2016 Family Care Programs Contract - Excerpts

The following are excerpts taken from the current Family Care contract for Managed Care Organizations. While the contact is a substantial document, the selected excerpts contain language referencing transportation service. The entire contact can be accessed through the Family Care website.

Website link:
http://mltc.wisconsin.gov/2016/

VII. Services

A. General Provisions

1. *Comprehensive Service Delivery System*

The MCO will provide members with high-quality long-term care and health care services that:

a. Are from appropriate and qualified providers;

b. Are fair and safe;

c. Serve to maintain community connections, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, and that are cost effective.

Services are delivered through a comprehensive interdisciplinary health and social services delivery system appropriate to the benefit package pursuant to this contract and any applicable state and federal regulations.

2. *Sufficient Services*

Services must be sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The MCO's benefit package services that are Medicaid state plan services as defined in Addendum IX, Section B for Family Care and Section C for Partnership and PACE must be no more restrictive than the Medicaid fee-for-service coverage. The MCO is responsible for covering services related to the following:

a. The prevention, diagnosis, and treatment of health impairments;

b. The ability to achieve age-appropriate growth and development;

c. The ability to attain, maintain, or regain functional capacity.

3. *Benefit Package Services*

Benefit package services must minimally include the services outlined in Addendum IX, Benefit Package Service Definitions.

4. *Inform Members of the Benefit Package*

The MCO will inform members of the full range of services in the benefit package appropriate for their level of care. The MCO will provide a range of services to meet the needs and outcomes of its members, as identified in the member-centered planning process (described in Article V.C.

5. *Alternate Services*

Members have a right to request any covered service, whether or not the service has been recommended as necessary or appropriate by a professional or the interdisciplinary team responsible for coordinating their care.

The MCO is not restricted to providing only the services in the benefit package. The MCO may provide, but is not required to provide, a support or service to a specific member that is not specified in the benefit package if the alternative support or service is:

a. An alternative to a support or service that is in the benefit package otherwise available to the member, and

b. Cost-effective in comparison to the support or service in the benefit package for which it is substituting, and

c. Appropriate to support that member's long-term care outcomes and needs, and

d. The member agrees to the alternative.

The cost of such alternatives that are specifically documented in the encounter reporting system defined in Article XIV, Reports and Data, will be examined by the Department's actuary and, if appropriate, will be included in the development of actuarially sound rates as defined in Addendum I, Actuarial Basis.

6 *In Lieu of Services*

a. Definition

In lieu of services are a subset of alternate services that the Department has, as a general matter, determined are medically appropriate and cost-effective substitutes for covered services in the benefit package, and:

i. Which are offered to a member at the discretion of the MCO;

ii. Which the member agrees to as an alternate service; and

iii. For which utilization and cost are taken into account in setting capitation rates, unless a statute or regulation explicitly requires otherwise.

b. In Lieu of Services for Members Functionally Eligible at the Nursing Home Level of Care

For a member functionally eligible at the nursing home level of care an MCO may supplement a member's payment of the non-covered residential care services portion of the cost of residential care as an in lieu of service where:

i. The MCO has authorized a residential care service in Addendum IX.A.16 and the member agrees to the service;

ii. The MCO determines as specified in Article III.F. that the member's income is insufficient to pay the full cost of non-covered residential care services in the facility;

iii. The MCO determines that without supplementation the member would need nursing home care;

iv. The amount of supplementation is less than the cost of non-covered residential care services in a nursing home, as specified by the Department.

c. In Lieu of Services for Members Functionally Eligible at the Non-Nursing Home Level of Care

For a member functionally eligible at the non-nursing home level of care the MCO may:

i. Provide the following services in lieu of home health care in Addendum IX.B.6 or personal care in Addendum IX.B.13:

a) Supportive home care in Addendum IX. A.24.;

b) Respite care in Addendum IX.A.17.;

c) Personal emergency response system in Addendum IX.A.13.;

d) Daily living skills training in Addendum IX.A.10.a.;

e) Day habilitation services in Addendum IX.A. 10.b.;

f) Prevocational services in Addendum IX.A.14.;

g) Residential care services in Addendum IX.A.16.;

h) Home delivered meals in Addendum IX.A.11.;

i) Counseling and therapeutic services in Addendum IX.A.7.; or

j) Congregate nutrition services under 42USC § 3030e.

ii. Provide specialized transportation–other transportation in Addendum IX.A.27 in lieu of transportation services in Addendum IX.B.16.

d. The Department may specify other services that may be provided in lieu of covering services in the benefit package in Addendum

IX. An MCO may only provide a service as an in lieu of service if it is so specified in this Contract.

7. *Long-term Care Services Where Members Live*

Members shall receive the long-term care services in the benefit package where they live, including:

a. The member's own home, including supported apartments.

b. Alternative residential settings including, but not limited to:

i. State Certified Residential Care Apartment Complexes (RCAC).

ii. Community-Based Residential Facilities (CBRF).

iii. Adult Family Homes (AFH).

c. Nursing Facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID).

8. *Services During Temporary Absence*

The MCO shall provide services during periods of temporary absence as described in Article V.L., Services During Periods of Temporary Absence.

9. *Self-Directed Supports*

The MCO shall provide support for self-directed care as described in Article VI, Self Directed Supports.

ADDENDUM

IX. Benefit Package Service Definitions

A. Home and Community-Based Waiver Services

Services under a waiver service category may not duplicate any service provided under another waiver service category or through the Medicaid State Plan.

The following services, defined in Wisconsin's s. 1915 (c) home and community-based waiver services waivers #0367.90 and #0368.90 required under Wis. Stat. § 46.281(1)(d) and approved by the Centers for Medicare & Medicaid Services (CMS) are included in the Family Care, Partnership and PACE benefit packages:

1. **Adaptive aids** are controls or appliances that enable members to increase their abilities to perform activities of daily living or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services and material benefits that enable members to access, participate and function in their community. These include the purchase of vehicle modifications (such as van lifts, hand controls, equipment modifications, etc. that allow the vehicle to be used by the member to access the community) or those costs associated with the maintenance of these items. The service may also include the initial purchase of a service dog and routine veterinary costs for a service dog. Excludes food and non-routine veterinary care for service dogs based on DHS guidelines. Providers of this service must be Medicaid certified providers. Electronic devices must meet UL or FCC standards. For service dogs, provider must be a reputable provider with experience providing and training service dogs.

2. **Adult day care services** are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision and/or protection. Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site. Transportation between the member's place of residence and the adult day care center may be provided as a component of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care services. Meals provided as part of adult day care may not constitute a "full nutritional regimen" (3 meals per day). For providers of this service, Wis. Stats. Chapter 49.45 applies.

3. **Assistive technology/communication aids** means an item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain or improve functional capabilities of members at home, work and in the community. Assistive technology service means a service that directly assists a member in the

selection, acquisition, or use of an assistive technology device. Assistive technology includes:

a. the evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the member in the customary environment of the member;

b. services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for members;

c. services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;

d. coordination and use of necessary therapies, interventions or services with assistive technology devices, such as therapies, intervention or services, associated with other services in the service plan;

e. training or technical assistance for the member, or where appropriate, the family members, guardians, advocates or authorized representatives of the member; and

f. training or technical assistance for professionals or other individuals who provide services to, employ or are otherwise substantially involved in the major life functions of members.

Assistive technology includes communication aids that are devices or services needed to assist members with hearing, speech, communication or vision impairments. These items or services assist the individual to effectively communicate with service providers, family, friends and the general public; decrease reliance on paid staff; increase personal safety; enhance independence; and improve social and emotional well-being.

Communication aids include any device that addresses these objectives such as augmentative and alternative communication systems, hearing or speech amplification devices, aids and assistive devices, interpreters, and cognitive retraining aids and the repair and/or servicing of such systems. Communication aids also include electronic technology such as tablets or mobile devices and related software that assist with communication, when the use provides assistance to a person who needs such assistance due to her/her disabilities. Applications for mobile devices or other technology also are covered under this service, when the use is primarily medical in nature or provides assistance to a person who needs such assistance due to his/her disabilities. This list is intended to be illustrative and is not exhaustive. Excludes interpreter services that are otherwise available, including for communication with the managed care organization, its contractors or other health care professionals, which are required to provide interpreter services as part of their rate.

Individual interpreters must be on the state or national interpreter registry. Communication aids vendors must be Medicaid certified providers. Electronic devices must meet UL or FCC standards.

4. **Care/case management services** (sometimes called support and service coordination) are provided by an interdisciplinary care management team (IDT). The member is the center of the IDT. The IDT consists of, at minimum, a registered nurse and a social services coordinator, and may also include other professionals as appropriate to the needs of the member, as well as family or other informal supports requested by the member. The IDT initiates and oversees the initial comprehensive assessment of needs and reassessment process, the results of which are used in developing the individual's member-centered plan of care. The IDT identifies the member's preferred outcomes and the services needed to achieve those outcomes and monitors the member's health and welfare, the delivery of services, and progress in achieving identified outcomes. The IDT also carries out activities that help members and their families to identify other service needs and gain access to medical, social, rehabilitation, vocational, educational and other services identified.

   Care management is always provided by individuals employed by the managed care organization or by a subcontracted agency of the managed care organization. Care management services are provided by the case manager with the member and other participants of the interdisciplinary team and include:

   a. A comprehensive assessment of the member's strengths, abilities, functional limitations, lifestyle, personal circumstances, values, preferences and choices;

   b. Development of an individualized plan of care;

   c. Authorization for the purchase of paid services identified in the plan of care;

   d. Monitoring of the delivery and quality of the paid services identified in the plan of care;

   e. Monitoring of the member's circumstances and ongoing health and well-being; and

   f. Maintenance of the member record and all documentation associated with the delivery of services and any required waiver procedures.

   For providers of this service: Wis. Stats. Chapter 441 applies to Registered Nurses; a four year bachelor's degree in a social services area (e.g. social work, rehabilitation, psychology, etc.) and knowledge of the conditions of LTC target populations is required for Social Service Coordinators; and Wis. Stats. Chapter 457 applies to Social Workers.

5. **Consultative clinical and therapeutic services for caregivers**. The purpose of consultative services is to improve the ability of unpaid caregivers and paid direct support staff to carry out therapeutic interventions.

   Clinical and therapeutic services assist unpaid caregivers and/or paid support staff in carrying out the member's treatment/support plans, are not covered by the Medicaid State Plan and are necessary to improve the member's independence and inclusion in their community.

   The service includes assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans and monitoring of the member and the caregiver/staff in the implementation of the plans.

   This service includes the provision of training for caregivers/staff that are or will be serving members with complex needs (beyond routine care). For example, when an individual with complex needs is relocating from one of the State Centers for the Intellectually Disabled, this service could be used to train caregivers/staff on the behavioral support plans necessary for community integration.

   This service may also include consultation with service providers and potential providers to identify providers that can meet the unique needs of the member and to identify additional supports necessary for caregivers to perform therapeutic interventions.

   Excludes training in member self-advocacy or caregiver advocacy on behalf of a member, which are covered under consumer education and training.

   Individual counselors must have current state licensure or certification in their field of practice. Counseling agencies must comply with Wis. Admin. Code DHS 61.35.

6. **Consumer education and training services** are designed to help a person with a disability develop self-advocacy skills, support self-determination, exercise civil rights and acquire skills needed to exercise control and responsibility over other support services; includes education and training for members, their caregivers and/or legal representatives that is directly related to building or acquiring such skills. Managed care organizations assure that information about educational and/or training opportunities is available to members and their caregivers and legal representatives. Covered expenses may include enrollment fees, books and other educational materials and transportation related to participation in training courses, conferences and other similar events. Excludes educationally related services available under Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq) or other relevant funding sources. Excludes education/training costs exceeding $2500 per participant annually. Excludes payment for hotel and meal expenses while

members or their legal representatives attend allowable training/education events.

Providers must have expertise in problem solving, self-advocacy skills development, self-determination, community integration, financial management and decision-making.

7. **Counseling and therapeutic services** is the provision of professional, treatment-oriented services to address a member's identified needs for personal, social, physical, medical, behavioral, emotional, cognitive, mental or substance abuse disorders.

   Counseling and therapeutic services may include assistance in adjusting to aging and/or disabilities including understanding capabilities and limitations. Services may also include assistance with interpersonal relationships, recreational therapies, music therapy, art therapy, nutritional counseling, medical counseling, weight counseling and grief counseling.

   Counseling and therapeutic services must meet clearly defined outcomes, be proven effective for the member's condition or outcome and be cost effective. Any alternative therapies and treatments must meet DHS requirements. Excludes inpatient services, services provided by a physician and services covered by the Medicare program (except for payment of any Medicare cost share).

   Counseling agencies must comply with Wis. Admin.Code DHS 61.35. All providers must have current state licensure or certification in their field of practice.

8. **Environmental accessibility adaptations (home modifications)** are the provision of services and items to assess the need for, arrange for and provide modifications and or improvements to a member's living quarters in order to provide accessibility or increase safety. Modifications may provide for safe access to and within the home, reduce the risk of injury, facilitate independence and self-reliance, allow the individual to perform more ADLs or IADLs with less assistance and decrease reliance on paid staff. Home modifications may include materials and services such as ramps, stair lifts, wheelchair lifts or other mechanical devices to lift persons with impaired mobility from one vertical level to another; kitchen/bathroom modifications; specialized accessibility/safety adaptations; and voice-activated, light-activated, motion-activated and electronic devices that increase the member's self-reliance and capacity to function independently. Home modifications may include modifications that add to the square footage of the residence if the modifications are to assure the health, safety or independence of the person and prevents institutionalization and the modification is the most cost effective means of meeting the accessibility or safety need compared to other more expensive options. Contractors must comply with local and/or state housing and building codes.

9. **Financial management services** are services to assist members and their families to manage service dollars or manage their personal finances to prevent institutionalization. This service includes a person or agency paying service providers after the member, guardian or other authorized representative authorizes payment to be made for services included in the member's approved self-directed supports plan. Financial management services providers, sometimes referred to as fiscal intermediaries or fiscal agents, are organizations or individuals that write checks to pay bills for personnel costs, tax withholding, worker's compensation, health insurance and other taxes and benefits appropriate for the specific provider consistent with the individual's self-directed supports plan and budget for services. Financial management services are purchased directly by the MCO and made available to the member/family to insure that appropriate compensation is paid to providers of services. It also includes the provision of assistance to members who are unable to manage their own personal funds to assist them to manage their personal resources. This service includes assistance to the member to effectively budget the member's personal funds to ensure sufficient resources are available for housing, board and other essential costs. This service includes paying bills authorized by the member or their guardian, keeping an account of disbursements and assisting the member to ensure that sufficient funds are available for needs. Excludes payments to court-appointed guardians or court-appointed protective payees if the court has directed them to perform any of these functions. Excludes payment for the cost of room and board.

   An MCO must have standards in place that ensure at minimum that a financial management services provider: 1) is an agency, unit of an agency or individual that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include self-directed supports; 2) has training and experience in accounting or bookkeeping; and 3) has a system in place that recognizes the authorization of payment by the participant or legal representative, that promptly issues payment as authorized and that documents budget authority and summarizes payments in a manner that can be readily understood by the participant or legal representative.

10. **HabilitationServices**

    a. **Daily living skills training** is the provision of education and skill development to teach members the skills involved in performing activities of daily living, including skills intended to increase the member's independence and participation in community life. It may include teaching money management, home care maintenance, food preparation, mobility training, self-care skills and the skills necessary for accessing and using community

resources. Daily living skills training may involve training the member or the natural support person to assist the member.

For daily living skills training agencies, the MCO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing this service, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services.

If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

For individual daily living skills trainers, the MCO shall assure that the provider has the ability and qualifications to provide this service, including a minimum of two years of experience working with the target population in providing this service, day habilitation, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services. However, a member self-directing this service may employ qualified persons with less experience. In that event, the MCO and member must ensure that the individual provider receives member-specific training sufficient to enable the individual to competently provide the daily living skills training services to the member consistent with the care plan. If personal care or housekeeping services are provided along with skills training, the provider shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

b. **Day habilitation services** are the provision of regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in performing activities of daily living and full community citizenship. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice.

Day habilitation services focus on enabling the member to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the member's person-centered services and support plan, such as physical, occupational, or speech therapy. For members with degenerative conditions, day habilitation activities may include training and supports to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills. Day habilitation services may also be used to provide retirement activities. As some members get older, they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities.

Day habilitation may be furnished in a variety of settings in the community except for the member's residence. Day habilitation services are not limited to fixed-site facilities but may take place in stores, restaurants, libraries, parks, recreational facilities, community centers or any other place in the community.

Transportation may be provided between a member's place of residence and the site of day habilitation activities or between habilitation activities sites (in cases where the member receives habilitation services in more than one place) as a component of day habilitation activities. Meals provided as part of these services shall not constitute a "full nutritional regimen��? (3 meals per day). Personal care/assistance may be a component of day habilitation services as necessary to meet the need of members, but may not comprise the entirety of the service. Members who receive day habilitation services may also receive educational, supported employment and prevocational services. Day habilitation may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).

For day habilitation providers, the MCO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable standards for a qualified entity, including a minimum of two years of experience working with the target population in providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services.

11. **Home delivered meals** are meals provided to recipients who are unable to prepare or obtain nourishing meals without assistance, including those who may be unable to manage a special diet recommended by their physician. Home-delivered meal costs may include the costs associated with the purchase and planning of food, nutrition services, supplies, equipment, labor and transportation to deliver one or two meals a day.

    Home delivered meals may not constitute a "full nutritional regimen" (3 meals per day).

    This service does not include payment for meals at federally subsidized nutrition sites.

    Hospitals and nursing homes must comply with Wis. Admin. Code DHS 124, DHS 132 and DHS 134; aging network agencies must comply with Wis. Stats. Chapter 46.82 (3); and restaurants must comply with Wis. Admin. Code DHS 196.

12. **Housing counseling** is a service which provides assistance to a member when acquiring housing in the community, where ownership or rental of housing is separate from service provision. The purpose of housing counseling is to promote consumer choice and control of housing and access to housing that is affordable and promotes community inclusion. Housing counseling includes exploring both home ownership and rental options, and both individual and shared housing situations, including situations where the individual lives with his or her family. Services include counseling and assistance in identifying housing options, identifying financial resources and determining affordability, identifying preferences of location and type of housing, identifying accessibility and modification needs, locating available housing, identifying and assisting in access to financing, explaining the rights and responsibilities of a tenant with disabilities, including how to ask for reasonable accommodations and modifications and how to file a complaint, and planning for ongoing management and maintenance. Housing counseling is not a one-time service and may be accessed by a member at any time. A qualified provider must be an agency or unit of an agency that provides housing counseling to people who need assistance with housing as a regular part of its mission or activities. Counseling must be provided by staff with specialized training and experience in housing issues. This service is excluded if it is otherwise provided free to the general public. This service may not be provided by an agency that also provides residential support services or support/service coordination to the member. Providers must have expertise in housing issues relevant to the participant and may not be a provider of residential support services to the participant.

13. **Personal emergency response system (PERS)** provides a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate

response and assistance in the event of a physical, emotional or environmental emergency. This service may include devices and services necessary for operation of PERS when otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as appropriate. Electronic devices must meet UL Standards. Telephonic devices must meet FCC regulations.

14. **Prevocational services** are designed to create a path to integrated community based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational services involve the provision of learning and work experiences where a member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time as determined by the member and his/her care planning team in the ongoing member-centered planning process. Services are expected to specifically involve strategies that enhance a member's employability in integrated, community settings.

    Prevocational services should enable each member to attain the highest possible wage and work which is in the most integrated setting and matched to the member's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment, including but not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

    Prevocational services may be delivered in a variety of locations in the community and are not limited to fixed-site facilities. Some examples of community sites may be the library, job center, banks or any business.

    Prevocational services, regardless of how and where they are delivered, are expected to help people make reasonable and continued progress toward participation in at least part-time, integrated employment. Prevocational services are not considered outcomes in and of themselves. Competitive employment and supported employment are considered successful outcomes of prevocational services.

    Prevocational services may be provided to supplement, but may not duplicate services provided as part of an approved Individualized Plan for Employment (IPE) funded under the Rehabilitation Act of 1973, as amended, or under an approved Individualized Education Plan (IEP) under the Individuals with Disabilities Education Act (IDEA).

The contracted provider of pre-vocational services must complete a six month progress report and service plan document for the IDT. The purpose is to ensure and document that prevocational services are assisting the member in progressing toward a goal of at least part-time, integrated employment. Timely completion of this document is required for the IDT to consider reauthorization of prevocational services.

Participation in prevocational services is not a pre-requisite for individual or small group supported employment services. Members who receive prevocational services may also receive educational, supported employment and/or day services. A member's care plan may include two or more types of non-residential services. However, different types of non-residential services may not be billed for the same period of time.

Members participating in prevocational services shall be compensated in accordance with applicable Federal and State laws and regulations, if those laws require compensation. The optimal outcome of the provision of prevocational services is permanent integrated employment at or above the minimum wage in the community.

Transportation may be provided between the member's place of residence and the site of the prevocational services or between prevocational service sites (in cases where the member receives prevocational services in more than one place) either as a component part of prevocational services or under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met. If the transportation is provided by the prevocational services provider, the cost of this transportation is included in the rate paid to the provider.

Personal care provided to a member during the receipt of prevocational services may be included in the reimbursement paid to the prevocational services provider, or may be covered and reimbursed under another waiver service so long as there is no duplication of payment.

Prevocational services may be provided to supplement, but may not duplicate services provided under supported employment or vocational futures planning and support services provided under the waiver.

The MCO shall assure the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

- Accreditation by a nationally recognized accreditation agency.
- Comparable experience for a qualified entity, including a minimum of two years of experience working with the target population providing employment-related services that have a goal of integrated employment in the community at minimum wage or above.

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

15. **Relocation services** are services and essential items needed to establish a community living arrangement for persons who are relocating from an institution or who are moving from a family home to establish an independent living arrangement. This service includes person-specific services, supports or goods that will be put in place in preparation for the member's relocation to a safe, accessible and affordable community living arrangement. Services or items covered by this service may not be purchased more than 180 days prior to the date the member relocates to the new community living arrangement. Relocation services may include the purchase of necessary furniture, telephone(s), cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings and kitchen appliances not otherwise included in a rental arrangement if applicable. Relocation services may include the payment of a security deposit, utility connection costs and telephone installation charges. This service includes payment for moving the member's personal belongings to the new community living arrangement and general cleaning and household organization services needed to prepare the selected community living arrangement for occupancy. Relocation services exclude home modifications necessary to address safety and accessibility in the member's living arrangement, which may be provided as the waiver service home modifications. Excludes housekeeping services provided after occupancy which are considered the waiver service supportive home care. Excludes the purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.). Providers must be reputable contractors or companies.

16. **Residential care**

Residential care services may be authorized only:

- When members' long-term care outcomes cannot be cost-effectively supported in the member's home, or when members' health and safety cannot be adequately safe-guarded in the member's home; or
- When residential care services are a cost-effective option for meeting that member's long-term care needs.

Types of residential care:

a. **Adult family homes of 1-2 beds** are places in which the operator provides care, treatment, support, or services above the level of

room and board to up to two adults. Services typically include supportive home care, personal care and supervision. Services may also include transportation and recreational/social activities, behavior and social supports, daily living skills training and transportation if provided by the operator or designee of the operator. It includes homes which are the primary domicile of the operator or homes which are controlled and operated by a third party that hires staff to provide support and services.

Adult family home services also include coordination with other services received by the participant and providers, including health care services, vocational or day services. Services may also include the provision of other waiver services as specified in the individual contract between the MCO and residential provider. Waiver funds may not be used to pay for the cost of room and board.

An adult family home sponsor must comply with WI Medicaid Waiver Standards for Certified 1-2 Bed AFH and Wis. Admin. Code DHS 82 for Barrett Homes.

b. **Adult family homes of 3-4 beds** are licensed under DHS 88 of the Wisconsin Administrative code and are places where 3-4 adults who are not related to the licensee reside, receive care, treatment or services above the level of room and board, and may include up to seven hours per week of nursing care per resident. Services typically include supportive home care, personal care and supervision. Other services provided may include behavior and social supports, daily living skills training and transportation performed by the operator or designee of the operator. This service type also includes homes of 3-4 beds, specified under s. 50.01 (1)(a) of the Wisconsin Statutes, which are licensed as a foster home under s. 48.62 of the Wisconsin Statutes and certified by a certifying agency as defined under DHS 82 of the Wisconsin Administrative Code. The latter are owner-occupied homes for persons with intellectual disabilities who are aging out of foster care. This category of homes permits such persons to remain in the same home, promoting continuity of care. Waiver funds may not be used to pay for the cost of room and board. A licensed adult family home must comply with Wis. Admin. Code DHS 88.

c. **Community-based residential facility (CBRF)** is a place where 5 or more adults, and in cases of persons with an intellectual disability up to 8 adults, who are not related to the operator or administrator reside and receive care, treatment, support, supervision and training. Services may include supportive home care, personal care, supervision, behavior and social supports, daily living skills training, transportation and up to three hours per week

of nursing care per resident. Waiver funds may not be used to pay for the cost of room and board. A licensed CBRF must comply with Wis. Admin. Code DHS 83.

d. **Residential care apartment complexes (RCAC)** are services provided in a homelike, community-based setting where 5 or more adults reside in their own living units that are separate and distinct from each other. Persons who reside in the facility also receive the following services: supportive services (e.g., laundry, house cleaning), personal assistance (e.g., personal care), nursing services (e.g., wound care, medication management), and assistance in the event of an emergency (e.g., PERS and response). Waiver funds may not be used to pay for the cost of room and board. A certified RCAC must comply with Wis. Admin. Code DHS 89.

17. **Respite care services** are services provided for a member on a short-term basis to ease the member's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in an institution such as a certified Medicaid setting (hospital, nursing home) or other licensed facility. Respite care may also be provided in a residential facility such as a certified or licensed adult family home, licensed community-based residential facility, certified residential care apartment complex, in the member's own home or the home of a respite care provider.

    For providers of this service: supportive home care agencies, individual respite providers and personal care agencies must comply with the Training and Documentation Standards for Supportive Home Care and In-Home Respite Care; 1-2 bed adult family homes must comply with WI Medicaid Waiver Standards for 1-2 bed adult family homes and Wis. Admin. Code DHS 82 for Barrett Homes; residential care apartment complexes must comply with Wis. Admin. Code DHS 89; and hospital, nursing homes, community-based residential facilities and 3-4 bed adult family homes must comply with DHS 124, DHS 132, DHS 134, DHS 83, and DHS 88 as applicable.

18. **Self-directed personal care services** are activities to assist a member with activities of daily living, instrumental activities of daily living and housekeeping services directly related to the care of the member to maintain the member in his or her place of residence and to assist the member to access the community. Services may include the following:

    a. Assistance with activities of daily living (ADLs): bathing; getting in and out of bed; oral, hair and skin care excluding skilled wound care; help with toileting; simple transfers; assistance with mobility and ambulation; assistance with eating; and assistance with dressing and undressing.

b. Assistance with instrumental activities of daily living (IADLs): managing medications and treatments normally self-administered, care of eyeglasses and hearing aids, meal preparation and serving, bill paying and other aspects of money management, using the telephone or other forms of communication, arranging and using transportation, and physical assistance to function at a job site.

c. Housekeeping services related to the care of the person: cleaning in essential areas of the home used when assisting with ADLs and IADLs, laundry of the member's clothes and bedding and changing of bedding, and shopping for the member's food.

d. Accompanying and assisting the member to access the community for medical care, employment, recreation, shopping and other purposes, as long as the provision of assistance with ADLs and IADLs is required during such trips.

e. Medically-oriented tasks delegated by a registered nurse pursuant to an agreement between the member and the interdisciplinary care team staff.

Services are provided by either an individual or agency selected by the member, pursuant to a physician's order (a state law requirement) and following a member-centered plan developed jointly by the member and interdisciplinary care team (IDT) staff including a registered nurse. The plan shall specify delegated nursing tasks, if any. The member may use as a provider any individual who passes a background check including a legally responsible relative who qualifies under Article VIII.P.2., or an agency or individual that is not barred from participating in the Medicaid or Medicare program. The member-centered plan, including self-directed personal care and all other services received, is reviewed by the member and care team staff at least every six months or more often as needed. Visits by the consulting RN, who may be a member of the IDT or other nurse consultant, to the member's residence will occur at least once a year unless the member and RN agree on a more frequent visits or the RN determines that delegated nursing tasks need to be reviewed more often. The member and care team staff will determine any training needed by selected providers and how it will be obtained. The member shall be the common law employer of individual providers; if the member selects an agency, the member shall be a managing, co-employer of the worker and the agency shall hire any worker referred by the member who passes the background check and is, or can become competent in required tasks. Services may be provided both in the member's residence and outside the residence in other community settings.

Members must have budget authority over an allocation of waiver funding through the Self-Directed Services option to receive personal care through this service and must function themselves or through a representative as

either the common law employer of an individual worker or the managing, co-employer of an agency-provided worker. Members without budget authority who are authorized by the MCO to receive personal care services would receive them through the State Plan personal care benefit instead.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days where there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment, or if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

f. Medically-Related

i. Hospitalization;

ii. Nursing home or ICF-I/ID admission;

iii. Receipt of medical or rehabilitative care entailing at least an overnight absence; or

iv. Participation in a therapeutic rehabilitative program as defined in DHS 101.03(175).

There is no yearly limit on the number of medically-related episodes for which retainer payments may be made.

g. Non-Medically Related

i. Planned vacation entailing at least an overnight absence and unaccompanied by the worker;

ii. Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence;

iii. Obtaining education, employment, or job, habilitative or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or

iv. Recreational activities unaccompanied by the worker entailing at least an overnight absence.

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

MCOs shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

Members must have budget authority over an allocation of waiver funding through the Self-Directed Services option to receive personal care through

this service and must function themselves or through a representative as either the common law employer of an individual worker or the managing, co-employer of an agency-provided worker. Members without budget authority who are authorized by the MCO to receive personal care services would receive them through the State Plan personal care benefit instead.

Agency-employed, member-directed workers must comply with Wis. Admin. Code DHS 105.17. Member-employed individual workers must comply with Training and Documentation Standards for Supportive Home Care and In-Home Respite Care.

19. **Skilled nursing services RN/LPN** is the "professional nursing��? as defined in Wisconsin's Nurse Practice Act. Wis. Stats, Chapter 441. Nursing services are those medically necessary, skilled nursing services that may only be provided safely and effectively by an advanced practice nurse, a registered nurse or a licensed practical nurse working under the supervision of a registered nurse. The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act, consistent with the Member Centered Plan, authorized by the MCO and are not otherwise available to the member under the Medicaid State Plan or for members enrolled in Medicare, services available through the federal Medicare program. However, the lack of coverage under the State Plan benefit or through Medicare does not preclude coverage of skilled nursing as a waiver service if services are within the scope of the Wisconsin Nurse Practice Act.

Under the Wisconsin Nurse Practice Act, professional nursing includes any of the following:

Professional skilled nursing means the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness that requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences. Professional skilled nursing includes any of the following:

a. The observation and recording of symptoms and reactions;

b. The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, podiatrist licensed under Wis. Stats. ch. 448, dentist licensed under Wis. Stats. ch. 447, or optometrist licensed under Wis. Stats. ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state;

c. The execution of general nursing procedures and techniques; or

d. The supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants in accordance with Wis. Stats 441.

Nursing services may include periodic assessment of the member's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention or to monitor and/or modify the medical treatment services provided by non-professional care providers. Services may also include regular, ongoing monitoring of a member's fragile or complex medical condition, as well as the monitoring of a member with a history of non-adherence with medication or other medical treatment needs.

Delegation of nursing tasks to less skilled personnel shall be in accordance with Wis. Stats. ch. 441 and Wis. Admin. Code ch. N.6. and the Guidelines for Registered Nurse Delegation to Unlicensed Assistive Personnel (Wisconsin Nurses Association).

These services are provided when nursing services identified as needed in a plan of care and furnished under the approved State plan limits are exhausted or when the nursing services are not covered under the Medicaid State Plan. For members enrolled in Medicare, excludes services available through the Medicare program except for payment of Medicare cost share. RNs and LPNs must comply with Wis. Stats. Chapter 441.

20. **Specialized medical equipment and supplies.** Specialized medical equipment, items, devices and supplies are those items necessary to maintain the member's health, manage a medical or physical condition, improve functioning or enhance independence. Items or devices provided must be of direct medical or remedial benefit to the member. Allowable items, devices or supplies may include: incontinence supplies; wound dressings; IV or life support equipment; orthotics; enteral nutrition products and associated supplies and equipment not covered under the Medicaid State Plan but needed for the member to obtain adequate nutrition; over the counter medications with a National Drug Code (NDC) if not covered under the State Plan drug benefit and when prescribed by any licensed and authorized prescriber; medically necessary prescribed skin conditioning lotions/lubricants; and prescribed Vitamin D, a prescribed multivitamin and prescribed calcium supplements. (The Department of Health Services may add other prescribed vitamins or nutritional supplements in the future based on clear and convincing evidence substantiating their safety and effectiveness in maintaining health or treating or managing a medical condition.) Additionally, allowable items may include books and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, humidifiers and water treatment systems may be allowable when needed to support a member's health and safety outcomes.

Items or devices provided may be in excess of the quantity of medical equipment or supplies covered under the Medicaid State Plan when coverage of the additional items or devices has been denied.

Excludes items considered as and regulated by the federal Food and Drug Administration (FDA) as nutritional supplements unless specifically covered under this definition or under the Medicaid State Plan.

Authorized DME vendors and licensed pharmacies must comply with Wis. Admin Code DHS 105.40 or Wis. Stats. Chapter 450.

21. **Support broker** is an individual who assists a member in planning, securing and directing self-directed supports. The services of a support broker are paid for from the member's self-directed supports budget authority. Support brokers are subject to criminal background checks and must be independent of any other waiver service provider. A support broker shall be knowledgeable of the local service delivery system and local community-integrated services and resources available to the member. A support broker shall also be knowledgeable of the typical kinds of needs of persons in the member's target group. The member and interdisciplinary team staff are responsible to assure that a support broker selected by the member has the appropriate knowledge.

    Excludes the cost of any direct services authorized and obtained by a consumer through an SDS plan, which is paid for and reported under the appropriate service definition. Excludes the cost of fiscal agent services, which is paid for and reported as financial management services.

    A provider of this service must have knowledge of the unique needs/preferences of the participant and the service system.

22. **Supported employment – individual employment support services** are the ongoing supports provided to members who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive, customized or self-employment in an integrated work setting in the general workforce. A member receiving this service shall be compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

    Individual employment support services are individualized and may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, job supports, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. Also included

are other workplace support services not specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Individual employment supports may include support to maintain self-employment, including home-based self-employment. Individual employment supports may also include services and supports that assist the member in achieving self-employment; however, Medicaid funds may not be used to defray the expenses associated with starting or operating a business. Assistance for self-employment may include: (a) aid to the member in identifying potential business opportunities; (b) assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the member to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched.

Individual employment support does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business. Individual employment support services may be provided by a co-worker or other job site personnel provided that the services are not part of the normal duties of the co-worker, supervisor or other personnel and these individuals meet the qualifications established below for individual providers of this service. Employers may be reimbursed for supported employment services provided by co-workers.

Supported employment services do not include vocational services provided in facility-based work settings or other types of vocational services furnished in specialized facilities that are not part of general community work places. Supported employment services may not include volunteer work.

Members receiving individual employment supports may also receive educational, pre-vocational and/or day services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded under the section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

Coverage does not include incentive payments, subsidies or unrelated vocational training expenses such as the following:

a. Incentive payment made to an employer to encourage or subsidize the employer's participation in supported employment; or

b. Wages or other payments that are passed through to users of supported employment services.

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

The cost of transportation for a member to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider, or may reimbursed under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider, or may be reimbursed under the waiver service supportive home care or self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

When personal care/assistance or transportation or both are a component of this service, payment may not be made for such assistance or transport under another waiver service for the same period of time.

For the individual on the job support person, the MCO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

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

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

For the supported employment agency, the MCO shall assure that the provider has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

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

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

23. **Supported employment - small group employment support services** are services and training activities provided in a regular business, industry or community setting for groups of two (2) to eight (8) workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Small group employment support must be provided in a manner that promotes integration into the workplace and integration between members and people without disabilities in those workplaces. The outcome of this service is sustained paid employment and work experiences leading to further career development and individual integrated community-based employment for which a member is compensated at or above the minimum wage, but not less than the customary wage level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

Small group employment support services may include any combination of the following activities: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systematic instruction, job coaching, work incentive benefits analysis and counseling, training and work planning, transportation and career advancement services. Also included are other workplace support services not specifically related to job skill training that enable the member to be successful in integrating into the job setting.

Small group employment support does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business. Small group employment support services may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker or other personnel and these individuals meet the qualifications established below for individual providers of service. Employers may be reimbursed for supported employment services provided by co-workers.

Supported employment services do not include vocational services provided in facility based work settings or other types of vocational services furnished in specialized facilities that are not part of general community work places. Supported employment services may not include volunteer work.

Members receiving small group employment support may also receive educational, pre-vocational, and/or day services and career planning services. However, different types of non-residential services may not be billed for the same period of time.

Before authorizing supportive employment services, documentation shall be maintained that the service has already been utilized or is not available under a program funded under the section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

Coverage does not include incentive payments, subsidies or unrelated vocational training expenses such as the following:

a. Incentive payment made to an employer to encourage or subsidize the employer's participation in supported employment; or

b. Wages or other payments that are passed through to users of supported employment services.

The cost of transportation for a member to get to and from a supported employment site may be included in the reimbursement paid to the supported employment provider, or may be covered and reimbursed under specialized (community) transportation, but not both. All providers of transportation shall ensure that the provider qualifications for specialized (community) transportation are met.

Personal care may be a component part of supported employment, but may not comprise the entire service. Personal care/assistance provided to a member during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider, or may be reimbursed under the waiver service supportive home care or

self-directed personal care. All providers of personal care/assistance shall meet the supportive home care provider qualifications.

When personal care/assistance or transportation or both are a component of supported employment services, payment may not be made for such assistance or transport under another waiver service for the same period of time.

The MCO shall assure that supported employment agencies have the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

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

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

The MCO shall assure that the individual on the job support person has the ability and qualifications to provide this service, demonstrated in at least one of the following ways:

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

In addition, the individual provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA) and if personal care services are provided, shall also meet the Supportive Home Care and In-Home Respite Training and Documentation Standards.

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

a. Hands-on assistance with activities of daily living such as dressing/undressing, bathing, feeding, managing medications and treatments that are normally self-administered, toileting, assistance with ambulation (including the use of a walker, cane, etc.), carrying out professional therapeutic treatment plans, grooming such as care of hair, teeth or dentures. This may also include preparation and cleaning of areas used during provision of personal assistance such as the bathroom and kitchen.

b. Direct assistance with instrumental activities of daily living, as well as observation or cueing of the member to safely and appropriately complete activities of daily living and instrumental activities of daily living. Providing supervision necessary for member safety at home and in the community. This may include observation to assure appropriate self-administration of medications, assistance with bill paying and other aspects of money management, assistance with communication, arranging and using transportation and personal assistance at a job site and in non-employment related community activities.

c. Routine housekeeping and cleaning activities performed for a member consisting of tasks that take place on a daily, weekly or other regular basis. These may include: washing dishes, laundry, dusting, vacuuming, meal preparation, shopping and similar activities that do not involve hands-on care of the member.

d. Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event for reasons of health and safety or the need to assure the member's continued community living. These may include: outdoor activities such as yard work and snow removal; indoor activities such as window washing; cleaning of attics and basements; cleaning of carpets, rugs and drapery; refrigerator/freezer defrosting; the necessary cleaning of vehicles, wheelchairs and other adaptive equipment and home modifications such as ramps. This also may include assistance with packing/unpacking and household cleaning/organizing when a member moves.

An unrelated live-in caregiver may provide any or all of the types of supportive home care services. Services by a related live-in caregiver are subject to the requirements in Article VIII.P.2. Payment of a live-in caregiver may be reduced by the value of room and board in accordance with any applicable wage and hour laws.

Excludes training provided to a member intended to improve the member's ability to independently perform routine daily living tasks, which may be provided as daily living skills training.

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days where there is a reasonable probability that in their absence the member would not be able to retain a preferred home care worker because the worker would seek other employment, or if the worker is employed by an agency, would be reassigned and may not return to serving the member. Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the member:

e. Medically- Related

i. Hospitalization;

ii. Nursing home or ICF-I/ID admission ;

iii. Receipt of medical or rehabilitative care entailing at least an overnight absence; or

iv. Participation in a therapeutic rehabilitative program as defined in DHS 101.03(175).

There is no yearly limit on the number of medically-related episodes for which retainer payments may be made.

f. Non-Medically Related

i. Planned vacation entailing at least an overnight absence and unaccompanied by the worker;

ii. Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence;

iii. Obtaining education, employment, or job, habilitative or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or

iv. Recreational activities unaccompanied by the worker entailing at least an overnight absence.

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

MCOs shall determine the amount of the per diem retainer payment, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

All workers must comply with the Training and Documentation Standards for Supportive Home Care and In-Home Respite Care.

25. **Training services for unpaid caregivers** is the provision of training services for individuals who provide uncompensated care, training, companionship, supervision, or other supports to members.

Training includes instruction about treatment regimens and other services included in the member's care plan, use of equipment specified in the service plan and guidance, as necessary, to safely maintain the member in the community. Training must be aimed at assisting the unpaid caregiver in meeting the needs of the member. All training for individuals who provide unpaid support to the member must be included in the member's care plan.

Training furnished to individuals who provide uncompensated care and support to the member must be directly related to their role in supporting the member in areas specified in the care plan.

This service includes, but is not limited to, on-line or in-person training, conferences, or resource materials on the specific disabilities, illnesses, conditions that affect the member for whom they care. The purpose of the training is for the caregiver to learn more about member's condition, what to expect, and how to provide the best care for someone with that specific condition. For example, training could be provided on effectively caring for a member with dementia.

Training includes the costs of registration and training fees associated with formal instruction in areas relevant to the needs identified in the member's care plan.

This service may not be provided in order to train paid caregivers. This service excludes payment for lodging and meal expenses incurred while attending a training event or conference. This service does not cover teaching self-advocacy which is covered under consumer education and training services.

This service must be provided by licensed, certified or accredited professionals who maintain current credentials in their field of practice. For example, training could be provided by registered nurses, licensed mental health professionals or licensed therapists.

26. **Transportation (specialized transportation) – community transportation** is the provision of transportation services or items that enable a member to gain access to waiver and other community services, activities and resources, as specified in the member's care plan. This service may consist of items such as tickets, fare cards, or other fare media

or services where the common carrier, specialized medical vehicle or other provider directly conveys a member and her or his attendant, if any, to destinations. Whenever possible, family, neighbors, friends or community agencies who can provide this service without charge will be utilized.

Excludes transportation to receive non-emergency medical services which are covered under the Medicaid State Plan transportation benefit, or in the case of a self-directing member with budget authority to purchase such services, under the Other Transportation service. Excludes emergency (ambulance) medical transportation covered under the Medicaid State Plan service.

Taxis or common carriers must comply with Wis. Stat. Chapter 194. Public mass transit must comply with Wis. Stat. Chapter 85.20.

27. **Transportation (specialized transportation) - other transportation** consists of transportation to receive non-emergency, Medicaid–covered medical services. This service may include items such as tickets, fare cards, or other fare media, reimbursement of mileage expenses, or payment for services where the provider directly conveys the member and her or his attendant, if any, by common carrier or specialized medical vehicle (SMV) as appropriate to and from receiving Medicaid–covered medical services.

Members eligible for this service must have decision-making authority over a budget for the purchase of such services. Such members are not limited to providers in the MCO's network (although the credentials of specialized medical vehicle providers must be verified by the MCO), do not require MCO prior authorization to purchase any transportation service from a qualified provider to any Medicaid coverable medical service if the member's budget is sufficient to pay the cost, and advanced scheduling of routine trips is not required if the member can obtain transport. Legally responsible relatives may be paid for providing this service if they meet the conditions under Article VIII.P.2.

Excludes ambulance transportation, which is available through the Medicaid State plan. Excludes non-emergency medical transportation when authorized by the MCO as a State Plan service for members without budget authority. Excludes non-medical transportation which is provided under the sub-service of Community Transportation; however the same ride may be used to provide transport to medical appointments and community activities as long as there is not duplication of payment.

Specialized transportation agencies must comply with Wis. Stats. Chapter 85.21 and Wis. Admin. Code DHS 61.45. Individual providers must have a valid driver's license and liability insurance.

28. **Vocational futures planning and support (VFPS)** is a person-centered, team-based comprehensive employment planning and support service that provides assistance for members to obtain, maintain or advance in

employment or self-employment/microenterprise. The agency providing VFPS services will ensure that the following service strategies are available as needed to the member:

a. Development of an employment plan based on an individualized determination of strengths, needs and interests of the individual with a disability, the barriers to work, including an assistive technology pre-screen or in-depth assessment, and identification of the assets a member brings to employment;

b. Work Incentive Benefits analysis and support;

c. Resource team coordination;

d. Career exploration and employment goal validation;

e. Job seeking support; and

f. Job follow-up and long-term support.

VFPS must be provided by qualified professionals that include, for example, an employment specialist, a benefits specialist and an assistive technology consultant. When this service is provided, the member record must contain activity reports, completed by the appropriate VFPS Team member(s), within thirty (30) days of completing a particular service strategy. When ongoing support is provided, monthly ongoing support reports must be completed by the provider of the ongoing support.

VFPS excludes services that could be provided as prevocational or as supported employment. Such services may be used to supplement, but may not duplicate any VFPS services provided under the waiver. VFPS excludes services funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401(16 and 17).

All providers shall have skills and knowledge typically acquired through completion of an advanced degree in human services, or an equivalent combination of education and experience, with ongoing training and technical assistance appropriate to their specific specialty.

AMENDED 7/28/2016

B. Medicaid State Plan Services – Family Care Benefit Package

The following Medicaid State Plan long-term care services defined in Wis. Admin. Code § DHS 107 with specific service definitions as noted in the reference(s) following each service are included in the Family Care Benefit Package. MCOs will determine which services require prior authorization and use the member-centered planning process to define the service limitations, rather than using the requirements in Wis. Admin. Code § DHS 107. For informational purposes, information about specific services is found in the BadgerCare Plus and Medicaid handbooks at: https://www.forwardhealth.wi.gov/WIPortal/OnlineHandbooks/Display/tabid/152/Default.aspx.

1. **AODA day treatment** services as defined in Wis. Admin. Code § DHS 107.13 (all settings, except hospital-based or physician provided)

1. **AODA** services as defined in Wis. Admin. Code § DHS 107.13 (not inpatient nor physician provided)

2. **Case management** as defined in Wis. Admin. Code § DHS 107.32 (includes assessment and care planning)

3. **Community support program** as defined in Wis. Admin. Code § DHS 107.13 (6) (except physician provided)

4. **Durable medical equipment** and **medical supplies** as defined in Wis. Admin. Code § DHS 107.24 (except hearing aids, prosthetics and family planning supplies)

5. **Home health** as defined in Wis. Admin. Code § DHS 107.11. The MCO shall only contract for home health care services with a licensed, Medicare certified home health agency that provides the Department with a surety bond as specified in § 1861(o)(7) of the Social Security Act.

6. **Mental health day treatment** services as defined in Wis. Admin. Code § DHS 107.13 (in all settings)

7. **Mental health** services as defined in Wis. Admin. Code § DHS 107.13 (not inpatient or physician provided)

8. **Nursing home** services as defined in Wis. Admin. Code § DHS 107.09 including ICF-IID and IMD. Inpatient services are not covered for IMD residents between the ages of 21 years and 64 years of age, except that services may be provided to a 21 year old resident of an IMD if the person

was a resident immediately prior to turning 21 and continues to be a resident after turning 21. This exception only applies until the person's 22nd birthday.

Nursing home services include coverage of 95% of the MCO's nursing home daily rate for MCO members who are in hospice and reside in nursing homes, excluding those members who are receiving nursing home hospice respite services for less than 5 day stays in a nursing home.

Nursing home services may be authorized to provide skilled nursing or rehabilitation services aimed at helping the member regain the ability to live more independently in his or her own home. Long-term care services in a nursing home may be authorized only:

a. When members' long-term care outcomes cannot be cost-effectively supported in the member's home, or when members' health and safety cannot be adequately safe-guarded, in the member's home; or

b. When nursing home services are a cost-effective option for meeting that member's long-term care needs.

9. **Nursing** services as defined in Wis. Admin. Code § DHS 107.11, 107.113 and 107.12 (including respiratory care, intermittent and private duty nursing)

10. **Occupational therapy** as defined in Wis. Admin. Code § DHS 107.17 (in all settings except inpatient hospital)

11. **Personal care** services as defined in Wis. Admin. Code § DHS 107.112

12. **Physical therapy** as defined in Wis. Admin. Code § DHS 107.16 (in all settings except inpatient hospital)

13. **Speech/language pathology** as defined in Wis. Admin. Code § DHS 107.18 (in all settings except inpatient hospital)

14. **Transportation** services as defined in Wis. Admin. Code § DHS 107.23 (except ambulance)