

Section 12

State of Wisconsin MA Waiver Information

In this section you will find information regarding the State's MA Waiver program, otherwise known as CIP in the developmental disabilities arena. Specifically, you will find a copy of the County's cover letter that outlines what documents are needed for MA Waiver eligibility and a copy of the Individual Service Plan (ISP). If you have questions regarding MA Waiver Eligibility paperwork, please contact Barb Rawling at 242-6224 or rawlings@co.dane.wi.us

In order to complete the Initial Eligibility and the Proposed Service Plan Documents, a Support Broker needs to become certified using the State's Long Term Care (LTC) Functional Screen software. Certification is done using an on-line course that can be found by clicking on this link and following the instructions:
<http://mynursingce.son.wisc.edu/index.pl?op=show;id=20101>

When taking the on-line LTC Functional Screen certification course, please allow 4-6 hours in order to complete it.

Once you have become a Certified LTC Functional Screen user, then you can access the Functional Screen and utilize all of its features. A good place to start with the LTC Functional Screen is the home page, which can be found by clicking here:
<http://dhfs.wisconsin.gov/LTCare/FunctionalScreen/Index.htm>

On the LTC home page you can find answers to commonly asked questions, access to the LTC Functional Screen, and instructions on using the LTC Functional Screen.

REMEMBER, each year at recertification time a broker must complete a Long Term Functional Screen for each waiver participant. When completing a new waiver application a broker must also complete the assessment form associated with the Long Term Functional Screen. An online "fillable" form can be found by clicking here:
<http://dhfs.wisconsin.gov/forms1/DDES/dde0980.doc>

NEW BEGINNING IN 2006: Once a person receives funding through a Medicaid Waiver the state conducts random reviews of participant's written files as well as periodic site reviews where they meet with a person and their team. Brokers will receive advance notice of these reviews ranging from days to weeks.

4. **RELEASE OF INFORMATION:** Please complete with necessary signatures.

PROPOSED SERVICE PLAN DOCUMENTS: This information is how you and the individual will recommend CIP funding be used. It gives us at the County a way to know we're all in agreement; and in turn, for the State to determine that the proposed services are meeting the person's needs and that the funding will be used as the federal government has intended. These documents need to be submitted to me either with the initial eligibility documents.

1. **ASSESSMENT:** Beginning October 1, 2005 the State is requiring that the on-line Assessment/Supplement to the Long Term Care Functional Screen be submitted (replacing the Initial Assessment Summary pages Dane County had formerly used). A link to find the Assessment/Supplement is located in the bottom right corner of the eligibility page on the Long Term Care Functional Screen.
2. **INDIVIDUAL SERVICE PLAN (ISP):** Complete the enclosed form, include all services the person will receive (residential, vocational, transportation, case management, recreation, medical, dental, therapies) regardless of funding source. You should provide information on the frequency of service and start dates, but any areas in gray on the ISP form you do not have to complete.
3. **ISP NARRATIVE:** This is a narrative description of the services you've listed in the ISP. The Narrative provides both a background picture of the individual as well as a description of how all services listed on the ISP will enhance or change the person's life. The Narrative, in conjunction with the Assessment and ISP, should provide a total picture of the Individual's community integration. (Please let me know if you'd like to see samples of other narratives written.)

If this is a request for Diversion funding, you must include in the Narrative a discussion of how this person is at risk of institutionalization.

If, for any reason, you cannot meet the above deadlines or have any questions, please call me. Thanks for your assistance!

Department of Health and Social Services

Wisconsin

Division of Community Services

Individual Service Plan

DCS-445 (Rev. 8/90)

Original CIP

Approval Date:

Target Group 01

New Plan
 Plan Update

Agency: **Dane Co Adult Comm Svcs**

- R D
- CIP 1A
 - CIP 1B
 - CIP II
 - COP W
 - BIW
 - CLTS
 - MA/Case Mgmt
 - COP
 - SHC

Recipient Name	Date of Birth
Address	
City, State, Zip	Telephone #

LTCFS Date
LTCFS Level of Care
Functional Screen Date

Service Plan Development Date
Cost Share Amount
Total Waiver Cost/Day 0.00

Guardian:

Medical Assistance #

SPC *	Service Type	Provider Name & Address	Start Date	Unit Cost (\$/Hr;Day)	Units & Frequency (#/Day; Wk; Mo)	Daily Cost (Annual/365)	CIP	MA Card	Other Funding
604	Case Management Case Manager/Broker:			per month	hrs/mo	0.00	X		
609 .10	Consumer Directed Supports	Fiscal Assistance of Dane Cty PO Box 7395 Madison, WI 53707		per day	Daily	0.00	X		
107 .30	Special Transportation Non-Medical			per trip	trips/wk	0.00	X		
	Special Transportation Medical								
	Dental				As Needed			X	
	Medical General		Ongoing		As Needed			X	

SPC *	Service Type	Provider Name & Address	Start Date	Unit Cost (\$/Hr;Day)	Units & Frequency (#/Day; Wk; Mo)	Daily Cost (Annual/365)	CIP	MA Card	Other Funding
	Counseling/Therapeutic Resources				As Needed			X	
507	Counseling/Therapeutic Resources			per hour	hrs/yr as needed	0.00			
507	Counseling/Therapeutic Resources			per hour	hrs/mo	0.00			
202	Adult Family Home Room & Board Supervision & Services								
	Personal Allowance	0							SSI, SSIE, Wages
	Room & Board		Ongoing		Monthly				County Levy/SSI, SSIE, Wages
103	Respite								
.99									

SPC *	Service Type	Provider Name & Address	Start Date	Unit Cost (\$/Hr;Day)	Units & Frequency (#/Day; Wk; Mo)	Daily Cost (Annual/365)	CIP	MA Card	Other Funding
203	Foster Care Room & Board Supervision & Services								
110	Daily Living Skills Community								
104 .11 .21	Supportive Home Care Days Hours								
108	Pre Vocational Services CIP 1A, CIP 1B								
615	Supported Employment CIP 1A, CIP 1B								
706	Day Services								
506	CBRF Room & Board Supervision & Services								



Dane County Department of Human Services

Division of Adult Community Services

Director – Lynn Green
 Division Administrator - Fran Genter

KATHLEEN FALK
 DANE COUNTY EXECUTIVE

ISP Conflict of Interest Attachment

Potential Conflict (select a box by double-clicking on it)

- Guardian acts as paid provider
- Residential agency acts as landlord/property owner
- AFH provider acts as guardian
- Other (describe):
- Other (describe):

Describe Potential Conflict:

Plan of Action for Monitoring:
 Team will identify and review conflict of interest twice per year. Broker will complete this form at annual planning meeting. 6-month review will be documented in individual’s case notes. Please see case notes in file for detailed information on the 6-month review.

Additional Monitoring if Necessary:

By my signature below, I acknowledge these potential conflicts of interest and I am satisfied with the actions to be taken to address them.

_____	_____	_____
Type/Print Consumer Name	Consumer Signature	Date
_____	_____	_____
Type/Print Guardian/Authorized Rep. Name	Signature	Date
_____	_____	_____
Type/Print Broker Director Name	Signature	Date

Waiver Wise technical assistance documents are intended to assist county staff in continuing to meet the standards and requirements for the CIP II/COP-W program.

From “Waiver Wise” Vol. 2, Issue 1 revised March, 2007. WI DHFS, Bureau of Long Term Support. http://dhfs.wisconsin.gov/LTC_COP/waiverwise/waiverwise.htm

Medical/Remedial Expenses and the three Waiver Groups.

Definition

Medical/Remedial expenses are monthly costs that directly relate to the person's care needs, and/or costs incurred while treating, preventing or minimizing the effects of illness, injury or other impairments due to the individual's physical or mental health.

Medical expenses include costs the person incurs for items or services that are prescribed or recommended by a medical practitioner licensed to practice in Wisconsin or another state. Medical expenses also include costs incurred for items or services that are prescribed or recommended by a practitioner of the healing arts who engages in the practice of his/her profession within the scope of his/her license, permit or certification in the state of Wisconsin or another state.

Medical expenses may include over the counter remedies, medical or therapeutic supplies, as well as deductibles or co-payments for Medicaid, Medicare or other health insurance premiums. Allowable expenses may also include bills for medical equipment, items or services that are not covered by Medicaid or by another payer; or bills for such medical costs that were incurred prior to Medicaid eligibility and which are currently being paid by the participant.

Remedial expenses include services or items that are identified in the individual's assessment, deemed necessary to assist the person in community living and may be included in the service plan, but will not be covered by Medicaid, a community waiver program or by COP or another payer.

Note that "Room and board" costs may not be counted as a medical or remedial expense, regardless of who is paying for them.

Medical/Remedial Expenses for Group A

Medical/Remedial Expenses have no significance for Group A waiver applicants/participants, since Group A individuals have no cost-share obligation, **except** when a Group A is a resident of a substitute care facility (see question/answer # 3).

Medical/Remedial Expenses for Group B

Under the waivers, medical/remedial expenses are treated differently for Group B and for Group C. Medical and remedial expenses for **Group B** participants are used to *offset* the cost share obligation. A cost share obligation is the amount the participant must contribute towards his/her waiver services each month. Only *out-of-pocket* medical/remedial expenses can be used in this calculation (for Group B participants, medical/remedial expenses funded by Medicaid, the waiver program or COP **cannot** be counted to reduce a cost-share). Group B participants with enough medical/remedial expenses may end up with no cost share liability.

Medical/Remedial expenses are compiled at initial application. Care managers or support and service coordinators (CM/SSC), and the participant, should use the most accurate Medical/Remedial information available. Bills and receipts for these expenses should be used for verification.

At times, it may be difficult to know the exact monthly dollar amount for certain items. This is most likely to occur with over the counter (OTC) items needed for a medical condition. For example, the participant may state that s/he purchases analgesics for arthritis every three months, but the amount and cost varies. In these cases, it would be appropriate for CM/SSC to use the previous year's total cost, divided by 12, to obtain a monthly average (please see also question/answer # 17 relating to Medicaid covered OTC items).

Best practice suggests that, three months following the application, CM/SSC and the participant meet again to review expenses and ensure accuracy. In addition, Medical/Remedial expenses must be reviewed **at least annually**.

At application, and at each review, waiver participants should be reminded, preferably in writing, that changes that may affect eligibility, including changes in Medical/Remedial expenses which may impact a cost-share (up or down), must be reported within ten days. If the changes are reported to the CM/SCC, s/he must relay them to the Income Maintenance Worker (IMW) right away. The IMW will run the information in CARES and will provide updated ECSC screens for the CM/SCC. These updated screens will be filed in the participant's case file. Reduction in cost-shares will be effective the month in which the change occurred, or the month the change is reported to the agency, whichever is later.

Medical/Remedial Expenses for Group C

Medical/Remedial expenses of a Group C individual are used ***to establish and to maintain month to month eligibility***. Medical/Remedial expenses for Group C must be incurred monthly by the individual as part of the "spend down." The spend down is the amount a Group C individual must incur **monthly to maintain eligibility**.

A "single" Group C waiver participant must both incur and be held responsible for his/her spend down amount on a monthly basis; a married Group C individual must incur the spend down amount on a monthly basis for eligibility purposes, but may not have to pay it when income is allocated to the community spouse. The definition of "single" includes member(s) of a couple, when the husband or wife is "institutionalized" or is also a waiver participant.

Commonly Asked Questions

Question 1 - A participant receives services from a chiropractor, and the chiropractor has recommended that the participant take a regimen of vitamins and herbal treatments. The participant would like to take the recommended supplements and use the cost as a medical/remedial expense to decrease his/her cost share obligation. Is the cost of the supplements recommended by the chiropractor an allowable medical/remedial expense?

Maybe. If the county's Long Term Support Committee has approved this type of "remedial" expense under their county plan, then the remedial expense could count to reduce the cost-share. The CM/SCC should familiarize themselves with the items/expenses allowable under their

county's COP Plan: items/expenses that are listed there can be counted as remedial expenses. Note that when counties add remedial expenses to their county COP Plan, these must be submitted to the State for review and approval (generally when they update their COP plans yearly). Note also that whenever alternative medicine supplements are used, the CM/SSC should advise the waiver participant to share the information with their medical practitioner, to prevent potential adverse effects that may occur when certain supplements are taken in conjunction with prescribed medication.

Question 2 - A participant has a cost share obligation of \$50/month and receives representative payee services (\$20/month). Can the participant pay for the representative payee services and use that cost as a medical/remedial expense?

Maybe. If the county's Long Term Support Committee has approved this type of expense under the county plan, then the remedial expense could count to reduce the cost-share.

Remember also that there are certain specific expenses (*other than representative payee fees*) that can be deducted from income to establish a cost-share liability. These are listed in Section 4.1.3.2 of the Medicaid Handbook under "Special Exempt Income" and include:

- Income used for supporting others
- Court-ordered attorney fees
- Court-ordered guardian and guardian ad litem fees
- Expenses associated with establishing and maintaining a guardianship
- Expenses associated with a Self-Support Plan
- Impairment Related Work Expenses (IRWE)
- Maintaining a home or apartment
- Costs associated with real estate property listed for sale

Consult with the IMW in your county if you have any questions about Special Exempt Income.

Question 3 - A participant is residing in a substitute care setting and does not need medical/remedial expenses to offset a cost share obligation. Does the care manager still need to document the amount of any medical/remedial expenses?

Yes. Even though the medical/remedial expenses are not needed to reduce or eliminate a cost share obligation, these costs need to be tabulated in order to determine what income the participant has available to pay toward the facility's room/board costs. This would include medical/remedial expenses for Group A waiver applicants/participants. To determine the amount of income a participant has available to pay towards the cost of room and board, use form DDE-920 - available at: <http://dhfs.wisconsin.gov/forms/DDEnum.asp>

The DDE-920 form has a line item for medical/remedial expenses. Note that medical/remedial expenses for Group C "single" waiver applicants/participants need not be listed, since they are part of the spenddown. Entering the out-of-pocket medical/remedial expenses in this formula allows the participant to retain income to fund the medical/remedial expenses, before contributing to the cost of room/board services. If the cost of these allowable deductions were not factored into the formula, the participant might not have enough income remaining to pay for

necessary medical/remedial expenses. The DDE-920 form gives line by line instructions about which items to enter on each line.

Question 4 - Can a waiver participant's payment for a life insurance policy be used as a remedial expense?

No. Life insurance policies benefit the estate and/or any surviving family members. They do not help to keep the individual in the community.

Question 5 - If a participant wants to supplement the wages of his/her supportive home care worker (who is funded by the waiver), can the supplementation be counted as a medical/remedial expense?

No. Supplementing the worker's wage cannot be used as a medical/remedial expense because it is prohibited under Medicaid rules. An option for the county is to increase the worker's hourly wage.

Question 6 - Can remedial expenses, over and above what has been authorized in the ISP as part of a "safe" plan, and which are being paid for by the participant, be counted as remedial expenses to reduce the cost-share obligation?

Example: The participant wants a scooter. There is no documentation or recommendation from any health care professional that supports the need or benefit of having a scooter. Therefore the CM/SSC cannot use waiver funds to purchase one. The participant decides to purchase the scooter him/herself. The participant is paying \$50 per month to the DME vendor. Can the \$50 be used as a remedial expense?

Yes. While the extra service is not going to be covered under the waiver because it is not an identified need for purposes of a safe ISP, its cost can be counted as a remedial expense.

Question 7- Can the extra monthly utility expenses that a waiver participant has due to running an air conditioner, ventilator, oxygen machine, etc. be counted as a medical/remedial expense?

Example: A participant's electrical bill is around \$75/month. The average, without using her oxygen machine, would be around \$35/month. Can the participant use the difference of \$40/month as a medical/remedial expense?

No, because extra utility costs are not allowable as a medical/remedial expense. These high utility expenses are taken into account by the IMW as part of the special housing deduction, which is a component of the personal maintenance allowance. However, when housing costs exceed the personal maintenance maximum, the difference may be counted as a medical/remedial expense for Group B or Group C individuals.

Question 8 - What expenses may be counted as remedial expenses when a participant has a live-in attendant?

In most cases, the cost of housing for a live-in attendant is not considered a medical/remedial expense. Generally housing costs are considered part of the special housing amount, which is a component of the personal maintenance allowance. However, there are some exceptions.

In the case of Group B waiver participants, when housing costs exceed the personal maintenance maximum, and the waiver participant is paying **for all** of their own room and board costs and **for all** of the room and board costs of their living attendant, the difference between the special housing amount and the maximum personal maintenance allowance may be counted as a remedial expense. Similarly, costs for the live-in attendant's living supplies (e.g., toilet paper, Kleenex, laundry soap, etc.) which are paid by the Group B waiver participant, can be counted as remedial expenses.

For a Group B participant, these expenses should be recorded on the medical/remedial line of the ECSC screen. Note that the wages for a live-in attendant are waiver-allowable and should be funded by the waiver program.

For a Group C participant, the food and living expenses of an attendant can be considered "remedial" expenses and can be used to meet the spend down, as long as the Group C participant is paying for these expenses.

In addition, for a Group C participant, certain housing costs paid by the Group C participant, when necessitated by having a live-in attendant (e.g., the difference in cost between a one-bedroom and a two-bedroom apartment, half of the basic monthly phone and utility bills) can be counted as medical and remedial expenses. All of these are recorded as medical/remedial expenses on the ECED screen because there is no other area to count these costs on the ECED.

Example: Group C Waiver participant Mary Brown has a live-in attendant. The cost of a one-bedroom apartment is \$500 per month and the cost of a two-bedroom apartment is \$800. Mary needs a two-bedroom apartment to accommodate her live-in attendant. Mary pays the full \$800 rent with her funds alone. In addition, the monthly basic phone is \$28.00/month, and the utility bill averages \$60/month, and Mrs. Brown pays for all of these costs also. What can the care manager count as "remedial" expense for Mrs. Brown?

Because Mrs. Brown pays these costs in full with her funds alone, the care manager can use the expenses necessitated by a live-in attendant, as follows:

- \$300 (the rent cost difference between a one-bedroom apartment and a two-bedroom apartment).
- \$14 for the telephone costs (half of \$28)
- \$30 for utilities (half of \$60).

As a result, the care manager would be able to use \$344 as a remedial expense for Mrs. Brown.

Question 9 - Can credit card payments, cash advances, bank loans, reverse or second mortgages that have been used to pay past medical bills qualify for a medical/remedial expense deduction?

Yes. Effective December 2002, monthly payments to a credit card company or bank may be considered a medical expense **if** certain criteria have been met. These criteria include: 1) the service/item purchased was a legitimate medical/remedial expense for the waiver applicant/participant, 2) the charges were for services/items that would qualify as an allowable medical/remedial expense or as an waiver allowable item or service and, 3) the original invoice/receipt or a copy of the original invoice/receipt can be obtained to confirm the date and that the service/item was obtained. See additional information on this topic in WaiverWise (Volume 02, Issue 07), available at: http://www.dhfs.state.wi.us/ltc_cop/waiverwise.htm.

Question 10 - If a lump sum payment was made to pay off a medical bill before a person became waiver eligible, can this be used to reduce the cost share?

No. If, for example, an applicant paid off a \$3,000 medical bill one month before starting on the waivers, the amount of the payment *cannot* be applied toward the cost share deduction because the debt was eliminated before the cost share obligation was established. However, note that this medical/remedial expense may be used by the IMW to establish Medicaid eligibility under the Medicaid deductible program.

Question 11 - Can you count a widow's payment on her deceased husband's medical debt as a medical/remedial expense for the waiver program? This expense is allowable when meeting a deductible.

No. This is not allowable for the Medicaid Waivers program. This is a personal debt. It is not *her* medical debt. Unlike the Medicaid deductible program, under the waiver program we consider the "individual", not the fiscal group when determining medical/remedial expenses. Moreover, under the waiver program, any paid bill cannot be counted even if it is in the applicant's name. However, it is possible for the IMW to simultaneously screen an applicant under the Medicaid deductible program to see if a medical bill for a member of the fiscal group can be considered under that program.

Question 12 - If a participant has made arrangements with a neighbor, friend, family member (not a spouse), etc. for transportation, and privately pays for this service, can this be counted as a remedial expense?

Example: Waiver applicant/participant, Mrs. Virginia Green, informs the CM/SSC that she gives her daughter, Carol, \$20.00/month for transporting her to the bank, to the nursing home so she can visit with her sister, to church, general errands, etc. Mrs. Green says - "I am so appreciative that she does it - and the money I give her is the least I can do". The CM/SSC talks to the daughter, Carol, and Carol confirms Mrs. Green gives her this money. Carol said, "I have told her a thousand times she does not have to give me anything but she insists, so I have stopped arguing with her. If it makes her feel good to do that, that's fine with me." When Carol is asked if she would like to be paid by the waiver program for the transportation she provides to Mrs. Green, Carol says "No." Can the \$20 be counted as a "remedial" expense?

Yes. This is one of those *rare* instances where it would be allowable for the waiver participant to count as a remedial expense a service that would ordinarily be paid by waiver funds. In order for a CM/SSC to use a dollar amount as a remedial expense under these circumstances, they should confirm with the person who is providing the transportation that he/she does not wish to be employed by an agency, or be paid with waiver funds through a fiscal agent. In this example, the \$20.00 would be allowable as a monthly remedial expense.

If it is determined that the neighbor, friend, family member (not a spouse) is providing *medical transportation*, the CM/SSC must calculate the appropriate dollar amount and subtract that amount from the dollar amount the waiver participant indicates he/she is paying the person for this transportation. Reason: persons providing medical transportation can be reimbursed by Medicaid through the county's IM unit. Check with the IM Worker about Medicaid criteria for coverage of medical transportation.

Question 13 - If a participant provides his/her own transportation in his/her own vehicle, can this be counted as a remedial expense?

Yes. While the waiver participant cannot be reimbursed for this expense, mileage costs can be counted as remedial expenses, regardless of whether the waiver participant is driving his own vehicle, or a friend/neighbor, etc. is driving the waiver participant's vehicle. In order to determine the appropriate remedial expense, the care manager should estimate the number of miles per month the participant is transported for medical**, or community purposes and multiply this figure by the federal reimbursement rate. Effective **2/1/07** the amount is 48.5 cents/mile. This figure changes yearly according to the standard mileage reimbursement rate for a privately owned automobile established by the Internal Revenue Service (IRS). As a point of information, unlike transportation reimbursement under the Medicaid card, under the Waiver program it is a requirement to use the federal transportation reimbursement rate when determining eligibility. To maintain consistency, the Bureau of Long-Term Support (BLTS) made a decision to use the same amount when determining a participant's cost share.

For accessible vans, BLTS allows 60 cents/mile. The participant may be either a driver or a passenger. It is not acceptable to calculate the cost of owning and operating the vehicle (e.g. insurance, title, license, registration, gas, repairs, and maintenance) and divide those annual costs by 12 months).

**Note: Medical transportation is generally covered under Medicaid. When Medicaid reimburses the participant's medical miles for less than the waiver reimbursement rate, the care manager can multiply the number of medical miles by the difference between the two rates and count the calculated dollar amount as a medical/remedial expense.

Question 14 - Can transportation expenses to concerts, dropping off children at school, little league games, etc. be counted as remedial expenses?

Maybe: this would be considered a "*remedial*" expense. If the county's Long Term Support Committee has approved this type of remedial expense under the county plan, then the remedial expense could count to reduce the cost-share.

Question 15 - Recognizing that the Waivers do not allow payments to spouses for any services provided to participants, can the value of such services be counted as a remedial expense?

Yes. The value of the services provided to the participant by his/her spouse may be counted as a remedial expense. The decision to allow such expenses must be affirmed by the local Long Term Support/COP Planning Committee, and the value attached must be consistently applied. For example, the committee may determine that a type of service provided is comparable to a similar service provided by a home care agency, and set the hourly rate value at or near the level paid to such agency by the program. For example, if the program pays the agency \$12 per hour for a comparable service, then the same "value" of \$12 can be assigned to the spouse's hourly service.

The care manager/support and service coordinator would need to determine the amount of hours the spouse provides the services to the participant each month, and the value of those services. If the value of the spouse's service is \$12, and the spouse provides 30 hours of said service per month, the total amount of monthly remedial expense would be \$360 ($12 \times 30 = 360$).

This amount is then provided to the IMW for both Group B and Group C participants. The CM/SSC is responsible for ongoing monitoring appropriate to the participant's Group B or C status.

Question 16 - An applicant/participant relays to the CM/SSC that s/he has to follow a special diet. Could the extra expense that may be related to a special diet be taken into account?

Yes, as long as the special diet is prescribed or recommended by the participant's MD or practitioner of the healing arts (if within the scope of his/her license), the CM/SSC would proceed in one of two ways:

1) The CM/SSC could take the cost difference between "regular" food and food that is low sodium/low sugar. For example, a can of "regular" canned corn may cost 40 cents and a can of "no salt/low sodium" may cost 50 cents: the care manager would count 10 cents towards medical/remedial expenses.

2) The CM/SSC could count the extra expense of certain required and recommended foods that is above and beyond what a person would ordinarily consume. For example, an individual's physician recommends that s/he drink six 8-oz glasses of cranberry juice a day to reduce the risk of urinary tract infections (UTIs). As a result, the participant drinks approximately 10 gallons of cranberry juice per month. The average consumption of cranberry juice is about 3 gallons a month. The CM/SSC would be able to count the full cost of the extra 7 gallons of cranberry juice as a medical/remedial expense.

Question 17 - Medicaid provides coverage for certain Over the Counter (OTC) medications, however the waiver participant's pharmacy will not bill Medicaid for them. Can their cost be used as a medical/remedial expense?

Best practice is for the waiver participant or the CM/SSC to find a pharmacy that will bill Medicaid covered OTCs to Medicaid. The list of Medicaid covered OTCs can be found under the Over-the-Counter Maximum Allowable cost list at:

http://dhfs.wisconsin.gov/medicaid4/pharmacy/data_tables/index.htm

If the waiver participant cannot find a pharmacy that will bill Medicaid, the cost of the OTCs could be used as a medical/remedial expense, or the county could use COP funds to pay for these OTCs. However, if COP funds are used, the cost of these OTCs cannot be counted as medical/remedial expenses.

NOTE:

Additional information regarding Medical/Remedial expenses can be found in:

- Chapter III of the COP Waiver Manual, accessible at: http://dhfs.wisconsin.gov/LTC_COP/waivermanual/index.htm
- The Waiver Basics Manual, which is available for free to attendants of the Waiver Basics training, or can be ordered for cost through The Management Group (TMG). <http://www.tmg-wis.com/>
- Also, visit http://www.dhfs.state.wi.us/ltc_cop/waiverwise.htm for additional WaiverWise on related topics

Tips for how to contact your worker in the STEP Unit

As we get busier, help us manage our time to best serve you by following these tips:

- 1) **We process paperwork and changes** within 10 days of receipt. You will receive written notice from our automated computer system of any changes in your benefits. **We act on applications** within 30 days. You will receive written notice from our automated computer system of your benefit awards and amounts.
- 2) **Use the ACCESS website** <https://access.wisconsin.gov/access/>
 - a. Find out if your case is open and the amount of benefits.
 - b. Report changes in your case.
 - c. Determine if you might be eligible for another program or apply for a new program.
 - d. We hope to provide terminals in our waiting rooms in the near future to make ACCESS available to you, or try it from your home computer or a public library.
- 3) **Write, call or email the Change Reporting Center 242-7500** CRC@co.dane.wi.us - Our Change Reporting Center can take information from you on most changes in your case.
- 4) **Call the Appointment Scheduler 242-7530 or email** apptscheduling@co.dane.wi.us Our support staff can schedule a time for you to complete any required eligibility review with your assigned worker except for W-2 cases. This includes rescheduling initial appointments as well as reviews.
- 5) **Call Connections 242-7441.** Our Connections phone line is answered from 7:45-4:30 Monday through Friday and can answer basic eligibility questions or arrange for intake appointments.
- 6) **Call the Medical Transportation Scheduler 242-4566 or email** Matransportation@co.dane.wi.us A cab ride can be authorized for MA eligible appointments if you qualify.
- 7) **Send a note or letter to your worker**– Please be sure to include:
 - a. Your name.
 - b. Your case number or SSN.
 - c. Name of your worker.
 - d. Your complete message.
 - e. Including a phone number will allow follow-up questions.
 - f. You can send this via US mail or use drop boxes and envelopes available in our Department offices to save postage. You can also fax it.
- 8) **Call your worker on the phone** – telephone numbers are listed on the STEP Unit Contact List.
 - a. Leave only one complete message. Leaving multiple messages can delay our response time and overload our phone system.
 - b. If you are calling to report a change, do not call your worker; call or email the Change Reporting Center at 242-7500 or CRC@co.dane.wi.us
 - c. You will not always receive a return call. If we can complete your case action with the information provided, we will not return your call. We will only call if we have questions, need more information, or need to tell you something. You will get a written notice as noted above, if your call results in a change to your case.
 - d. Do not call to confirm receipt of your message/fax/paperwork.
- 9) **Email us** – Email addresses are included on the STEP Unit Contact List.

We only see walk-in customers at our offices where we determine there is a bona fide emergency and the alternate contact methods listed above are not adequate for the situation.

Here are some additional tips we hope are helpful.....

- ❑ General website where there is a lot of useful info: (handbooks, ops memos, etc)
<http://dhfs.wisconsin.gov/em/index.htm>
- ❑ Income Maintenance Forms are at:
<http://dhfs.wisconsin.gov/em/forms/imforms.htm>
- ❑ Medicaid forms by title are at:
<http://dhfs.wisconsin.gov/em/forms/medicaid/medicaidtitle.asp>
- ❑ Below is the form you complete for a Medicaid application or review. This form does not contain the instructions. If you need the instructions you can locate that form on the same page.

Wisconsin Medicaid for the Elderly, Blind and Disabled Application / Review - Includes HCF 10101B, Medicaid Request for Backdated Coverage	HCF 10101	PDF - Fillable	1/1/2005
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- ❑ Below is the form you complete for a Medicaid and/or Food Share Authorization of Representative. A client can only have one authorized representative at a time, and it needs to be an individual rather than an agency. If the client has a guardian of estate or person, they must sign the authorized representative form. The form must be witnessed by a third person.

Medicaid / FoodShare Wisconsin Authorization of Representative	HCF 10126	PDF - Fillable	1/1/2005
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If you have a question on a case and you know the worker's name, email that worker first. Only if you get the "out of office" response from the assigned worker should you email the entire group. In the subject line or the body of the email include the full name of the client, the case number and/or the social security number. Also include in the email the assigned worker's name. The email address for the waiver group is waiver.step@co.dane.wi.us.

If you are using email to notify the worker of a change please email the Change Reporting Center at crc@co.dane.wi.us rather than the individual worker.

Change Reporting Center Phone (608) 242-7500
Change Reporting Center Fax (608) 240-2050
Step Unit Fax Number (608) 242-7410

If you are contacting your worker to schedule a review, please contact the review scheduler at 242-7530. PLEASE leave only one message as multiple messages cause a huge backlog, as all messages must be listened to and acted on.

PLEASE NOTE: if the customer is NOT on FoodShare, a phone or face-to-face review is not necessary. Because of current workload issues, the review line is usually quite busy. It will take less time of the Case Manager to 1) make a copy of the application when it is originally submitted and keep that in your customers file. 2) use that copy to help them update a new booklet when their review is due. Because you have saved your template this will only take 10 to 15 minutes. 3) send the booklet to us. This is much easier for you, as the Case Manager than

calling, waiting for a call back, setting up a time, going through the entire application process over the phone with the worker and 4) still having to go help your client get their verifications and get the signature page back to us.

We realize a lot of you are not the authorized representative for a customer's Medicaid application but everyone can save time if mail in reviews are used.

- ❑ When you do an application by mail with your client, it is important that you send the MA Initial/Renewal worksheet with it so we know a) that it is a waiver (sometimes new applications arrive with nothing and we don't open the correct sub-program) and b) who the Case Manager is.

Once the client is ongoing, it is only necessary to send a waiver worksheet if you are changing the med remedials or the shelter costs, as long as you update the information on the DHFS functional screen. If you do not automatically update, then you need to provide the waiver renewal form to us yearly.

- ❑ When you are helping a customer complete a new application, make a copy of it before you send it to us. The next time you help them with their review, it'll only take you a few minutes.
- ❑ If you wait until AFTER the COLA is processed to update your client's med remedial, you are then requesting screens twice and that's extra work for the person responsible for giving them to you.
- ❑ Do NOT ask the ESS worker what you can use for med remedial, you are supposed to TELL us.
- ❑ Do not ask the ESS worker what a client's income is. You are supposed to communicate with your client for that. They may have sources we don't even know about. If they absolutely can't remember their social security amount, the clerical staff can look it up on AFUI in the CARES system, but again, that may not tell you all you need to know. If a client is so low functioning they can't tell you some of these things, you may have to look to a family member or others.
- ❑ When you have a client in a CBRF or AFH, you tell us what the shelter expense is by correctly completing that line on the information sheet you send us. Don't attach the CBRF printout and expect us to do your calculations for you.
- ❑ On the waiver renewal form there is a place to indicate that the case manager wishes to receive a copy of consumer's mail. Receiving their mail will ensure you know of any changes such as a review not being completed, cost share changes, or even a case closing for any reason. If you choose not to receive a copy of their mail, then you need to rely on the consumer to keep you informed.
- ❑ Please notify us, and send a new authorized representative form, any time a case manager changes.

STEP Unit Contact Information

STEP Unit Workers	Phone	e-mail	Cares ID # (listed on all letters sent)
RON REDELL (Supervisor)	242-4575	redell@co.dane.wi.us	XDA143
CATHY BEHN	242-4598	behn@co.dane.wi.us	XDA242
JEREMIAH COOK	288-2591	cook.jeremiah@co.dane.wi.us	XDA450
JOAN CORCORAN	242-4573	Corcoran@co.dane.wi.us	XDA744
ALYSSA GUNDERSON	242-7536	gunderson@co.dane.wi.us	XDA250
SHAUN JOHNSON	242-7537	johnson.shaun@co.dane.wi.us	XDA616
MEGAN SMOLER	242-7467	smoler@co.dane.wi.us	XDA970
DARCY STECKLEIN	242-4544	stecklein@co.dane.wi.us	XDA680
TAMMY TEDESCHI	242-7518	tedeschi@co.dane.wi.us	XDA428
ELLIOT WILLIAMS	288-2451	williams.elliott@co.dane.wi.us	XDA761

As of right now all workers have some waiver cases; **the majority of the waiver cases are with Tammy Tedeschi** though. If a waiver participant does not have Tammy as their assigned STEP Unit worker, please inquire.

Email-other

Apptscheduling@co.dane.wi.us

CRC@co.dane.wi.us

Key Contacts

Member Services Health Care 1-800-362-3002

QUEST Card Customer Service 1-877-415-5164

Health Insurance Premium Info 1-888-907-4455

HMO – Enrollment Information 1-800-291-2002

HMO – Complaints 1-800-760-0001

Websites

ACCESS: www.access.wi.gov

To apply for benefits, check your benefits and report changes.

**MA INITIAL/RENEWAL INFORMATION SHEET
CIP-1A, CIP-1B, CIP-II, OR COP-W**

To be completed by the Case Manager and sent to the Economic Support

Attach this Completed Form to "Request for Assistance Form" or submit at time of review to consumer's assigned ESS or mail completed form to STEP Unit, 1819 Aberg Ste D 53704 and Fax 242-7410

1. Date of referral from case manager to Economic Support: if ongoing case please use today's date
2. Applicant Name: _____ SSN: _____
Address: _____ Phone no. _____
Marital Status: Single _____ Married: _____
3. Contact Person, phone # & complete address _____

4. Case Manager (name and phone #) _____
5. Case Manager wants to receive copy of consumer's mail Yes _____ No _____
6. Type of MA Waiver: CIP 1A _____ CIP II or COP-W _____ Partnership _____
CIP 1B _____ Dual Waiver _____ PACE _____ Brain Injury Waiver _____
Nursing Home Relocation _____ Diversion Slot _____

-
7. Anticipated Waiver Start Date or Actual Start Date if PACE/Partnership _____
 8. Level of Care _____ (SNIF, ICF, of CNF)
 9. Community Waiver Functional Eligibility? Yes _____ No _____

-
10. Monthly medical/remedial expenses for Group B or Group C applicant: _____
 - For Group B these are items and services not covered by MA that are paid by the participant.
 - For Group C, in the addition to the above, any expenses that would be covered by the Waiver or COP, such as case management, home delivered meals, would be included. Do not include health insurance premiums or CBRF/AFH room/board cost.
 11. Monthly MA card coverable expenses for Group C Applicant _____
 12. Monthly medical/remedial expense for Group C cost share _____
 13. Group B and living in an AFH or CBRF. Shelter Cost _____
(Shelter Cost = Rent/Mortgage, Property Taxes, Insurance, Building & Grounds/Maintenance Repairs, Resident's furnishings, Household supplies needed by the facility for inside maintenance & upkeep, and Utilities. "General rule of thumb:" is to subtract the food, phone & cable cost from the Room/Board rate.)
 14. Living Arrangement: _____ Adult Family Home _____ CBRF
_____ Living in own home or apartment _____ Adult Foster Home
_____ Residential Care Apt. Complex
-

CIP 1A/1B APPLICATION REVIEW CHECKLIST FOR CIS

1. Applicant Name:

2. County:

3. Date App. Received:

4. Date App. Approved:

5. Start Date of Services:

6. _____ Long Term Care Functional Screen Completed
1. _____ Date Completed _____ (Waiver start date can be + or - 90 days)
 2. _____ DD level of care rating assigned (Circle one: DD1a, DD1b, DD2 or DD3).
 3. _____

7. _____ Individualized Service Plan Development Date (DSL 445):

1. _____ All services person is receiving are listed, including any non-waiver supports/services.
2. _____ Room and board costs (for regulated settings) and personal needs money listed on ISP.
3. _____ If there's a cost share with CARES, is reflected on the ISP and is being applied toward a waiver allowable service.
4. _____ Signed and dated by person and/or guardian
5. _____ "Service Plan Development Date" is prior or equal to service start date
6. _____ Outcomes documented on ISP
7. _____ Dental provider is listed on the ISP.
8. _____ Medical providers are listed on the ISP.

8. _____ Assessment includes:

1. _____ The assessment identifies informal and formal supports and/or services necessary to meet the applicant's needs. Including the applicant's preferences and lifestyle choices.
2. _____ Assessment information is current and accurate.
3. _____ Background and social history.
4. _____ Physical and medical health history.
5. _____ Individual outcomes important to the person.
6. _____ Ability to perform physical activities of daily living.
7. _____ Ability to perform instrumental activities of daily living.
8. _____ Emotional and cognitive function.
9. _____ Behaviors that positively or negatively affect lifestyle or relationships.
10. _____ Social participation, friendships, existing formal and informal social supports.
11. _____ Cultural, ethnic and spiritual influences.
12. _____ Community participation and involvement.
13. _____ Personal preferences as to how and where to live, preferred daily activities/routines and their environment.
14. _____ Risks associated with choices made in living arrangement, activities and relationships and behaviors.
15. _____ Economic resources available and how they are managed.
16. _____ Formal and informal supports available to the person.
17. _____ A discussion of participant rights and responsibilities including the individual's capability to understand and exercise them.
18. _____ A review of the applicant/participant's interest and ability to direct his/her own supports.

9. _____ Narrative Summary

1. _____ Includes description of the services listed on the ISP.
2. _____ Narrative Summary discusses/lists services at the time of application.
3. _____ Narrative Summary addresses specific forms of intervention needed by the person in the day, evening, and on the weekend.
4. _____ The narrative description identifies the physical, mental and/or emotional needs of the person,
5. _____ The narrative description identifies the services and formal and informal supports which will be provided or arranged to meet those needs.
6. _____ The narrative identifies the ways in which the person will utilize community

7. _____	resources and participate in community activities.
8. _____	The narrative identifies and explains the possibility for natural relationships.
9. _____	The narrative provides a comprehensive view of the participant's history, current situation, and future plans.
9. _____	Any Restrictive Measures are identified, applied for, and approved by the Department.
10. _____	Cost Share or CARES: MA Eligibility Date: _____
	*If Cost Share Worksheet (DSL 919):
1. _____	Completed appropriate sections. (Top of page, Section I, Section II, Section V)
2. _____	Person is an SSI Recipient (Group A)
3. _____	"MA Eligibility Date" on cost share is prior to or on the start date.
	*If CARES Form (If Group B or C, CARES form substitutes DSL 919):
1. _____	I.M./E.S. completed the form.
2. _____	If cost share determined, dollar amount is reflected on the ISP for MA waiver service.
3. _____	MA start date is prior to or on the Waiver start date.
4. _____	CARES reflects a "Pass" status on the screen
5. _____	OR if "Pending" status on the CARES screen, after county receipt of the waiver approval letter a "Pass" screen is completed by the county.
11. _____	HSRS "Long Term Support Client Registration" Screen (L1) is printed out.
12. _____	Cover letter from county agency submitting the plan, includes:
1. _____	County authorization of plan – county requesting review and approval of application
2. _____	Name of individual
3. _____	Type of slot requested
4. _____	Requested start date
5. _____	Request for variance <u>or</u> request to waive any requirement (if applicable)
6. _____	Service Coordinator start up hours (hours beyond 90 days, but less than 180 days, prior to the start date have CIS approval for submission to the waiver and are documented on the ISP)
13. _____	Service Coordinator hours prior to the start date:
1. _____	Hours addressing transition and placement planning up to 90 days prior to the start date are documented on the ISP.
2. _____	Hours beyond 90 days, but less than 180 days prior to the start date have CIS approval for submission to the waiver and are documented on ISP.
14. _____	Variances Requested:
1. _____	Services on the grounds of institution, include all information required. (i.e. Day Services)
15. _____	Housing modifications documentation (All Ramp Requests and any other Housing Modification in excess of \$2,000)
1. _____	Written rationale and request for the housing modification.
2. _____	Modifications are listed on the ISP.
3. _____	Copy of the estimate for the modifications.
4. _____	A photograph, drawing, or copy of plan that illustrates the modifications.
16. _____	Housing Start up – only applies for a person moving from an institution or from a home to establish an independent living arrangement
1. _____	Items purchased within 180 days of the individuals start date
2. _____	Items requested are allowable under service definition in Manual
3. _____	Written rationale for all items
4. _____	Start up is listed on the ISP
17. _____	CIS Completing Form: _____ Date: _____

VARIANCE REQUEST – WAIT LIST

A variance request is required in order to receive an exception to the Medicaid Home and Community-Based Waiver wait list policy.
Use of this form is optional.

Name – Applicant	Date of Request
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Potential Funding Source (Check one)

- | | | |
|----------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> COP – W | <input type="checkbox"/> CIP IA | <input type="checkbox"/> CLTS DD |
| <input type="checkbox"/> CIP II | <input type="checkbox"/> CIP IB | <input type="checkbox"/> CLTS PD |
| <input type="checkbox"/> BIW | | <input type="checkbox"/> CLTS SED |

Name - Agency and Care Manager / Support and Service Coordinator
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Detail reason applicant should receive variance to statewide waitlist policy:

Submit variance request to:

- COP-W / CIP II – Kimberly Schindler (BLTS)
- CIP 1A / 1B – Community Integration Specialist (CIS)
- CLTS – Children’s Services Specialist (CSS)

Approved Denied

SIGNATURE – Authorized BLTS Representative	Date Approved/Denied
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