapeutic Services for Caregivers		Hours	54	41.75	19.20	43286.40	
<b>Consumer Education and Training Total:</b>							
Consumer Education and Training		Hours	157	153.75	32.70	789337.12	
<b>Counseling and Therapeutic Resources Total:</b>							
Counseling and Therapeutic Resources		Hours	1452	29.95	30.46	1324626.20	
<b>Environmental Accessibility Adaptations (Home Modifications) Total:</b>							
Environmental Accessibility Adaptations (Home Modifications)		Projects	864	3.55	673.69	2066341.97	
<b>Home Delivered Meals Total:</b>							
Home Delivered Meals		Meals	4819	158.99	8.98	6880231.83	
<b>Housing Counseling Total:</b>							
Housing Counseling		Hours	1	26.37	63.37	1671.07	
<b>Personal Emergency Response Systems (PERS) Total:</b>							
Personal Emergency Response Systems (PERS)		Month	8694	8.94	29.20	2269551.31	
<b>Relocation services Total:</b>							
Relocation services		Projects	395	1.20	569.15	269777.10	
<b>Self-Directed Personal Care Total:</b>							
Self-Directed Personal Care		Hours	27	976.32	14.04	370103.39	
<b>Skilled Nursing Services RN/LPN Total:</b>							
Skilled Nursing Services RN/LPN		Hours	213	689.22	34.54	5070605.32	
<b>Specialized Medical Equipment and Supplies</b>							
							2389853.16
<b>GRAND TOTAL:</b>							2060664589.64
Total: Services included in capitation:							2060664589.64
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							71840
Factor D (Divide total by number of participants):							28684.08
Services included in capitation:							28684.08
Services not included in capitation:							
Average Length of Stay on the Waiver:							302

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Total:</b>							
Specialized Medical Equipment and Supplies		Items	11450	386.52	0.54	2389853.16	
<b>Supported Employment - Small Group Employment Support Total:</b>							2346565.57
Supported Employment - Small Group Employment Support		Hours	551	335.07	12.71	2346565.57	
<b>Supportive Home Care Total:</b>							412784045.93
Supportive Home Care		Hours	30508	783.46	17.27	412784045.93	
<b>Training Services for Unpaid Caregivers Total:</b>							185590.40
Training Services for Unpaid Caregivers		Hours	893	10.35	20.08	185590.40	
<b>Transportation (Specialized Transportation) - Community Transportation Total:</b>							44762515.88
Community Transportation		Trips	19750	162.47	13.95	44762515.88	
<b>Transportation (Specialized Transportation) - Other Transportation Total:</b>							619744.38
Transportation (Specialized Transportation) - Other Transportation		Trips	1120	19.72	28.06	619744.38	
<b>Vocational Futures Planning and Support Total:</b>							46450.58
Vocational Futures Planning and Support		Hours	30	23.28	66.51	46450.58	
<b>GRAND TOTAL:</b>							2060664589.64
Total: Services included in capitation:							2060664589.64
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							71840
Factor D (Divide total by number of participants):							28684.08
Services included in capitation:							28684.08
Services not included in capitation:							
Average Length of Stay on the Waiver:							302

## Appendix J: Cost Neutrality Demonstration

### J-2: Derivation of Estimates (9 of 9)

#### d. Estimate of Factor D.

ii. **Concurrent §1915(b)/§1915(c) Waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.** Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

**Waiver Year: Year 5**

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
<b>Adult Day Care Services Total:</b>							19862504.88
Adult Day Care Services		Hours	2550	691.76	11.26	19862504.88	
<b>Care Management Total:</b>							239086978.67
Care Management		Hours	57335	50.03	83.35	239086978.67	
<b>Daily Living Skills Training Total:</b>							4747240.46
Daily Living Skills Training		Hours	953	202.33	24.62	4747240.46	
<b>Day Habilitation Services Total:</b>							95833412.64
Day Habilitation Services		Hours	8278	803.95	14.40	95833412.64	
<b>Prevocational Services Total:</b>							52391614.48
Prevocational Services		Hours	7066	606.76	12.22	52391614.48	
<b>Respite Total:</b>							11271788.92
Respite		Hours	2285	317.64	15.53	11271788.92	
<b>Supported Employment - Individual Employment Support Total:</b>							13287971.36
Supported Employment - Individual Employment Support		Hours	2779	189.82	25.19	13287971.36	
<b>Consumer Directed Supports (Self-Directed Supports) Broker Total:</b>							483761.08
Consumer Directed Supports (Self-Directed Supports) Broker		Hours	691	18.26	38.34	483761.08	
<b>Financial Management Services Total:</b>							17903445.28
Financial Management Services		Hours	25784	14.22	48.83	17903445.28	
<b>Adaptive aids Total:</b>							1652302.96
Adaptive aids		Items	3865	6.94	61.60	1652302.96	
<b>Adult residential care - 1-2 bed adult family homes Total:</b>							181791969.63
Adult residential care - 1-2 bed adult family homes		Days	3059	265.65	223.71	181791969.63	
<b>Adult Residential Care - 3-4 Bed Adult Family Homes Total:</b>							453084208.68

GRAND TOTAL:

2172082509.42

Total: Services included in capitation:

2172082509.42

Total: Services not included in capitation:

Total Estimated Unduplicated Participants:

73973

Factor D (Divide total by number of participants):

29363.18

Services included in capitation:

29363.18

Services not included in capitation:

Average Length of Stay on the Waiver:

303

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Residential Care - 3-4 Bed Adult Family Homes		Days	8353	302.91	179.07	453084208.68	
<b>Adult Residential Care - Community-Based Residential Facilities (CBRF) Total:</b>							510728676.78
Adult Residential Care - Community-Based Residential Facilities (CBRF)		Days	17924	261.39	109.01	510728676.78	
<b>Adult Residential Care - Residential Care Apartment Complexes (RCAC) Total:</b>							61402895.19
Adult Residential Care - Residential Care Apartment Complexes (RCAC)		Days	3731	242.20	67.95	61402895.19	
<b>Assistive Technology/Communication aids Total:</b>							179326.56
Assistive Technology/Communication aids		Items	424	28.50	14.84	179326.56	
<b>Consultative Clinical and Therapeutic Services for Caregivers Total:</b>							45942.51
Consultative Clinical and Therapeutic Services for Caregivers		Hours	56	41.90	19.58	45942.51	
<b>Consumer Education and Training Total:</b>							828490.70
Consumer Education and Training		Hours	161	154.30	33.35	828490.70	
<b>Counseling and Therapeutic Resources Total:</b>							1396276.48
Counseling and Therapeutic Resources		Hours	1495	30.06	31.07	1396276.48	
<b>Environmental Accessibility Adaptations (Home Modifications) Total:</b>							2177197.74
Environmental Accessibility Adaptations (Home Modifications)		Projects	890	3.56	687.16	2177197.74	
<b>Home Delivered Meals Total:</b>							7252308.36
Home Delivered Meals		Meals	4962	159.56	9.16	7252308.36	
<b>Housing Counseling Total:</b>							1710.76
Housing Counseling		Hours	1	26.47	64.63	1710.76	
<b>Personal Emergency Response Systems (PERS) Total:</b>							2391317.32
Personal Emergency						2391317.32	
<b>GRAND TOTAL:</b>							2172082509.42
Total: Services included in capitation:							2172082509.42
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							73973
Factor D (Divide total by number of participants):							29363.18
Services included in capitation:							29363.18
Services not included in capitation:							
Average Length of Stay on the Waiver:							303

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Systems (PERS)		Month	8952	8.97	29.78		
<b>Relocation services Total:</b>							283530.85
Relocation services		Projects	407	1.20	580.53	283530.85	
<b>Self-Directed Personal Care Total:</b>							392856.60
Self-Directed Personal Care		Hours	28	979.79	14.32	392856.60	
<b>Skilled Nursing Services RN/LPN Total:</b>							5336489.97
Skilled Nursing Services RN/LPN		Hours	219	691.67	35.23	5336489.97	
<b>Specialized Medical Equipment and Supplies Total:</b>							2515059.37
Specialized Medical Equipment and Supplies		Items	11789	387.89	0.55	2515059.37	
<b>Supported Employment - Small Group Employment Support Total:</b>							2470946.08
Supported Employment - Small Group Employment Support		Hours	567	336.26	12.96	2470946.08	
<b>Supportive Home Care Total:</b>							435200917.15
Supportive Home Care		Hours	31414	786.25	17.62	435200917.15	
<b>Training Services for Unpaid Caregivers Total:</b>							195575.81
Training Services for Unpaid Caregivers		Hours	920	10.38	20.48	195575.81	
<b>Transportation (Specialized Transportation) - Community Transportation Total:</b>							47183617.70
Community Transportation		Trips	20336	163.05	14.23	47183617.70	
<b>Transportation (Specialized Transportation) - Other Transportation Total:</b>							653047.44
Transportation (Specialized Transportation) - Other Transportation		Trips	1153	19.79	28.62	653047.44	
<b>Vocational Futures Planning and Support Total:</b>							49127.01
Vocational Futures Planning and Support		Hours	31	23.36	67.84	49127.01	
<b>GRAND TOTAL:</b>							2172082509.42
Total: Services included in capitation:							2172082509.42
Total: Services not included in capitation:							
Total Estimated Unduplicated Participants:							73973
Factor D (Divide total by number of participants):							29363.18
Services included in capitation:							29363.18
Services not included in capitation:							
Average Length of Stay on the Waiver:							303