Medicaid Managed Care Contract Matrix: Wisconsin

Programmatic Element	Standards	Source
Program Name	Family Care	
Date of Transition	Family Care started as a pilot program in 1998. In 2015, state legislation expanded the program statewide; implementation has been gradual on a county-by-county basis. Enrollment in the final county began in February 2018.	Current Landscape: Managed Long-Term Services and Supports for People with I/DD, ANCOR
Total Enrollment	23,252 (individuals with I/DD)	Family Care, Family Care Partnership, and PACE Enrollment Data
Enrollment Type	Voluntary	IV. Enrollment and Disenrollment
Plans Operating in the State	Care Wisconsin, Community Care Inc., Inclusa, Lakeland Care, My Choice Family Care	Family Care Geographic Service Regions (GSR)
Authority for Managed Care	1915 (b) and (c) waivers	WI Family Care Waiver, CMS
Eligibility	Family Care covers individuals 18 years of age and older that require nursing facility level of care or non-nursing home level of care that have: 1. Physical disabilities, including persons with Alzheimer's disease or terminal illness; 2. Developmental disabilities; and 3. Frail elders, including persons with Alzheimer's disease or terminal illness. Members enrolled in Family Care may be eligible at a Wisconsin Medicaid nursing home-certifiable level of care or at a non-nursing home level of care. One of these functional levels of care is required as a condition of eligibility.	Article XIX. MCO Specific Contract Terms
Benefit Design	Family Care covers Medicaid State Plan LTSS and HCBS waiver services, including: • Alcohol and other drug abuse (AODA) day treatment services • AODA services • Case management (includes assessment and care planning) • Community support program (except physician provided)	VIII. Benefit Package Service Definitions

	• Durable medical equipment and medical supplies (except hearing aids, prosthetics, and family planning supplies) • Home health • Mental health day treatment services (in all settings) • Mental health services (except not inpatient or physician provided or comprehensive community services) • Medicare deductible and coinsurance amounts for a dual eligible Family Care member[1] • Nursing home services including ICF-IID and IMD[2] nursing services (including respiratory care, intermittent and private duty nursing) • Occupational therapy (in all settings except inpatient hospital) • Personal care services • Physical therapy • Speech/language pathology • Non-emergency medical transportation Physical health, behavioral health (except some limited mental health services), pharmacy, and dental services are carved out of Family Care.	
Plan Type	Wisconsin uses regional non-profit MCOs to operate Family Care.	Current Landscape: Managed Long-Term Services and Supports for People with I/DD, ANCOR
Integration with Medicare	No integration.	
Residential Services	Members can receive LTSS in the benefit package where they live, including ICF/IID facilities. Residential care services (including adult family homes[3], community-based residential facilities[4] and residential care apartment complexes[5]) may be authorized only:	VII. Services Addendum VIII

[1] MCOs must pay any deductible, coinsurance or copayment amount for a Medicare service that Medicaid would pay for fee-for-service recipients if the service is also a Medicaid State Plan service in the Family Care benefit package. For out-of-network providers, the MCO must remit Medicare deductible and coinsurance amounts to providers if the claim is submitted within 365 days from the date of service or 90 days from Medicare disposition, whichever is later, in accordance with Wis. Admin. Code § DHS 106.03

[2] Inpatient services are only covered for IMD nursing home residents under the age of 21 years or age 65 or older, 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.

	• 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.	
Care Coordination Model	*Care management generally*—Care/case management services (sometimes called support and service coordination) are provided by an interdisciplinary care management team (IDT), which consists of, at minimum, a registered nurse and a social services coordinator,[6] and may also include other professionals as appropriate to the needs of the member, as well as family or other informal supports, as requested by the member. The IDT staff must ensure coordination of long term care services with health care services received by the member, as well as other services available from natural and community supports. This includes but is not limited to assisting members to access social programs when they are unable to do so themselves and, if requested, providing information to a member about how to choose a Medicare Part D prescription drug plan. Care management services are provided by the case manager with the member and other participants of the IDT and include: • A comprehensive assessment of the member's strengths, abilities, functional limitations, lifestyle, personal circumstances, values, preferences and choices; • Development of an individualized plan of care; • Authorization for the purchase of paid services identified in the plan of care; • Monitoring of the delivery and quality of the paid services identified in the plan of care; • Monitoring of the member's circumstances and ongoing health and wellbeing; • Maintenance of the member record and all documentation associated with the delivery of services and any required	V. Care Management Addendum VII

[3] Adult family homes are places in which the operator provides care, treatment, support, or services above the level of room and board. 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.

[4] Community-based residential facility (CBRF) is a place where five or more adults, and in cases of persons with an intellectual disability up to eight 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.

[5] Residential care apartment complexes (RCAC) are services provided in a homelike, community-based setting where five 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).

[6] Social service coordinators must have a social worker certification, have a bachelor's degree in a human services area or a bachelor's degree in any other area and have three years' experience in social service care management or related social service experience with persons in the MCO's target population.

	waiver procedures. *IDT*—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. *Comprehensive assessment*—MCOs must assess members through a face-to-face interview. As a part of the comprehensive assessment, the IDT must review the functional screen, all available medical records of the member and any other available background information. MCOs are required to use a standard format, developed by the state, for documenting the information collected during the comprehensive assessment. *Reassessment*—MCOs must routinely reassess members every six months and as appropriate, update all of the sections in the member's comprehensive assessment and member-centered plan (MCP) as the member's long term care outcomes change. At a minimum, the reassessment and MCP review must take place every six months, but reassessments must occur whenever there is a significant change in the member's long term care or health care condition or situation or a request for reassessment by the member, the member's legal decision maker, or the member's primary medical provider. During the member's comprehensive reassessment and MCP review, the IDT must review with the member, the member's preference regarding vocational or educational goals, including opportunities to pursue integrated employment. *Member-centered plan*—Member-centered planning (and the member-centered plan) is based on the comprehensive assessment. The IDT must review the assessment and member-centered plan every six months or whenever there is a significant change in the member's health or functional status. The member-centered plan must be written in a way that is understandable to the member, provided to the member and must include, among other things, information about the member's strengths and preferences, the frequency of face-to-face and other contacts, informal supports and services, non-covered services provided to the member, and potential risks to the member. *Frequency of contacts*—MCOs are required to engage in care management contacts as follows: • The initial contact (face-to-face or by phone) must occur within three calendar days of enrollment. • The initial assessment (face-to-face) must occur within 10 days from enrollment. • The initial service authorization must be developed and implemented within five calendar days of enrollment. • The initial member-centered plan must be developed within 10 calendar days of enrollment, and the fully developed member-centered plan must be develop within 60 calendar days of enrollment.	

	• The comprehensive assessment must be completed within 30 calendar days of enrollment. • Face-to-face contacts must be established based on the complexity of the member's needs and the risk in the member's life, including an assessment of the member's potential vulnerability/high risk. However, IDT staff is required to conduct a face-to-face visit with a member quarterly and both the social services coordinator and registered nurse are required to conduct a face-to-face visit in the member's residence at minimum every 12 months as part of the annual comprehensive assessment; and every six months for vulnerable/high risk members as part of the annual comprehensive assessment and subsequent six month reassessment. • Phone contacts must occur in each month where there is not a face-to-face meeting with the member. *Risk mitigation*—MCOs must have policies and procedures on member safety and risk in order to balance member needs for safety, protection, good physical health, and freedom from accidents, with overall quality of life and individual choice and freedom. MCOs must have a mechanism to monitor, evaluate and improve their performance in the area of safety and risk issues in order to ensure that the plan offers individualized supports to facilitate a safe environment for each member.	
Dental Services	Dental services are carved out of Family Care.	
Optical Services	Optical services are carved out of Family Care.	
Workforce	Wisconsin has a Direct Care Workforce Funding Initiative that included a $60.8 million provision in the state's 2017-19 biennial budget to fund increases for the direct care portion of managed long term care capitation rates. Any agreements with direct care workers[7] must include the provisions regarding the use of any funds received pursuant to the Direct Care Workforce Funding Initiative that limit the use of funds for the following purposes or to pay for employer payroll tax increases that result from using the funds for one of the following purposes: • Wage increases; • Retention/longevity bonuses;	Article VIII, Provider Network Direct Care Workforce Funding Initiative

[7] A direct care worker is defined as an employee who contracts with or is an employee of an entity that contracts with an MCO to provide adult day care services, daily living skills training, habilitation services, residential care, respite care services provided outside of a nursing home, and supportive home care, and who provides one or more of the following services through direct interaction with members: assisting with activities of daily living administering a member's medications, providing personal care or treatments for a member, conducting activity programming for a member, or providing services such as food service, housekeeping, or transportation to the member. Staff who would be excluded from the definition of "direct care worker" include but are not limited to: licensed practical nurses, registered nurses, nurse practitioners, nursing home staff, personal care agency staff, staff in marketing, sales, reception, finance, maintenance/plant operations and those staff who work exclusively in food service, transportation, and housekeeping and do not have direct contact with members.

	• Performance bonuses; • Employee paid time off; • Staff referral bonus; • Sign on bonus. In compliance with state statute, the state may make payments to the MCO, which the MCO must distribute to direct care workforce providers under specific terms and conditions.	
Plan Rates	MCOs are paid a monthly capitation rate for all covered services, which must be based on an actuarially sound methodology as required by federal regulations. The capitation rates shall include funding to support relocation of members from institutional settings into the most integrated community setting. *Pay for Performance*—Wisconsin is implementing a pay for performance mechanism in 2019. This incentive applies only to CY 2019 and will not be renewed automatically. The pay for performance withhold payments will be based on results from the member satisfaction survey and competitive integrated employment plan. MCOs may additionally be eligible for an incentive payment based on results from the member satisfaction survey, competitive integrated employment actions, and assisted living quality improvement incentive. The following three programs and any payments thereunder are expressly contingent upon receiving federal approval for the programs. • Member Satisfaction Survey—The state will conduct a member satisfaction survey that will be sent to a sample of each MCO's members. The pay for performance criteria will be based on four questions that assess member access to services, member participation in the care planning process, member satisfaction with care plan/team, and member satisfaction with services. All MCOs will have 0.25% of their calendar year 2019 capitation rate withheld to be returned based on the MCO's performance on the member satisfaction survey. The MCO will receive one fourth of the withhold for each survey question in which they meet the minimum performance standard set by the state. MCOs that meet the minimum performance standards for all four questions will earn back all of the withhold. MCOs will earn a 0.05% performance enhancement to their rate for each targeted performance benchmark they meet. • Competitive Integrated Employment[8]—All MCOs will have 0.25% of their calendar year 2019 capitation rate withheld to be returned based on approval by the state of the MCO's competitive integrated employment plan ("CIE Plan"). To be eligible for the incentive payment, an MCO must have a state approved CIE Plan. An MCO will receive 0.08% of its 2019 capitation rate as	XVIII. Payment to the Managed Care Organization Article VIII. Provider Network Family Care: Calendar Year DD Center Rates for MCOs

[8] Competitive integrated employment is work performed on a full-time or part-time basis, compensated not less than the applicable state or local minimum wage law (or the customary wage), or if self–employed, yields income comparable to persons without disabilities doing similar tasks. The worker should be eligible for the level of benefits provided to other employees and the job should present opportunities for advancement. The work should be at a location typically found in the community where the employee with a disability interacts with other persons who do not have disabilities and are not in a supervisory role.

	an incentive payment if the MCO documents employment interests of 90% of its members aged 18-45 years old. An MCO will receive 0.12% of its 2019 capitation rate as an incentive payment if the MCO documents a state-approved employment activity with 90% of members who are currently enrolled in the MCO and identified to be currently working in CIE, interested in working in CIE; or may be interested in CIE. • Assisted Living Quality Improvement Incentive—MCOs may receive an incentive payment for each member residing in an assisted living facility if the assisted living facility either qualifies for the abbreviated Division of Quality Assurance survey and is compliant with Home and Community-Based Services settings rule; or qualifies for the abbreviated Division of Quality Assurance survey, is compliant with the Home and Community-Based Services settings rule, and is a member in good standing with Wisconsin Coalition for Collaborative Excellence in Assisted Living. The amount of the per member incentive payment will be determined by state with the total amount to be distributed for the assisted living quality improvement incentive is $2 million.	
Value-Based Payment Arrangements	No information available.	Article XVIII. Payment to the Managed Care Organization
Employment	MCOs are required to support members in obtaining employment and work in competitive integrated settings. Competitive integrated employment is defined as work performed on a full-time or part-time basis, compensated not less than the applicable state or local minimum wage law (or the customary wage), or if self–employed, yields income comparable to persons without disabilities doing similar tasks. MCOs must develop and submit a Competitive Integrated Employment Plan (CIE Plan) to the State that outlines how the MCOs will support members in achieving integrated employment. All MCOs have 0.25% of their calendar year 2019 capitation rate withheld to be returned based on approval by the state of the MCO's CIE Plan *(see Plan Rates section above for more details)* Employment services in the Family Care benefit package (HCBS waiver services) include: • Prevocational services • Supported employment – individual employment support services • Supported employment – small group employment support services • Vocational futures planning and support (VFPS)	Article XVIII. Payment to the Managed Care Organization VIII. Benefit Package Service Definitions
Assistive Technology	Assistive technology/communication aids are included as covered as part of the HCBS waiver. Assistive technology and communication aids include items, pieces of equipment or product systems, 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. These services	VIII. Benefit Package Service Definitions

	include services that directly assist a member in the selection, acquisition, or use of an assistive technology device.	
Utilization Management (UM)	MCOs are required to use state approved service authorization policies and procedures. The MCO may place appropriate limits on a service on the basis of criteria such as medical necessity; or for the purpose of utilization management, provided the services furnished can reasonably be expected to support the member's long term care outcomes. However, the MCO cannot deny services that are reasonable and necessary to cost-effectively support the member's long term care outcomes identified in the comprehensive assessment as well as those necessary to assist the member to be as self-reliant and autonomous as possible. The MCO is authorized to have access to, and make use of, data found in the LTCare Data Warehouse operated for the state. The MCO will be able to use the data for utilization management, network development, and quality assurance and improvement. *IDT*—UM is generally done by the IDT. If the MCO has received approval from the state to conduct service authorization decisions outside of the IDT, including any situations in which IDT staff are required to seek approval for an authorization it would like to make from supervisory, clinical or administrative staff within the MCO, the MCO must maintain written decision-making criteria and specify the information required for service authorization decisions in its policies and procedures. *Limitations on UM staff*—The MCO shall not compensate individuals or entities that conduct utilization management or prior authorization activities in such a way as to provide incentives for the individual or entity to deny, limit, or discontinue for members services necessary to support outcomes. *Prior authorization*—For Medicaid State Plan services covered by Family Care, 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 applied in the fee-for-service program. The state will waive, to the extent allowed by law, any present state requirements for prior authorization, second opinions, co-payment, or other Medicaid restrictions for the provision of contract services including LTC benefit package services provided by the MCO to members. *Timeframes*—Standard service authorization decisions must be made no later than 14 calendar days following receipt of the request for the services unless the MCO extends the timeframe for up to 14 additional calendar days. The MCO must make an expedited service authorization no later than 72 hours after receipt of the request. The MCO may extend the timeframes of expedited service authorization decisions by up to 11 additional calendar days if the member or a provider requests the extension or if it is needed by the MCO to gather more information. Failure to reach a service authorization decision within the specified timeframes constitutes a denial and therefore requires a notice of adverse benefit determination.	Article V. Care Management Article XIV. Reports and Data Article XV. Functions and Duties of the Department Article VII. Services Addendum VII. Benefit Package Service Definitions
Enrollee Protections	The MCO must provide education to members on the grievance and appeal process within 90 calendar days of enrollment. Responsibility for member education may be delegated to the member's lead/primary care manager. *Member rights specialist*—The MCO must designate a member rights specialist to serve as a member advocate within the agency,	Article X. Member Rights and Responsibilities Article VIII. Provider Network

	tasked with providing support for all members in understanding their rights and responsibilities The MCO member rights specialist must have direct access to top level management of the MCO, and must perform the following functions, at a minimum: assist individual members with issues and concerns that relate to the care management or the services provided through the MCO and in assuring quality services throughout the MCO. The MCO must assure that, within 90 calendar days after enrollment, members have had a face-to-face contact to make certain they are aware of the advocacy services available to them. This contact may be done by the interdisciplinary team. *Notice of provider terminations*—The MCO must make a good faith effort to give written notice of termination of a contracted provider, within 15 business days after receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. When the state determines that a network change is significant, the MCO must provide each member and the Aging and Disability Resource Centers (ADRCs) in the service area affected by the change, written notice of the change at least 30 calendar days before the effective date of the change. *Restrictive settings*—MCOs are responsible for reviewing and approving requests for restrictive measures before forwarding them to the state for approval. MCOs must ensure that their providers follow the state's statutes, regulations, and guidance on the use of isolation, seclusion, and restrictive measures in community settings. *Responding to member incidents*—MCOs must develop and maintain an incident management system, which manages, investigates and reports incidents occurring at the member and provider levels, in order to assure member health and safety, reduce member incident risks, and enable development of strategies to prevent future incident occurrences. *MCO Member Advisory Committee*—MCOs must create and staff a Member Advisory Committee to advise the MCO on its policies and operations (including the MCO's quality management program), how it is meeting the needs of members and how operations and outcomes may be improved. The Committee must include a reasonably representative sample of members from the MCO's target populations or other community individuals representing those members and meet at least once a year.	Article V. Care Management Article II. MCO Governance and Consumer and Member Involvement
Network Adequacy	MCOs must allow any community-based residential facility (CBRF), residential care apartment complex (RCAC), community rehabilitation program, home health agency, day service provider, personal care provider, or nursing facility to serve as a network provider if the provider agrees to accept the MCO's negotiated rate and the provider meets all guidelines established by the MCO related to quality of care, utilization, and other criteria applicable to providers under contract for the same care, services, and supplies. However, MCOs are not required to contract with providers beyond the number necessary to meet the needs of its members, are not precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty or from establishing measures that are designed to maintain quality of services and control costs and are consistent with its	Article VIII. Provider Network

	responsibilities to members. MCOs are required to meet, and must require participating providers to meet, state standards for timely access to care and services; to ensure that participating providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service members; to make benefit package services that are necessary to support outcomes or that are medically necessary, available 24 hours a day, seven days a week, as appropriate. MCOs must demonstrate to the state that they have adequate internal staff and provider capacity to provide the projected membership in the service area with: • The appropriate range of services to make all services in the benefit package readily available to all members, including those with limited English proficiency or physical or mental disabilities • A sufficient number, mix, and geographic distribution of providers of all services • Access to prevention and wellness services • Specialized expertise with the target populations served by the MCO • Culturally competent providers • Services that are physically accessible and available on a timely basis	
Provider Protections	*Provider contracts*—The MCO's provider agreements must specify the start date of the provider agreement and the means to renew, terminate and renegotiate. The provider agreement specifies the MCO's ability to terminate and suspend the provider agreement based on quality deficiencies and a process for the provider appealing the termination or suspension decision. The MCO will ensure that provider agreements reflect all current MCO contract and provider agreement requirements. *Service authorizations*—MCOs must ensure service authorization is given to the provider prior to the start date of designated services by the provider. When prior written authorization is not practicable, verbal authorization should be provided for the service and written authorization issued thereafter. Revised service authorizations must be issued to providers promptly, with sufficient notice to allow providers to comply with the terms of the revised service authorization (for example, to prevent providers from unknowingly exceeding reduced authorized service units) and to timely submit accurate claims during the appropriate billing period. *Rate Negotiations*—Except for nursing home services, MCOs may pay providers less than the Medicaid FFS rates, including HCBS providers. In the event that an MCO contracts at a rate above the Medicaid fee-for-service rate, the MCO must submit a notification to the state. MCOs are prohibited from including in a contract for residential services, prevocational services, or supported employment services a provision that requires a provider to return to the MCO any funding that exceeds the cost of those services.	Article VIII. Provider Network
Telehealth	Telehealth is carved out of Family Care.	
Self-Direction	Under self directed supports (SDS), a member may purchase long term care benefits, include adaptive aids, adult day care services,	Article VI. Self-Directed Supports

	assistive technology, consultative clinical and therapeutic services for caregivers, consumer education and training services, counseling and therapeutic services, environmental accessibility adaptations, financial management services, habilitation services, home delivered meals, housing counseling, personal emergency response system, prevocational services, relocation services, respite care, self-directed personal care services, skilled nursing services, specialized medical equipment, support broker, supported employment services, supportive home care, training services for unpaid caregivers, transportation, and vocational futures planning and support (except for residential care services and care/case management services), if they are identified by the IDT as consistent with the member's outcomes. Members who live in residential settings can self-direct services that are not part of the residential rate. MCOs must present SDS as a choice to all members and the member is able to self-direct in accordance with the requirements set by the state. Specific responsibilities of the MCO include: • Ensuring that SDS funds are not used to purchase residential services that are included as part of a bundled residential services rate in a long term care facility. • Determining the cost of services to be self-directed, which must be used in establishing the member's SDS budget. • Continuing to expand the variety of choices and supports available within SDS. • Ensuring that all IDT staff understand SDS or have access to MCO staff who have expertise in SDS. • Ensuring that all IDT staff understand how to create a budget with a member or have access to MCO staff who have expertise in SDS who can assist with setting budgets. • Ensuring that all IDT staff understand how to monitor SDS with a member and their IDT or have access to MCO staff who have expertise in SDS who can assist with monitoring for quality and safety. • Ensuring that all IDT staff understand how to mitigate the potential conflicts inherent when a legal decision maker is self-directing on behalf of the member or have access to MCO staff who have expertise in SDS who can assist with mitigating such conflicts. • Collaborating with the state in its efforts to develop systems for evaluating the quality of SDS, including members' experiences with SDS. • Developing and implementing a state-approved policy and procedure describing conditions under which the MCO may restrict the level of self-management exercised by a member where the team finds, for instance, the health and safety of the member or another person is threatened. • Assuring that persons providing services to members on a self-directed basis who do not otherwise have worker's compensation coverage for those services have coverage provided as follows: ○ Where the member is the common law employer of the person providing services, the fiscal services management entity (also called the fiscal/employer agent) that performs employer-related tasks for the member must purchase and	Managed Care Organization Training and Documentation Standards for Supportive Home Care

	manage a worker's compensation policy on behalf of the member, who must be the worker's compensation employer ○ Where the member is the managing co-employer of the person providing services with a co-employment agency (also called an agency with choice) as the common law employer, the co-employment agency must provide worker's compensation coverage as the worker's compensation employer. *IDT Staff Responsibilities*—It is the responsibility of the IDT staff to provide information regarding the philosophy of SDS and the choices available to members within SDS, annually obtain a written statement from the member or member's legal decision maker stating that the IDT has explained SDS and indicating whether the member has elected to participate in the program, work jointly with members to ensure all key SDS components are addressed, ensure all key SDS components are included in the member-centered plan and mechanisms are in place for ongoing check-in and support, implement the policies and procedures regarding member safety and risk to assure the health and safety of such members and validate or arrange for validation of supportive home care workers pursuant to the MCO training and documentation standards for supportive home care. *Self-Directed Services Employment Models* • Member as Employer—The SDS member or representative is considered the employer of the member-recruited/selected supportive home care (SHC) and/or respite care workers. The SDS member selects a fiscal/employer agent from among those offered by the MCO to handle payroll, background checks, and other employment responsibilities. • Agency/Member Co-Employer—An organization serves as the primary or legal employer of member-selected workers, while the member or representative serves as the secondary or managing employer. It is possible for the same entity to be an SHC agency, a co-employment agency, and a fiscal/employer agent, or any two of these, depending on the services it contracts with an MCO to offer members. However, for an individual member, it should function as only one of these.	