

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 §4 (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 §110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

Peer Supports	
<p>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.</p>	
Additional needs-based criteria for receiving the service, if applicable (<i>specify</i>):	
Specify limits (if any) on the amount, duration, or scope of this service for (<i>chose each that applies</i>):	
<input type="checkbox"/>	Categorically needy (<i>specify limits</i>):
<input type="checkbox"/>	Medically needy (<i>specify limits</i>):

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/Care Services Agency or Individual			Providers are subject to caregiver, criminal and licensing background checks. Orientation for job duties, policies 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,	Every other year
	Human Service Department Care Manager	Ongoing oversight & monitoring
Service Delivery Method. (Check each that applies):		
<input type="checkbox"/> Participant-directed	<input checked="" type="checkbox"/> Provider managed	

2. **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box the State assures that):* There are policies pertaining to payment the State makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the State makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS ; (b) 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):

<input checked="" type="radio"/>	The State does not offer opportunity for participant-direction of State plan HCBS.
<input type="radio"/>	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.
<input type="radio"/>	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. <i>(Specify criteria):</i>

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):

<input type="radio"/>	Participant direction is available in all geographic areas in which State plan HCBS are available.
<input type="radio"/>	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. <i>(Specify the areas of the State affected by this option):</i>

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
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="radio"/>	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
<input type="radio"/>	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):*

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8. Opportunities for Participant-Direction

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

<input type="radio"/>	The State does not offer opportunity for participant-employer authority.
<input type="radio"/>	Participants may elect participant-employer Authority <i>(Check each that applies):</i>
<input type="checkbox"/>	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.
<input type="checkbox"/>	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):*

<input type="radio"/>	The State does not offer opportunity for participants to direct a budget.
<input type="radio"/>	Participants may elect Participant–Budget Authority.
	Participant-Directed Budget. <i>(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):</i>
	Expenditure Safeguards. <i>(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):</i>

Quality Improvement Strategy

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

Requirement	Discovery Activities			Remediation		
	Discovery Evidence (Performance Measures)	Discovery Activity (Source of Data & sample size)	Monitoring Responsibilities (agency or entity)	Frequency	Remediation Responsibilities (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

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	<p>4. Participant needs assessment conducted by the case manager.</p> <p>5. All willing providers have the opportunity to register with the DHS.</p>	<p>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.</p> <p>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.</p> <p>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.</p>	<p>4. DHS (SMA)</p> <p>5. DHS (SMA)</p>	<p>4. Annually</p> <p>5. Annually</p>	<p>4. DHS (SMA)</p> <p>5. DHS (SMA)</p>	<p>and the state will respond in 15 days for a total of 30 days.</p> <p>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.</p> <p>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.</p>
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	<p>6. Services are delivered in accordance with the service plan.</p>	<p>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.</p>	<p>6. DHS (SMA)</p>	<p>6. Annually</p>	<p>6. DHS (SMA)</p>	<p>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.</p>
<p>Providers meet required qualifications.</p>	<p>1. All providers meet requirements established by DHS and documented by the case manager.</p> <p>2. All providers have a current agreement with the SMA.</p>	<p>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.</p> <p>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</p>	<p>1. DHS (SMA) 2. DHS (SMA)</p>	<p>1. Annually 2. Annually</p>	<p>1. DHS (SMA) 2. DHS (SMA)</p>	<p>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.</p> <p>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.</p>

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				approved 1915i participants. The sample size will be determined by applying the methodology to the universal population.			
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Requirement	Discovery Activities				Remediation	
	Discovery Evidence <i>(Performance Measures)</i>	Discovery Activity <i>(Source of Data & sample size)</i>	Monitoring Responsibilities <i>(agency or entity)</i>	Frequency	Remediation Responsibilities <i>(Who does this)</i>	Frequency of Analysis and Aggregation
The SMA retains authority and responsibility for program operations and oversight.	<p>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.</p> <p>2. Presence of the county entities entering accurate information into the automated functional screen.</p>	<p>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.</p> <p>2. All (100%) initial and updated automated functional screens will be reviewed when service plan packets are submitted by the county entity.</p>	<p>1. DHS (SMA)</p> <p>2. DHS (SMA)</p>	<p>1. Annually</p> <p>2. Ongoing</p>	<p>1. DHS (SMA)</p> <p>2. DHS (SMA)</p>	<p>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.</p> <p>2. If a corrective action plan is needed, it must be provided within 15 days and the state will respond in 15 days.</p>

<p>The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</p>	<p>1. DHS oversight through the MMIS system to assure claims are coded and paid in accordance with the state plan.</p> <p>2. Representative sample of claims, case files and service plans.</p> <p>3. Claims are authorized and furnished appropriately.</p>	<p>1. MMIS Reports</p> <p>2. Program review of MMIS Reports, documentation of sample selection process.</p> <p>3. Program testing in annual single audit of county agency.</p>	<p>1. DHS (SMA)</p> <p>2. DHS (SMA)</p> <p>3. DHS (SMA)</p>	<p>1. Ongoing</p> <p>2. Annually</p> <p>3. Annually</p>	<p>1. DHS (SMA)</p> <p>2. DHS (SMA)</p> <p>3. DHS (SMA)</p>	<p>days for a total of 30 days.</p> <p>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</p> <p>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</p> <p>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</p>
<p>The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.</p>	<p>1. Service plans address health and welfare needs of the participant</p>	<p>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</p>	<p>1. DHS (SMA)</p>	<p>1. Annually</p>	<p>1. DHS (SMA)</p>	<p>1. Immediate safety issues identified must have a corrective action plan within 3 days if a corrective</p>

	<p>2. Providers will complete and submit incident reports as required by DHS policy.</p> <p>3. CLASS providers supply medication reminders to participants and monitor their signs and symptoms and side effects.</p>	<p>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.</p> <p>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.</p> <p>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.</p>	<p>2. DHS (SMA)</p> <p>3. DHS (SMA)</p>	<p>2. Ongoing</p> <p>3. Annually</p>	<p>2. County Agency and DHS (SMA)</p> <p>3. DHS (SMA)</p>	<p>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.</p> <p>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.</p> <p>3. Immediate safety issues identified must have a corrective action plan within 3 days.</p>
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		<p>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</p>				<p>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</p>
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System Improvement: <i>(Describe process for systems improvement as a result of aggregated discovery and remediation activities.)</i>			
Methods for Analyzing Data and Prioritizing Need for System Improvement	Roles and Responsibilities	Frequency	Method for Evaluating Effectiveness of System Changes
<p>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.</p>	<p>This analysis will be done by the DHS (SMA)</p>	<p>Annually</p>	<p>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.</p>
<p>2. Adverse incident reports will also be tracked</p>	<p>DHS (SMA)</p>	<p>Annually</p>	<p>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.</p>

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):*

<input type="checkbox"/>	HCBS Case Management
<input type="checkbox"/>	HCBS Homemaker
<input type="checkbox"/>	HCBS Home Health Aide
<input type="checkbox"/>	HCBS Personal Care
<input type="checkbox"/>	HCBS Adult Day Health
<input type="checkbox"/>	HCBS Habilitation
<input type="checkbox"/>	HCBS Respite Care

For Individuals with Chronic Mental Illness, the following services:	
<input type="checkbox"/>	HCBS Day Treatment or Other Partial Hospitalization Services
<input checked="" type="checkbox"/>	<p>HCBS Psychosocial Rehabilitation</p> <p><u>COMMUNITY LIVING SUPPORTIVE SERVICES</u></p> <p><u>OVERVIEW</u></p> <p>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.</p> <p><u>INTERIM RATES</u></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>

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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 contracted 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 contracted 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.

	<p>COST RECONCILIATION AND COST SETTLEMENT</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
<input type="checkbox"/>	HCBS Clinic Services (whether or not furnished in a facility for CMI)