



Wisconsin IRIS Allocation Adjustment/Exceptional Expense Review Committee

Purpose:

1. To review and approve or deny requests for time specific and or infrequent expenses (home modification expense for instance) that will serve as a short term add on to the IRIS participant individual monthly budget allocation;
2. To serve as the Department budget allocation review process for persons who seek to have their ongoing monthly IRIS allocation adjusted either temporarily, or on an ongoing basis.

POLICY

The long term care functional screen (LTCFS) calculates the monthly individual allocation amount for each IRIS participant. The allocation amount is the funding over which the participant has authority to fund the goods and services listed on the participant plan. The IRIS Consultant works with each IRIS participant to create an approvable support and service plan that can be funded with the allocation amount. There are some goods, supports and services which IRIS participants may need that are not ongoing in nature. When such services and supports are needed and cannot be paid within the monthly allocation amount, the Wisconsin Department of Health Services (DHS) needs a fair and prompt process to make decisions surrounding how to review funding requests for such goods, services or supports and to distribute funds to those requests it approves.

The DHS recognizes that there are some situations where the IRIS allocation calculation results in an amount that is insufficient to fund the IRIS participant's ongoing support and service costs. The first step in such a situation is to verify that the LTCFS is accurate and if needed, to make a correction the participant's screen record. After this verification, and only if the correction has not produced an allocation that could fund the participant's plan, the IRIS Consultant will assist the participant to make a request to the DHS for an adjustment of the monthly allocation amount. The IRIS Consultant Agency will finalize all requests and will submit them to the Department for review. The Department reviews each request and has the authority to approve, modify or deny such requests and also to request additional information.

Urgently needed or emergency based allocation adjustment requests will be allowed without DHS approval for up to three days provided such increased costs do not exceed a total of \$300 for each occurrence. All emergency and/or urgent cases will be defined by the IRIS Consultant Agency and shall be reported in writing to the DHS IRIS Manager no later than 14 days of the occurrence.

PROCEDURE

- 1) Composition and decision making of the IRIS AA/EE review committee
 - a) Committee Members: IRIS Waiver Program Manager, representative from the IRIS Implementation Advisory Committee, a member of the Division of Long Term Care Fiscal Services Section.
 - b) The BLTS IRIS Manager will serve as the chairperson.
 - c) Each member will have equal weight in the decision making process.
 - d) Decisions shall be reached by consensus and are subject to review by the BLTS Director or designee as indicated below.

- 2) Scheduling Meetings
 - a) Meetings are scheduled weekly and the committee will meet only if requests for review have been received prior to the meeting.
 - b) The IRIS Manager schedules the meetings in advance to help members meet their appointments.
 - c) Requests must be complete and accurate before they will be reviewed.

- 3) Requests that **are reviewed** by the IRIS AA/EE review committee
 - a) Requests to raise the allocation amount for an ongoing time period;
 - b) Requests to raise the allocation amount for a time limited period EG: short term use of AFH, CBRF, or temporary increase in hourly units of supportive home care;
 - c) Request to fund a good, service or support used infrequently -EG Housing Modification, Adaptive Aid or another item /good that is not ongoing routine service, and other situations as determined by the IRIS Manager.
 - d) All requests shall be presented to the Department AA/EE committee by the IRIS Consultant Agency in written form.

- 4) Requests that **are not reviewed** by IRIS AA/Exceptional Expense review committee
 - a) Requests involving reasonably permanent changes in a participant's condition (increased funding that can be addressed through a new LTC-FS monthly allocation calculation).
 - b) Requests for a good, support or service that could be paid by setting aside up to 12 months of unspent monthly allocation.
 - c) Requests that are urgent or emergency related as defined above.
 - d) Requests for funding before an individual is determined to be IRIS eligible and also requests for a good, support or service that could be paid through the Medicaid Card or any other payer.
 - e) Requests by an IRIS participant who is in some way meeting his/her program responsibilities. A person who is not meeting his obligation to pay a Medicaid cost share payment to the Financial Services Agency for instance, is not permitted to submit a request since his/her eligibility is soon to end.
 - f) Requests that are not presented by the IRIS Consultant Agency.

- 5) IRIS Consultant Agency/IRIS Consultant duties to prepare the request for the AA/Exceptional Expense review committee
 - a) Using DHS prescribed forms; the IRIS Consultant Agency prepares all information that is needed for the review and presents the request to the Department. Each request must include narrative statements that describe the request. As appropriate, the IRIS Consultant Agency gathers supporting documentation or information that could include but is not limited to information from family members, vocational, or other contributors and any related clinical or medical information. Any community specific characteristics that influence the request should also be included in this information.
 - b) The IRIS Consultant Agency may also be asked to provide additional information to that which is required on the prescribed forms.
 - c) The IRIS Consultant Agency can request to have expert opinion provided during the review meeting. In such cases, the DHS IRIS manager must be informed of this fact in writing prior to the scheduled meeting.
 - d) Any IRIS participant who wishes to prepare his/her own AA/EE request may do so, but the IRIS Consultant Agency must submit the request to the Department for review. Communications regarding AA/EE reviews and decisions will generally only be between IRIS Consultant Agency and the Department.

- 6) IRIS Consultant Agency duties in preparing a request for the review committee
 - a) Discuss the details of the request with the IRIS participant and also their IRIS Consultant.
 - b) Gather all required documentation and list the activities and approaches that were already tried but proved insufficient or to be inadequate remedy.
 - c) Gather other information including but not limited to:
 - i) The IRIS participant preferences on the requested remedy;
 - ii) A copy of the IRIS participant's most recent Long Term Care Functional Screen;
 - iii) The most recent approved Support and Service Plan (IRIS or other) if applicable;
 - iv) Service utilization reports on paid services from either the Financial Services Agency or from other sources.
 - d) Define the requested effective period specific to the request.
 - e) Complete the state required forms which must accompany each request and also document the IRIS Consultant Agency recommended action.
 - f) Send the request on Department prescribed forms to the IRIS Waiver Manager through electronic-mail at least 7 days in advance of the next scheduled review meeting.
 - g) Prepare additional written materials for review by the committee.

- 7) Meetings and Making Decisions
 - a) The IRIS Waiver Manager notifies the committee that a request has arrived and shares a copy of the request with each review team member.

- b) The review meeting convenes, and reviews each request in detail. This review may include contacting the IRIS Consultant Agency or others by telephone to answer any questions that remain after their review of submitted materials.
 - c) The IRIS Consultant Agency may arrange for additional details to be shared either in person, by phone, by videoconference, or by letter. If approved in advance, other individuals may present information at the meeting.
 - d) After a review of all information presented the review team will discuss the request and evaluate it only according to the pre-established criteria listed at the end of this policy.
 - e) The review team decision will be achieved through a consensus process, and will be documented in writing summarizing the team decision.
 - f) The review process includes review and consideration of highly sensitive confidential and private information. Extreme care will be exercised by all involved to actively prevent any breach of the participant's ultimate right to confidentiality.
- 8) Outcomes of Allocation Adjustment/Exceptional Expense review meetings
- a) Approval of the request as presented.
 - i) Revision of the monthly allocation for a specified period of time.
 - ii) Short term increase of funding for period of one year or less. The IRIS Consultant Agency may be required to submit a progress plan that includes a timeline for restoring the participant's prior level of independence.
 - b) Approval of a lesser dollar amount than was requested and/or for a different duration.
 - c) Denial of request.
 - d) Tabling of request until more information is received. Such requests will be returned to the IRIS Consultant Agency with an explanation of the information still needed. A subsequent team meeting will review additional information submitted.
 - e) The Bureau Director or their designee will be informed of the decision.
- 9) Department responsibilities after the AA/EE review decision is made
- a) The decision summary will be reviewed by the Bureau of Long Term Care Director or designee.
 - b) The Department forwards the decision summary to the IRIS Consultant Agency.
 - c) The IRIS Consultant Agency will inform the IRIS participant, the IRIS Consultant and the Financial Services Agency of the IRIS AA/EE decision by letter within 10 business days of the decision.
 - d) DLTC Fiscal Services will place a copy of the IRIS AA/EE request form, along with a notation of the decision in an AA/Exceptional Expense decision file.
 - e) The Department will maintain an electronic file that will log all decisions of the review committee. The file information shall identify the individual, the

decision along with corresponding dates and also any and all other conditions that apply to the decision.

- 10) Program integrity and quality management responsibilities
 - a) Revision of monthly allocation amounts
 - i) The IRIS Consultant Agency will include persons who have received an allocation adjustment as one of the targeted groups of quality management reviews and also will include verifying that monthly allocation increases continue to be needed as an element of their internal Quality Management/ Improvement program.
 - ii) The Financial Services Agency will include verification that the monthly allocation increase is recognized in their routine and ongoing claims payment processes and procedures.
 - b) A short term increase of funding for period of one year or less is subject to additional monitoring
 - i) The initial communication to the IRIS Consultant Agency identifies any and all conditions which must be applied to the increase. The IRIS Consultant Agency is expected to implement any and all conditions applied to a decision.
 - ii) The IRIS Consultant Agency shall make routine reports available on the monitoring it does to the DHS IRIS Program Waiver Manager.
 - iii) The DHS IRIS Program Waiver Manager can adjust specific timelines of such contingencies as warranted.
 - iv) The DHS IRIS Waiver Manager will decide on appropriate steps which may include modifying the approved funding contingencies, and in any circumstance where warranted, shall consult with the DHS Medicaid Fraud Unit.

- 11) Process for Appealing the decision of the IRIS AA/EE review committee
 - a) AA/EE Decision Review: IRIS participants, who are dissatisfied with the AA/EE decision, may send a letter to the Bureau of Long Term Care Director or designee within 10 business days of their being informed of the initial decision. Letters of appeal should explain the reason for requesting a decision review.
 - b) The Bureau Director (or designee) may confer with the review team to reconsider the request.
 - c) The answer to the requested appeal from the Bureau Director (or designee) will be shared with the participant and also the IRIS Consultant Agency, Financial Services Agency and the IRIS Waiver Manager within 10 business days of receipt of the request.
 - d) This Bureau Director (or designee) review does not replace any Medicaid Appeal Rights available to the IRIS participant.

**Extraordinary Expense/Individual Budget Allocation Committee
Decision-making Criteria**

1. The requested good, item or service has a direct correlation to at least one of the IRIS participant's long term care related outcomes. The request includes clear documentation of the relationship between the item good or service and the long term care related outcome(s). Only goods, items or services that are intended primarily as a benefit to the status of the IRIS program participant will be considered for approval.
2. The requested good, support or service if approved, will compensate the vendor or provider within the range of rates that is typical of what others may purchase the same or a similar good, support or service.
3. The requested item or service if approved is documented as needed to either maintain or improve or to prevent the decrease in a functional skill; or
The requested item or service if not approved would result in a health and or safety risk for the participant, or
The requested item or service if not approved would likely cause a situation of non-compliance of law, rule or regulation including but not limited to situations defined as neglect and/or abuse.
4. The request for the good, support or service includes a IRIS Consultant Agency recommendation to approve, and also a detailed explanation of how the item, good, support or service helps to meet the individual's long term care/personal experience outcome(s) in the most cost effective manner possible. Efforts to attempt to create a support and service plan within the existing individual allocation have occurred and the request includes a brief description of the result of such efforts.
5. The request includes a description of the time/duration of need for the increase- eg: 3 months, long term, etc...and the description of timing is consistent with other variables that relate to the participant's plan and current budget allocation. For example, an allocation that is \$5,000 per month with a monthly budget of \$2,000 per month must first use their monthly under-spending to fund the request. The request then would be reduced by \$3,000, the amount of any actual under-spending.