Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

JUN - 3 2010

Jason A. Helgerson, Administrator
Division of Health Care Access and Accountability
Wisconsin Department of Health Services
1 West Wilson Street
P. O. Box 309
Madison, Wisconsin 53701-0309

Dear Mr. Helgerson:

I am pleased to inform you that the Centers for Medicare and Medicaid Services (CMS) has approved State Plan Amendment (SPA) Transmittal #09-017. This SPA authorizes Wisconsin to implement an optional 1915 (i) State plan home and community-based service, specifically psychosocial rehabilitation services. The effective date of the amendment is January 15, 2010.

Please be advised that Wisconsin will need to submit a SPA to CMS to comply with changes to 1915(i) under Sections 2402(b) through 2402(f) of the Affordable Care Act no later than December 31, 2010 that will take effect October 1, 2010. Additionally, upon publication of the final regulations concerning Section 1915 (i), Wisconsin will need to come into compliance with any requirements imposed by those regulations.

If you have any additional questions, please have a member of your staff contact Cynthia Garraway at (312) 353-8583 or Cynthia.Garraway@cms.hhs.gov.

Sincerely,

Verlon Johnson
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Cc: Al Matano, Wisconsin Department of Health Services

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 09-017

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/01/2009

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1915 (i) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2010 ..... $7,489K
b. FFY 2011 ..... $9,739K

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-G, pages 1 to 27. .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
New

10. SUBJECT OF AMENDMENT:
Home and Community-Based Psychosocial Rehabilitation

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

Laura A Pabilonia

12. SIGNATURE OF STATE AGENCY OFFICIAL:
for JAH

13. TYPED NAME:
Jason A. Helgerson

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
November 10, 2009

16. RETURN TO:
Jason A. Helgerson
State Medicaid Director
Division of Health Care Access and Accountability
1 W. Wilson St.
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
November10, 2009

18. DATE APPROVED:
June 3, 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUN - 3 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
Verlon Johnson

21. TYPED NAME:
Verlon Johnson

22. TITLE:
Associate Regional Administrator

23. REMARKS:

FORM HCFA-179 (07-92)

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

Administration and Operation

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

1. **Services.** *(Specify service title(s) for the HCBS listed in Attachment 4.19-B that the State plans to cover):*

HCBS Psychosocial Rehabilitation

2. **Statewideness.** *(Select one)*:

○	The State implements the 1915(i) State plan HCBS benefit statewide, per §1902(a)(1) of the Act.
●	The State implements this benefit without regard to the statewideness requirements in §1902(a)(1) of the Act. State plan HCBS will only be available to individuals who reside in the following geographic areas or political subdivisions of the State. *(Specify the areas to which this option applies)*:
	Services will be available in the following Wisconsin counties: Adams, Barron, Buffalo, Chippewa, Clark, Dane, Dodge, Dunn, Eau Claire, Forest, Green, Green Lake, Jackson, Jefferson, Kenosha, LaCrosse, Langlade, Lincoln, Marathon, Milwaukee, Monroe, Oneida, Ozaukee, Pepin, Pierce, Portage, Richland, Rock, Sheboygan, St. Croix, Trempealeau, Vernon, Vilas, Washington, Waukesha, Wood

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

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

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

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

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

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

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

Numbers 1, 2, 3, 6, 7 and 8 are performed by County Human Services Departments or in a few counties a Department of Community Programs that has a specific focus on persons with mental illness and/or developmental disabilities in addition to the SMA. Number 9 has been completed under contract with The Public Consulting Group.

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

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

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

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

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

8. X **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals To Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	1/16/10	9/30/10	1077
Year 2			
Year 3			
Year 4			
Year 5			

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

3. **Optional Annual Limit on Number Served.** *(Select one):*

O	The State does not limit the number of individuals served during the year or at any one time. **Skip to next section.**
●	The State chooses to limit the number of *(check each that applies):*

☐ Unduplicated individuals served during the year. *(Specify in column **A** below):*

X Individuals served at any one time ("slots"). *(Specify in column **B** below):*

Annual Period	From	To	A Maximum Number served annually *(Specify):*	B Maximum Number served at any one time *(Specify):*
Year 1	1/16/10	9/30/10		938
Year 2				
Year 3				
Year 4				
Year 5				

☐ The State chooses to further schedule limits within the above annual period(s). *(Specify):*

4. **Waiting List.** *(Select one only if the State has chosen to implement an optional annual limit on the number served):*

O	The State will not maintain a waiting list.
●	The State will maintain a single list for entrance to the State plan HCBS benefit. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; and ensure that only individuals enrolled in the State plan HCBS benefit receive State plan HCBS once they leave/are taken off of the waiting list.

Financial Eligibility

1. X **Income Limits.** *(By checking this box the State assures that):* Individuals receiving State plan HCBS are in an eligibility group covered under the State's Medicaid State plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL). Individuals with incomes up to 150% of the FPL who are only eligible for Medicaid because they are receiving 1915(c) waiver services may be eligible to receive services under 1915(i) provided they meet all other requirements of the 1915(i) State plan option. The State has a process in place that identifies individuals who have income that does not exceed 150% of the FPL.

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

○	The State does not provide State plan HCBS to the medically needy.
●	The State provides State plan HCBS to the medically needy *(select one):*
○	The State elects to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.
●	The State does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III).

Needs-Based Evaluation/Reevaluation

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual according to the requirements of 42 CFR §441.556(a)(1) through (5). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*select one*):

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

2. Qualifications of Individuals Performing Evaluation/Reevaluation. The independent evaluation is performed by an agent that is independent and qualified as defined in 42 CFR §441.568. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The1915(i) program will use Wisconsin's Functional Eligibility Screen for Mental Health and Mental Health & AODA (Co-Occurring) Services in doing the independent evaluation of needs based criteria. This will be conducted by a trained certified screen administrator. Certified screeners are knowledgeable about mental health issues, interviewing skills needed to gather information, conducting a holistic dialogue, recovery-based best practices, including learning what the person needs help with within a larger, recovery-focused dialogue that includes the person's strengths, values, goals and perspectives. All persons administering the functional screen must meet the following conditions:

1. Meet the following **minimum criteria for education and experience**:
– Nursing license or a BA or BS, preferably in a health or human services related field, and at least one year of experience working with people with chronic needs, or
– Prior approval from the Department based on a combination of post-secondary education and experience or on a written plan for formal and on-the-job training to develop the required expertise; and
2. Meet all **training requirements** as specified by the Department. Currently that means:
– Completing the online course, or
– Attending an in-person training by Department staff (or watching video of same), **and**
– Reading and following screen instructions.

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

Wisconsin's Mental Health and AODA functional screen has been in use since 2005 to identify individual's functional needs. The screen has three sections: Community living skills inventory, crisis and situational factors (factors such as a history of inpatient stays, emergency detentions, suicide attempts etc.) and risk factors (substance use, housing instability etc.). The functional screen is web based and can be completed only by certified screeners. The needs based eligibility criteria are incorporated into the screen logic to provide an automated determination of eligibility or ineligibility. The functional screen will be completed annually. Screen reports are available showing when annual screens are due or are late.

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

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

Wisconsin's 1915(i) needs based criteria requires an individual to have a variety of combinations of risk factors and functional need for assistance with community living skills such that those needs cannot be met by an outpatient clinic service. ("Assistance" is defined as including any kind of support from another person (monitoring, supervising, reminders, verbal cueing, or hands-on assistance) needed because of a physical, cognitive, or mental health condition disorder)
The following is the minimum possible combinations of factors that demonstrate 1915i eligibility:

The criteria for eligibility group seven (the lowest level of eligibility) are that the individual's needs can not be met by an outpatient clinic service plus they meet the following:

- Applicant meets at least one Eligibility Group Two criteria

OR

- Applicant meets at least one Eligibility Group Three criteria

-AND-

At least 3 of the following are true for the applicant

- Needs assistance to work or to find work less than monthly OR needs assistance with schooling less than monthly
- Needs help with home hazards 1 to 4 times a month
- Needs help to use effective social/interpersonal skills
- Needs help with money management 1 to 4 times a month
- Needs help with maintaining basic nutrition 1 to 4 times a month
- Needs help with transportation because person cannot drive due to physical, psychiatric or cognitive impairment.

Group Two eligibility criteria normally require two of the following but any one of these criteria meets the first part of the group seven requirement.

- Needs help in maintaining basic safety
- Needs assistance to manage psychiatric symptoms more than once a week
- Needs assistance with taking medications 2 to 6 days per week OR needs monitoring medication effects 2 to 6 days per week
- Has required use of emergency rooms, crisis intervention or detox units 4 or more time in the past year OR has had 1 to 3 psychiatric inpatient stays within the past year OR has had 1 to 3 emergency detentions within the past year
- Has had 4 or more psychiatric inpatient stays within the past 13 months to 3 years OR has made 4 or more suicide attempts within the past 13 months to 3 years
- Has had incidents of physical aggression 4 or more times within the past year OR has had involvement with the corrections system 4 or more times within the past year

Group 3 eligibility requires three of the following but for Group seven only one of the following is sufficient to meet the first part of the eligibility.

- Needs assistance to work more than 1 time per week
- Needs help with home hazards more than once a week
- Needs help with money management more than once a week
- Needs help with basic nutrition more than once a week
- Needs help performing general health maintenance at least 1 to 4 times a month
- Needs help managing psychiatric symptoms 1 to 4 times a month

- Needs assistance with taking medications 1 to 4 days a month or needs monitoring medication effects 1 to 4 days a month
- Has required use of emergency rooms, crisis intervention, or detox units at least 1 time in the past year; or has had 1 to 3 psychiatric inpatient stays within the past year
- Has required use of emergency rooms, crisis intervention, or detox units 4 or more times within the past 13 months to 3 years; OR has had at least 1 psychiatric inpatient stay within the past 13 months to 3 years OR has made at least one suicide attempt within the past 13 months to 3 years.
- Has had at least 1 emergency detention within the past 13 months to 3 years
- Has had at least 1 incident of physical aggression in the past year; OR has had involvement with the correctional system 4 or more times within the past 13 months to 3 years
- Currently homeless (on the street or no permanent address) OR has been evicted 2 or more times in the past year; OR homeless more than half of the time in the past year; OR currently homeless, not in transitional housing OR in Transitional Housing – Mental Health, Substance Abuse or Corrections System
- Has demonstrated self-injurious behaviors within the past year; OR has demonstrated self-injurious behaviors 13 months to 3 years ago
- Has at least one Substance-Related diagnosis except nicotine dependence or other related disorder; OR in the past 12 months, person has experienced negative consequences in legal (including OWI), financial, family, relational, or health domains that are linked to substance use

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

Needs-Based/Level of Care (LOC) Criteria

State plan HCBS needs-based eligibility criteria	NF (& NF LOC waivers)	ICF/MR (& ICF/MR LOC waivers)	Applicable Hospital* LOC (& Hospital LOC waivers)
The needs based eligibility criteria are described in #4.	Wisconsin Law allows reimbursement to nursing homes for eligible persons who require skilled, intermediate, or limited levels of nursing care. Wis. Stat. § 49.45(6m)(i). Those levels are defined in Wis. Adm. Code § DHS 132.13. Wisconsin's BC waiver criteria for nursing home level of care are as follows: A person is functionally eligible at the nursing home level if the person requires ongoing care, assistance or supervision from another person, as is evidenced by any of the following findings from application of the functional screening: 1. The person cannot safely or appropriately perform 3 or more activities of daily living. 2. The person cannot safely or appropriately perform 2 or more ADLs and one or more instrumental activities of daily living. 3. The person cannot safely or appropriately perform 5 or more IADLs.	ICF_MR referred to in Wisconsin as FDD (Facility serving people with developmental disabilities) Wis. Adm. Code § DHS 134.13 contains the following definitions: **(13)** "FDD" or "facility serving people with developmental disabilities" means a residential facility with a capacity of 4 or more individuals who need and receive active treatment and health services as needed. **(2)** "Active treatment" means an ongoing, aggressive and consistently applied program of training and treatment services to allow the client to function as independently as possible and maintain his or her maximum functional	For inpatient hospital psychiatric emergency detention or involuntary commitment, state statutes require that: 1) The individual is mentally ill, drug dependent, or developmentally disabled; 2) The individual presents an immediate danger of harm to self or others based on a recent act or omission; and 3) Inpatient hospitalization is the least restrictive placement consistent with the requirements of the individual (i.e., the individual's needs can only be met on an inpatient basis). IMD hospital admissions nearly always occur on an emergency detention or involuntary commitment basis. For a voluntary admission (to a psychiatric unit of a general hospital), the inpatient services must: 1) Directed by a

		abilities. **(9)** "Developmental disability" means mental retardation or a related condition such as cerebral palsy, epilepsy or autism, but excluding mental illness and infirmities of aging, which is: (a) Manifested before the individual reaches age 22; (b) Likely to continue indefinitely; and (c) Results in substantial functional limitations in 3 or more of the following areas of major life activity: 1. Self–care; 2. Understanding and use of language; 3. Learning; 4. Mobility; 5. Self–direction; and 6. Capacity for independent living.	physician or dentist; and 2) Be medically necessary as certified by a physician or dentist. Among the criteria in the state definition of "medical necessity" is the requirement that the service (e.g., inpatient hospitalization) is the most appropriate level of service that can safely and effectively be provided to the recipient/individual.

*Long Term Care/Chronic Care Hospital

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

6. **X Reevaluation Schedule**. Needs-based eligibility reevaluations are conducted at least every twelve months.

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

8. **X** **Residence in home or community**. The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not in an institution. The State attests that each individual receiving State plan HCBS:

(i) Resides in a home or apartment not owned, leased or controlled by a provider of any health-related treatment or support services; or

(ii) Resides in a home or apartment that is owned, leased or controlled by a provider of one or more health-related treatment or support services, if such residence meets standards for community living as defined by the State. *(If applicable, specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS. Describe the standards for community living that optimize participant independence and community integration, promote initiative and choice in daily living, and facilitate full access to community services):*

Wisconsin's 1915i services will expect recovery, outcome based services that are individualized based on the needs identified through the comprehensive assessment and person-centered planning process. This includes identifying the type of community setting most able to meet the individuals assessed support needs and individual choice. There is not an automatic placement into a service. An individual choice may require that professionals assess the housing choice and assist with recommendations for modifications that promote both independence and safety. A care manager is required to use a person centered planning process. The consumer and the care manager decide together on the appropriateness of the community setting.

The choice of the home and the decoration of personal space by the individual as well as the neighborhood are basic rights promoted through the use of person centered planning. Opportunity to exercise personal freedom in all domains will be promoted through training of qualified staff. Participation in community events, activities and resources will be supported and limits exercised only where required to assure safety. As an example, if a person is at risk around sharp knives they would not be excluded from activities in their kitchen. Instead the knives would be stored safely. Community integration has many features and are dependent on the person's preferences and availability. Establishing choices for each person is a process of asking, learning in a trusting relationship, and providing the means to access services, supports and naturally occurring activities offered to anyone in the community at large. Many of the services offered to gain such participation will be skill building and self management strategies. Peer Specialists are often the best teachers and models supporting this type of service. They are part of the state work force to bring about system and person specific transformation.

The type of residential setting needed would be determined by the person-centered assessment. Allowable settings other than the individuals own home or apartment are Adult Family Homes (AFH), Residential care apartment complex (RCAC), and community based residential facilities (CBRF).

RCACs are by definition independent apartments with a lockable entrance and exit, a kitchen including a stove and individual bathroom, sleeping and living areas. RCAC settings are apartment complexes that offer additional services and supports to its residents. These settings are the individual's home apartment. As in any apartment setting, the owner/manager of the building may have rules or limitations to manage the building and the day to day management of the environment and services. The state has administrative rules and quality oversight that assure individuals' rights and safety in such settings.

Care Managers would be responsible for determining that AFH's offer individuals opportunity to participate in community activities. AFH's would need to offer private personal quarters or the choice of whom to share their room with and access to food and food preparation areas.

CBRF's are the most restrictive of the community residential options which is a facility that provides from 5 to 16 beds (inclusive). For this reason, only individuals whose health and safety are at risk without 24hr supervision will receive 1915(i) services in a CBRF. The care manager together with the person receiving 1915(i) services will determine that the residence is a community setting and offers opportunities for independence, choice and community integration. Wisconsin has developed standards to ensure that these facilities are community based.

Person-Centered Planning & Service Delivery

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

1. X There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment is based on:

- An objective face-to-face assessment with a person-centered process by an agent that is independent and qualified as defined in 42 CFR §441.568;
- Consultation with the individual and if applicable, the individual's authorized representative, and includes the opportunity for the individual to identify other persons to be consulted, such as, but not limited to, the individual's spouse, family, guardian, and treating and consulting health and support professionals caring for the individual;
- An examination of the individual's relevant history, including findings from the independent evaluation of eligibility, medical records, an objective evaluation of functional ability, and any other records or information needed to develop the plan of care as required in 42 CFR §441.565;
- An examination of the individual's physical and mental health care and support needs, strengths and preferences, available service and housing options, and when unpaid caregivers will be relied upon to implement the plan of care, a caregiver assessment;
- If the State offers individuals the option to self-direct State plan HCBS, an evaluation of the ability of the individual (with and without supports), or the individual's representative, to exercise budget and/or employer authority; and
- A determination of need for (and, if applicable, determination that service-specific additional needs-based criteria are met for), at least one State plan home and community-based service before an individual is enrolled into the State plan HCBS benefit.

2. X Based on the independent assessment, the individualized plan of care:

- Is developed with a person-centered process in consultation with the individual, and others at the option of the individual such as the individual's spouse, family, guardian, and treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;
- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes those services, the purchase or control of which the individual elects to self-direct, meeting the requirements of 42 CFR §441.574(b) through (d);
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 12 months and as needed when there is significant change in the individual's circumstances.

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

The assessment will be completed by a care manager.

1. A care manager shall have the skills and knowledge typically acquired:

a. Through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience working with persons living with mental illness, or

b. Through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons living with mental illness, or

c. Through a minimum of four years experience as a care manager, or

d. Through an equivalent combination of training and experience that equals four years of long term support and/or mental health practice in care management, or

e. The completion of a course of study leading to a degree as a registered nurse and one year employment working with persons living with mental illness.

2. The care manager shall be knowledgeable of person centered planning, the service delivery system, the needs of persons living with mental illness, and the availability of mental health recovery focused services and resources or the need for such services and resources to be developed.

3. Providers of care management are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by the SMA.

4. **Responsibility for Plan of Care Development**. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care. *(Specify qualifications):*

The service plan will be developed by the care manager with the participant and other appropriate parties determined appropriate by the participant.

1. A care manager shall have the skills and knowledge typically acquired:

a. Through a course of study and practice experience that meets requirements for state certification/licensure as a social worker and also one year experience working with persons living with mental illness, or

b. Through a course of study leading to a BA/BS degree in a health or human services related field and one year of experience working with persons living with mental illness, or

c. Through a minimum of four years experience as a care manager, or

d. Through an equivalent combination of training and experience that equals four years of long term support and/or mental health practice in care management, or

e. The completion of a course of study leading to a degree as a registered nurse and one year employment working with persons living with mental illness.

2. The care manager shall be knowledgeable of person centered planning, the service delivery system, the needs of persons living with mental illness, and the availability of mental health recovery focused services and resources or the need for such services and resources to be developed.

3. Providers of care management are subject to the required criminal, caregiver and licensing background checks and hiring prohibitions as prescribed by the SMA.

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

The care manager will provide information both verbally and in writing to the participant about the person-centered planning process, their opportunity to include others to participate in the planning, the services available through the program and that they will be able to select qualified service providers of their choice. The care manager will ensure that the participant and others they choose are fully involved in the plan development. Service plan meetings are conducted at times and places that are convenient for the participant. The care manager will document on the service plan those in attendance at the plan development. The care manager will ensure that the participant and legal representative sign and date the service plan and that they receive a copy of the completed plan.

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

The care manager will provide information and answer questions before and during the service plan development about the qualified service providers available to meet the assessed needs of the participant. The care manager will assist the participant in contacting and /or visiting the service provider to determine if they are a good match. On an ongoing basis thereafter, the care manager will assist the participant in interactions with service providers, including but not limited to selecting different providers who may prove to be a better match for them. All willing providers will have the opportunity to register with the DHS. The care manager will assist the person on an ongoing basis to assure that the service plan continues to meet their needs.

7. **Process for Making Plan of Care Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the plan of care is made subject to the approval of the Medicaid agency):*

The care manager will submit the completed and signed service plan to the DHS. Services are not authorized until DHS has approved the service plan.

8. **Maintenance of Plan of Care Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

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

Services

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

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the State plans to cover):*	
Service Title:	Psychosocial Rehabilitation
Service Definition (Scope):	

Community Living Supportive Services (CLSS)

This service covers activities necessary to allow individuals to live with maximum independence in community integrated housing. Activities are intended to assure successful community living through utilization of skills training, cuing and/or supervision as identified by the person-centered assessment. Community Living supportive services consist of meal planning/preparation, household cleaning, personal hygiene, reminders for medications and monitoring symptoms and side effects, teaching parenting skills, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills. CLSS tasks, such as meal planning, cleaning, etc. are not done for the individual, but rather they are delivered through training, cueing, and supervision to help the participant become more independent in doing these tasks.

Wisconsin would make these services available in a variety of community locations that encompass residential, business, social and recreational settings. Residential settings are limited to an individual's own apartment or house, supported apartment programs, adult family homes (AFH), residential care apartment complexes (RCAC), and community based residential facilities (CBRF's) of from 5 to 16 beds (inclusive). The type of residential setting needed would be as agreed upon in the person-centered assessment. Individuals needing services in a CBRF setting would be those whose health and safety are at risk without 24hr supervision. Payment is not made for room and board including the cost of building maintenance.

The services provided under 1915(i) will not be duplicative of other State Plan services, including but not limited to personal care and transportation.

Supported employment

This service covers activities necessary to assist individuals to obtain and maintain competitive employment. This service may be provided by a supported employment program agency or individual employment specialist. The service will follow the Individual Placement and Support (IPS) model recognized by SAMHSA to be an evidence-based practice. This model has been shown to be effective in helping individuals obtain and maintain competitive employment. This promotes recovery through a community integrated socially valued role and increased financial independence. The core principles of this supported employment approach are:

- Participation is based on consumer choice. No one is excluded because of prior work history, hospitalization history, substance use, symptoms, or other characteristics. No one is excluded who wants to participate.
- Supported employment is closely integrated with mental health treatment. Employment specialists meet frequently with the mental health treatment team to coordinate plans.
- Competitive employment is the goal. The focus is community jobs anyone can apply for that pay at least minimum wage, including part-time and full-time jobs.
- Job search starts soon after a consumer expresses an interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like pre-vocational work units, transitional employment, or sheltered workshops).
- Follow-along Supports are Continuous. Individualized supports to maintain employment continue as long as the consumer wants assistance.
- Consumer preferences are important. Choices and decisions about work and support are individualized based on the person's preferences, strengths, and experiences.

The service covers supported employment intake, assessment (not general 1915(i) intake and assessment), job development, job placement, work related symptom management, employment crisis support, and follow-along supports by an employment specialist. It also covers employment specialist time spent with the individual's mental health treatment team and Vocational Rehabilitation (VR) counselor. The Wisconsin 1915(i) HCB services will not duplicate other State Plan services. The Supported employment service does not include services available as defined in S4 (a) (4) of the 1975 Amendments to the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a State or local educational agency and vocational rehabilitation services which are otherwise available to the individual through a program funded under S110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Peer Supports
Individuals trained and certified as Peer Specialists serve as advocates, provide information and peer support for consumers in outpatient and other community settings. All consumers receiving 1915(i) peer support services will reside in home and community settings. Certified Peer Specialists perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process. Peer Specialists function as role models demonstrating techniques in recovery and in ongoing coping skills through: (a) offering effective recovery-based services; (b) assisting consumers in finding self-help groups; (c) assisting consumers in obtaining services that suit that individual's recovery needs; (d) teaching problem solving techniques; (e) teaching consumers how to identify and combat negative self-talk and how to identify and overcome fears; (f)assisting consumers in building social skills in the community that will enhance integration opportunities; (g) lending their unique insight into mental illness and what makes recovery possible; (h) attending treatment team and crisis plan development meetings to promote consumer's use of self-directed recovery tools; (i) informing consumers about community and natural supports and how to utilize these in the recovery process; and (j)assisting consumers in developing empowerment skills through self-advocacy and stigma-busting activities. 1915(i) HCBS will not duplicate other State Plan services.
Additional needs-based criteria for receiving the service, if applicable *(specify):*
Specify limits (if any) on the amount, duration, or scope of this service for *(chose each that applies):*
☐ Categorically needy *(specify limits):*
☐ Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:			
Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Other Standard *(Specify)*:
Community Living Supportive Services:			
➢ **Adult Family Homes (AFH)**	WI Statute Chapter 50 and Administrative Rule DHS 88 for 3-4 bed Adult Homes		Providers are subject to the required caregiver, criminal and licensing background checks. 15 hrs of training related to fire safety, first aid, health, safety and welfare of residents, resident rights, and treatment.
➢ **Community Based Residential Facility (CBRF)**	WI Statute Chapter 50 and Administrative Rule DHS 83 for 5 to 16 beds		Providers are subject to the required caregiver, criminal and licensing background checks. Orientation and ongoing training required that includes: training on job responsibilities, prevention and reporting of resident abuse, neglect, assessing needs and individual services, emergency and disaster plans and evacuation procedures, recognizing and responding to resident changes of condition, fire safety, first aid and choking, medication safety, standard precautions, resident rights, recognizing, preventing and responding to challenging behaviors.
➢ **Residential Care Apartment Complex (RCAC)**	WI Statute Chapter 50 and Administrative Rule DHS 89		Providers are subject to the required caregiver, criminal and licensing background checks. Training required in the services the staff are assigned; safety procedures, including fire safety, first aid, universal precautions and the facilities emergency plan, tenant rights and privacy, autonomy and independence, physical, functional and psychological characteristics of the tenant population.
➢ **Supportive Home Care Agency , Home Health Agency or Individual**	WI Statute Chapter 50. Administrative Rule DHS 133.	Administrative Code DHS 105.17.	Providers are subject to the required caregiver, criminal and licensing background checks. Orientation to job duties, policies of agency, information on other community agencies, ethics, confidentiality of patient information and patients' rights, prevention of infections. Continuing education required as appropriate to job.
➢ **Household/Chore Services Agency or Individual**			Providers are subject to caregiver, criminal and licensing background checks. Orientation for job duties, polices of agency, information about other community agencies, ethics, confidentiality of patient information, patients' rights, infection control and continuing education as required by duties.

Supported Employment:			
➢ **Supported Employment Program or Individual Employment Specialist**			One year experience working with persons living with mental illness and IPS Supported Employment Specialists Competencies developed by Dartmouth (09/09).
Peer Supports:			
➢ **Peer Specialist Agency or Individual**		Certification that the Peer Specialist has successfully completed an approved training course and that they have passed the competency based exam.	Providers are subject to caregiver, criminal and licensing background checks. Curricula of Wisconsin approved Certified Peer Specialist training include cultural competence, consumer rights, ethics and boundaries, crisis planning, trauma-informed care, and specifics to the peer specialist's role. Peer specialists will be supervised by a mental health professional.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):		
Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Adult Family Homes (AFH)	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Community Based Residential Facility (CBRF)	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Residential Care Apartment Complex (RCAC)	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Supportive Home Care Agency or Individual	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Household/Chore Services Agency or Individual	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Supported Employment Prog. or Individual Employment Specialist	**County/Tribal Agency – Human Service Department or Department of Community Programs**	**Annually**
Peer Specialist Agency/Individual	**County/Tribal Agency – Human Service Department or Department of Community Programs,** **Human Service Department Care Manager**	**Every other year** **Ongoing oversight & monitoring**

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

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

Wisconsin's 1915(i) program will be consistent with the DHS HCBS 1915 c waiver programs in regards to payment for State plan HCBS furnished by relatives, legally responsible individuals and legal guardians. Thus the following limitations will be followed. Legal guardians, spouses of 1915(i) participants or the parents of minor children who are 1915 (i) participants will not be paid for providing any service. However, county/tribal agencies may choose to reimburse those persons for services provided to 1915(i) participants using other funding sources. Relatives not falling under the above exceptions may provide HCBS services in the quantity and to the extent determined by the needs of the consumer as specified in the individual assessment and care plan.

Oversight of this policy will be part of the on-going quality review of the person centered plan of care and provider qualifications conducted on an ongoing basis by the DHS. Further provider qualifications review will occur at the annual review process.

Participant-Direction of Services

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

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

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

2. **Description of Participant-Direction.** *(Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

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

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

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

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

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

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

6. ☐ **Participant–Directed Plan of Care.** *(By checking this box the State assures that):* Based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Be developed through a person-centered process that is directed by the individual participant, builds upon the individual's ability (with and without support) to engage in activities that promote community life, respects individual preferences, choices, strengths, and involves families, friends, and professionals as desired or required by the individual;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual participant;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques, including contingency plans that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of this plan based upon the resources and support needs of the individual.

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

8. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff). *(Select one):*

○	The State does not offer opportunity for participant-employer authority.
○	Participants may elect participant-employer Authority *(Check each that applies):*
☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide 1915 (i) services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide 1915 (i) services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget). *(Select one):*

○	The State does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the plan of care):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):*

Quality Improvement Strategy

(Describe the State's quality improvement strategy in the tables below):

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity)*	**Frequency**	**Remediation Responsibil-ities** *(Who does this)*	**Frequency** *of Analysis and Aggregation*
Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.	1. Service plans will reflect the use of the person-centered planning approach.	1. All (100%) initial and updated service plans will be reviewed when submitted by the provider.	1. DHS (SMA)	1. Ongoing	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. Participants choice of providers will be documented in the service plan by the case manager.	2. All (100%) service plans will be reviewed for documentation of participant choice of providers	2. DHS (SMA)	2. Annually	2. DHS (SMA)	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	3. Interviews of participant satisfaction will be conducted.	3. Representative sampling of interview results will be reviewed and put into a summary report. The State's sampling methodology will ensure a 95 percent confidence	3. DHS (SMA)	3. Annually or at disenrollment	3. DHS (SMA)	3. If a corrective action plan is needed it must be provided within 15 days

		level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.				and the state will respond in 15 days for a total of 30 days.
	4. Participant needs assessment conducted by the case manager.	4. Representative sampling of case files will be reviewed. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	4. DHS (SMA)	4. Annually	4. DHS (SMA)	4. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	5. All willing providers have the opportunity to register with the DHS.	5. Representative sampling of service plans will be reviewed. . The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	5. DHS (SMA)	5. Annually	5. DHS (SMA)	5. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.

	6. Services are delivered in accordance with the service plan.	_6. Representative sampling of services delivered will be reviewed. . The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	6. DHS (SMA)	6. Annually	6. DHS (SMA)	6. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
Providers meet required qualifications.	1. All providers meet requirements established by DHS and documented by the case manager.	1. Representative sampling of case files will be reviewed. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	1. DHS (SMA)	1. Annually	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. All providers have a current agreement with the SMA.	2. Presence of MA agreement in sampling of case records. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of	2. DHS (SMA)	2. Annually	2. DHS (SMA)	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.

		approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.				

Discovery Activities					Remediation	
Requirement	**Discovery Evidence** *(Performance Measures)*	**Discovery Activity** ***(Source of Data & sample size)***	**Monitoring Responsibilities** *(agency or entity)*	**Frequency**	**Remediation Responsibil-ities** *(Who does this)*	**Frequency** *of Analysis and Aggregation*
The SMA retains authority and responsibility for program operations and oversight.	1. Case files will reflect that local non-state entities and providers adhere to federal and state program requirements, policies and regulations for 1915i program.	1. Representative sampling record reviews of case files, mental health functional screen, service provider records, monitoring reports and on-site interviews. The State's sampling methodology will ensure a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.	1. DHS (SMA)	1. Annually	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. Presence of the county entities entering accurate information into the automated functional screen.	2. All (100%) initial and updated automated functional screens will be reviewed when service plan packets are submitted by the county entity.	2. DHS (SMA	2. Ongoing	2. DHS (SMA	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15

						days for a total of 30 days.
The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.	1. DHS oversight through the MMIS system to assure claims are coded and paid in accordance with the state plan.	1. MMIS Reports	1. DHS (SMA)	1. Ongoing	1. DHS (SMA)	1. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days
	2. Representative sample of claims, case files and service plans.	2. Program review of MMIS Reports, documentation of sample selection process.	2. DHS (SMA)	2. Annually	2. DHS (SMA)	2. If a corrective action plan is needed it must be provided within 15 days and the state will respond in 15 days for a total of 30 days
	3. Claims are authorized and furnished appropriately.	3. Program testing in annual single audit of county agency.	3. DHS (SMA)	3. Annually	3. DHS (SMA)	3. If a corrective action plan is needed it must be provided within 45 days and the state will respond in 45 days for a total of 90 days
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	1. Service plans address health and welfare needs of the participant.	1. Representative sampling record reviews of case files, service plans and outcomes, mental health functional screen, service provider records, monitoring reports and on-site interviews. The State's sampling methodology will ensure	1. DHS (SMA)	1. Annually	1. DHS (SMA)	1. Immediate safety issues identified must have a corrective action plan within 3 days. If a corrective

		a 95 percent confidence level with a 5 percent margin of error (confidence interval). The sample will be drawn from the universal population, which is defined as the total number of approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.				action plan is needed that is not urgent, it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.
	2. Providers will complete and submit incident reports as required by DHS policy.	2. All (100%) of incident reports will be reviewed to ensure appropriate actions have been taken. Adverse incidents are reported to the county case manager (CM). The CM reviews the situation and takes steps to protect safety of participant. The CM immediately notifies, as appropriate, the DHS Division of Quality Assurance. The CM also notifies the state 1915(i) coordinator. All critical incidents tracked by the state 1915(i) coordinator who will follow-up as needed. Coordinator will review incidents for any patterns that would suggest the need for further investigation or technical assistance.	2. DHS (SMA)	2. Ongoing	2. County Agency and DHS (SMA)	2. Reported to care manager within 24 hrs. Reported to state within 3 days with corrective action plan. State reviews plan and responds within 10 days. Formal report submitted by county to state on outcome of corrective action in 30 days.
	3. CLSS providers supply medication reminders to participants and monitor their signs and symptoms and side-effects.	3. Representative sampling record reviews of case files, service provider records, monitoring reports and on-site interviews. The State's sampling methodology will ensure a 95 percent confidence	3. DHS (SMA)	3. Annually	3. DHS (SMA)	3. Immediate safety issues identified must have a corrective action plan within 3 days.

		level with a 5 percent margin of error (confidence interval). The sample will be drawn from the population of 1915(i) CLSS recipients, and not the universal 1915(i) population				If a corrective action plan is needed that is not urgent, it must be provided within 15 days and the state will respond in 15 days for a total of 30 days.

System Improvement: *(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)*			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
1. The automated functional screen provides a great deal of information regarding individuals' functioning. Wisconsin intends to compare the initial screen to subsequent annual screens. We expect to see decreases in a variety of indicators such as ER use, inpatient stays, emergency detentions, physical aggression, and housing instability. Previous analysis of this data with other MH programs has demonstrated a high degree of statistical significance.	This analysis will be done by the DHS (SMA)	Annually	1. Counties with a high rate on one of these indicators that does not show comparable decreases over time will be asked to develop a Quality Improvement project around that indicator. Counties will be expected to maintain data to track improvements from the changes they make and to continue to make adjustments until they see an improvement in the specific indicator.
2. Adverse incident reports will also be tracked	DHS (SMA)	Annually	2. Counties with a pattern of incident reports may be asked to obtain training and/or implement a quality improvement project as appropriate. If patterns of adverse incident reports are noted across counties, the state will provide training to address those issues.

Methods and Standards for Establishing Payment Rates

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

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☐	HCBS Adult Day Health
☐	HCBS Habilitation
☐	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:

☐	HCBS Day Treatment or Other Partial Hospitalization Services
X	HCBS Psychosocial Rehabilitation

COMMUNITY LIVING SUPPORTIVE SERVICES

OVERVIEW

Providers will be reimbursed on an interim basis for Medicaid-covered Community Living Supportive Services provided to Medicaid-eligible clients for covered services delivered on or after the implementation date of these services. Providers submit CMS-approved annual cost reports of certified public expenditures, identifying total allowable Medicaid costs, including both federal and nonfederal expenditures for Medicaid-covered services provided by Medicaid qualified providers. The annual cost report will utilize federal principles of cost apportionment and federally required reporting methods. The report will include all expenditures related to the calculation of the Medicaid-allowable cost per unit of service. The Wisconsin Department of Health Services (DHS) will reconcile the Medicaid-allowable cost per unit of service to the provider's interim rate and cost settle the difference on all units of service delivered to Medicaid-eligible clients during the reporting period.

INTERIM RATES

On an interim basis, providers will be reimbursed the lower of billed charges or the interim rate. The interim rate is provisional payment pending the completion of the cost reconciliation and cost settlement processes for the cost report year. Public providers provide the nonfederal share through the certification of public expenditures process and, as a result, will only be reimbursed the federal share on an interim basis and upon final settlement.

Interim rates for Community Living Supportive Services are established by the State. There will be two rates; one for services in the individual's own home or apartment and another for residential settings such as CBRF's and AFH's. There is a high degree of variability of the costs of residential settings currently serving individuals with mental illness. This variability is a result of the level of need of the individuals in a particular setting. Some AFHs serve individuals with greater needs than some CBRF's and vice versa. The residential interim rate was set at a level to meet the costs of a majority of residential settings, but not so high as to result in frequent overpayments.

Initial interim rates are based on a review of rate setting methods for similar services of selected states and a review of rates for similar services currently provided in Wisconsin.

The review of selected states determined reimbursement practices used in other states for similar services. Information reviewed included the scope of the programs under which the services are provided, the eligibility criteria for the programs and the methodology each state uses to calculate and set interim rates. Considerations for

selecting states included geography, demographics, history of individual states' waiver programs, and examples of states cited as national models.

The review analyzed programs within Wisconsin that provide services to persons with mental illness that are similar in scope. Survey data was collected regarding those costs. Additional in depth analysis was completed at two counties currently providing these services.

The combination of the results of the other state review and review of similar state services determined best practices that the state followed in developing its interim rates.

After the completion and desk review of the first full year cost report, DHS will reevaluate its interim rates and revise them to reflect actual 1915(i) cost data reported by the counties.

ANNUAL COST REPORT PROCESS

Each governmental provider will complete an annual cost report in the format required by DHS and approved by CMS. Such cost report shall utilize and be incorporated into the state's proven Wisconsin Medicaid Cost Report (WIMCR) system, but with refinements to capture greater unit cost detail related to 1915(i).The report will cover services delivered in the prior calendar year and be due by May 1 of the following year. The following steps will be used to determine Medicaid-allowable cost per unit of service:

A. The provider will identify direct costs to provide the covered services. Direct costs include residential facility costs exclusive of room and board, including residential staff costs, and operating costs such as client transportation, staff training, and staff certification

B. The provider will identify nondirect and overhead costs to provide the covered services. Allocation of these costs to the covered services can be based on the salaries method, cost-to-cost method, or pro rata method. Nondirect and overhead costs include costs for nondirect service staff (e.g., administrators, supervisors, clerical, and other) and allowable overhead costs as dictated by the DHS Allowable Cost Policy Manual and OMB Circular A-87.

C. The results from Paragraph A will be combined with the results from Paragraph B, to result in total allowable costs for the covered service for all payers.

D. The results from Paragraph C will be divided by the total number of units of service irrespective of payer for the reporting period to result in the cost per unit of service.

E. The results from Paragraph D will be multiplied by the number of Medicaid allowable units of service.

COST RECONCILIATION AND COST SETTLEMENT

DHS will review the annual cost reports submitted by providers, making adjustments as necessary in accordance with cost report instructions and the scope of costs approved by CMS.

The adjusted Medicaid-allowable cost per unit of service will be compared/reconciled to the provider's interim rate per service. The difference will be applied to the provider's total Medicaid allowable units of service in the cost settlement process.

Providers will be notified of all adjustments to their cost reports and the resulting cost settlement amounts, indicating the amount due to or from the provider, no later than 24 months after the close of the applicable cost-reporting period.

The State cannot adjust its interim rates prospectively to account for overpayment. Instead, if the provider's interim payments exceed the actual, certified costs of the provider, the federal share of the overpayment will be recouped either from offsetting all future claims payments from the provider until the amount of the federal share of the overpayment is recovered or the provider will return an amount equal to the overpayment in a lump sum payment.

If the provider's Medicaid-allowable costs exceed its interim payments, the federal share of the difference will be paid to the provider in accordance with the final certification agreement and claims will be submitted to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

SUPPORTED EMPLOYMENT

OVERVIEW

Providers will be reimbursed on an interim basis for Medicaid-covered Supported Employment services provided to Medicaid-eligible clients delivered on or after the implementation date of these services. Providers submit CMS-approved annual cost reports of certified public expenditures, identifying total allowable Medicaid costs, including both federal and nonfederal expenditures for Medicaid-covered services provided by Medicaid qualified providers. The annual cost report will utilize federal principles of cost apportionment and federally required reporting methods. The report will include all expenditures related to the calculation of the Medicaid-allowable cost per unit of service. The Wisconsin Department of Health Services (DHS) will reconcile the Medicaid-allowable cost per unit of service to the provider's interim rate and cost

settle the difference on all units of service delivered to Medicaid-eligible clients during the reporting period.

INTERIM RATES

On an interim basis, providers will be reimbursed the lower of billed charges or the interim rate. The interim rate is provisional payment pending the completion of the cost reconciliation and cost settlement processes for the cost report year. Public providers provide the nonfederal share through the certification of public expenditures process and, as a result, will only be reimbursed the federal share on an interim basis and upon final settlement.

Interim rates for Supported Employment services are established by the State and there is a single statewide interim rate for the service.

Initial interim rates are based on a review of rate setting methods for similar services of selected states and a review of rates for similar services currently provided in Wisconsin.

The review of selected states determined reimbursement practices used in other states for similar services. Information reviewed included the scope of the programs under which the services are provided, the eligibility criteria for the programs and the methodology each state uses to calculate and set interim rates. Considerations for selecting states included geography, demographics, history of individual states' waiver programs, and examples of states cited as national models.

The review analyzed programs within Wisconsin that provide services to persons with mental illness that are similar in scope. Survey data was collected regarding those costs. Additional in depth analysis was completed at two counties currently providing these services.

The combination of the results of the other state review and review of similar state services determined best practices that the state followed in developing its interim rates.

After the completion and desk review of the first full year cost report, DHS will reevaluate its interim rates, and revise them to reflect actual Community Recovery Services (1915(i)) cost data reported by the counties.

ANNUAL COST REPORT PROCESS

Each governmental provider will complete an annual cost report in the format required by DHS and approved by CMS. Such cost report shall utilize and be incorporated into the state's proven Wisconsin Medicaid Cost Report (WIMCR) system, but with refinements to capture greater unit cost detail related to 1915(i). The report will cover services delivered in the prior calendar year and be due by May 1 of the following year. The following steps will be used to determine Medicaid-allowable cost per unit of service:

F. The provider will identify direct costs to provide the covered services. Direct costs include staff costs (e.g., salaries, payroll taxes, employee benefits, and contacted compensation) of service providers and costs directly related to the approved services providers for the delivery of covered services, such as purchased services, staff travel/training, licensure/certification renewal and/or continuing education costs, and materials and supplies.

G. The provider will identify nondirect and overhead costs to provide the covered services. Allocation of these costs to the covered services can be based on the salaries method, cost-to-cost method, or pro rata method. Nondirect and overhead costs include costs for nondirect service staff (e.g., administrators, supervisors, clerical, and other) and allowable overhead costs as dictated by the DHS Allowable Cost Policy Manual and OMB Circular A-87.

H. The results from Paragraph F will be combined with the results from Paragraph G, to result in total allowable costs for the covered service for all payers.

I. The results from Paragraph H will be divided by the total number of units of service irrespective of payer for the reporting period to result in the cost per unit of service.

J. The results from Paragraph I will be multiplied by the number of Medicaid allowable units of service.

COST RECONCILIATION AND COST SETTLEMENT

DHS will review the annual cost reports submitted by providers, making adjustments as necessary in accordance with cost report instructions and the scope of costs approved by CMS.

The adjusted Medicaid-allowable cost per unit of service will be compared/reconciled to the provider's interim rate per service. The difference will be applied to the provider's total Medicaid allowable units of service in the cost settlement process.

Providers will be notified of all adjustments to their cost reports and the resulting cost settlement amounts, indicating the amount due to or from the provider, no later than 24 months after the close of the applicable cost-reporting period.

The State cannot adjust its interim rates prospectively to account for overpayment. Instead, if the provider's interim payments exceed the actual, certified costs of the provider, the federal share of the overpayment will be recouped either from offsetting all future claims payments from the provider until the amount of the federal share of the overpayment is recovered or the provider will return an amount equal to the overpayment in a lump sum payment.

If the provider's Medicaid-allowable costs exceed its interim payments, the

federal share of the difference will be paid to the provider in accordance with the final certification agreement and claims will be submitted to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

PEER SUPPORTS

OVERVIEW

Providers will be reimbursed on an interim basis for Medicaid-covered Peer Supports services provided to Medicaid-eligible clients delivered on or after the implementation date of these services. Providers submit CMS-approved annual cost reports of certified public expenditures, identifying total allowable Medicaid costs, including both federal and nonfederal expenditures for Medicaid-covered services provided by Medicaid qualified providers. The annual cost report will utilize federal principles of cost apportionment and federally required reporting methods. The report will include all expenditures related to the calculation of the Medicaid-allowable cost per unit of service. The Wisconsin Department of Health Services (DHS) will reconcile the Medicaid-allowable cost per unit of service to the provider's interim rate and cost settle the difference on all units of service delivered to Medicaid-eligible clients during the reporting period.

INTERIM RATES

On an interim basis, providers will be reimbursed the lower of billed charges or the interim rate. The interim rate is provisional payment pending the completion of the cost reconciliation and cost settlement processes for the cost report year. Public providers provide the nonfederal share through the certification of public expenditures process and, as a result, will only be reimbursed the federal share on an interim basis and upon final settlement.

Interim rates for Peer Supports services are established by the State and there is a single statewide interim rate for the service.

Initial interim rates are based on a review of rate setting methods for similar services of selected states and a review of rates for similar services currently provided in Wisconsin.

The review of selected states determined reimbursement practices used in other states for similar services. Information reviewed included the scope of the programs under which the services are provided, the eligibility criteria for the programs and the methodology each state uses to calculate and set interim rates. Considerations for selecting states included geography, demographics, history of individual states' waiver programs, and examples of states cited as national models.

The review analyzed programs within Wisconsin that provide services to persons with mental illness that are similar in scope. Survey data was collected regarding those costs. Additional in depth analysis was completed at two counties currently providing these

services.

The combination of the results of the other state review and review of similar state services determined best practices that the state followed in developing its interim rates.

After the completion and desk review of the first full year cost report, DHS will reevaluate its interim rates, and revise them to reflect actual 1915(i) cost data reported by counties.

ANNUAL COST REPORT PROCESS

Each governmental provider will complete an annual cost report in the format required by DHS and approved by CMS. Such cost report shall utilize and be incorporated into the state's proven Wisconsin Medicaid Cost Report (WIMCR) system, but with refinements to capture greater unit cost detail related to 1915(i).The report will cover services delivered in the prior calendar year and be due by May 1 of the following year. The following steps will be used to determine Medicaid-allowable cost per unit of service:

K. The provider will identify direct costs to provide the covered services. Direct costs include staff costs (e.g., salaries, payroll taxes, employee benefits, and contacted compensation) of service providers and costs directly related to the approved services providers for the delivery of covered services, such as purchased services, staff travel/training, licensure/certification renewal and/or continuing education costs, and materials and supplies.

L. The provider will identify nondirect and overhead costs to provide the covered services. Allocation of these costs to the covered services can be based on the salaries method, cost-to-cost method, or pro rata method. Nondirect and overhead costs include costs for nondirect service staff (e.g., administrators, supervisors, clerical, and other) and allowable overhead costs as dictated by the DHS Allowable Cost Policy Manual and OMB Circular A-87.

M. The results from Paragraph K will be combined with the results from Paragraph L, to result in total allowable costs for the covered service for all payers.

N. The results from Paragraph M will be divided by the total number of units of service irrespective of payer for the reporting period to result in the cost per unit of service.

O. The results from Paragraph N will be multiplied by the number of Medicaid allowable units of service.

		COST RECONCILIATION AND COST SETTLEMENT DHS will review the annual cost reports submitted by providers, making adjustments as necessary in accordance with cost report instructions and the scope of costs approved by CMS. The adjusted Medicaid-allowable cost per unit of service will be compared/reconciled to the provider's interim rate per service. The difference will be applied to the provider's total Medicaid allowable units of service in the cost settlement process. Providers will be notified of all adjustments to their cost reports and the resulting cost settlement amounts, indicating the amount due to or from the provider, no later than 24 months after the close of the applicable cost-reporting period. The State cannot adjust its interim rates prospectively to account for overpayment. Instead, if the provider's interim payments exceed the actual, certified costs of the provider, the federal share of the overpayment will be recouped either from offsetting all future claims payments from the provider until the amount of the federal share of the overpayment is recovered or the provider will return an amount equal to the overpayment in a lump sum payment. If the provider's Medicaid-allowable costs exceed its interim payments, the federal share of the difference will be paid to the provider in accordance with the final certification agreement and claims will be submitted to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)