Application for a Â§1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

General Changes - Updated language throughout the waiver application to reflect current policy and practice, clarify processes where necessary, improve organization, and better respond to the waiver application prompts based on CMS technical guidance.

Main Waiver - Updated Brief Waiver Description to reflect the program's self-direction definition, which incorporates CMS requirements and clarifies the legal decision maker's required role in the program, if applicable.

B.3.e - Checked “waiver capacity is managed on a statewide basis” since the waiver program is now statewide and there is no longer a waitlist.

B.5.b.iii - Checked “Medically needy income standard” rather than “AFDC standard” to align with current practice.

B.6.h - Changed dial selection to indicate that those performing re-evaluations must have the same qualifications as those performing the initial evaluations.

C-1/C-3 - Updated the service definitions for Day Habilitation (previously Day Services), Prevocational Services, Individual Supported Employment (previously Supported Employment- Individual), Small Group Employment Support (previously Supported Employment- Group), and Vocational Futures Planning and Support (previously Vocational and Futures Planning) to describe the scope and intended outcomes of the respective services more accurately.

C-1/C-3 – Merged Daily Living Skills Training and Consumer Education and Training service definitions into a combined service category renamed Life Skills Training and Education.

C-1/C-3 – Modified Respite services to align more closely with the CMS core definition, applicable federal requirements, and current practices.

C-1/C-3 – Updated Assistive Technology to include the coverage of devices for remote service delivery and qualified provider types.

C-1/C-3 – Moved Interpreter Services into the Assistive Technology service category.

C-1/C-3 - Updated Community Transportation to include Transportation Network Companies (TNCs) as allowable provider types.

C-1/C-3 - Made CIE Exploration into an independent service category. CIE Exploration was previously covered under the Individual Supported Employment service category.

C-1/C-3 - Renamed Counseling and Therapeutic Services to Counseling, Therapeutic, and Wellness Services. This category was updated to include culturally competent wellness services and qualified provider types.

C-1/C-3 - Removed Fiscal Employer Agent (FEA) service category from Appendix C and identified this as an administrative activity, as detailed in Appendix E.

C-1/C-3 - Modified Housing Counseling and Relocation- Community Transition service definitions to align more closely with CMS-proposed core definitions.

C-1/C-3 - Renamed Home Modifications to Environmental Accessibility Adaptations (Home Modifications). This category was also updated to better reflect CMS requirements and other long-term care programs.

C-1/C-3 - Removed Live-in Caregiver service category (i.e., the coverage of room and board expenses for unrelated live-in caregivers) from the waiver.

C-1/C-3 - Renamed Personal Emergency Response System (PERS) to Virtual Monitoring and Emergency Response Systems. This service was also modified to more accurately reflect allowable virtual monitoring and oversight services.

C-1/C-3 - Updated Support Broker Services to clarify the scope and intended functions of the service more accurately.

E.1.i - Updated the provision of financial management services (FMS) to an administrative activity.

G.1.b – Revised the list of incidents required to be reported to the SMA.

G.QI.a.i.c - Updated restrictive measures performance measure to reflect current policy and practice.

J.2.b - Removed outdated references to the wavier waitlist, which no longer exists.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

A. The **State** of **Wisconsin** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

IRIS (Include, Respect, I Self-Direct) Waiver

C. Type of Request: renewal

Requested Approval Period:*(For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)*

○ **3 years** ◉ **5 years**

Draft ID: **WI.004.04.00**

D. Type of Waiver *(select only one):*

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

01/01/26

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155**

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☒ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**

☐ **Waiver(s) authorized under section 1915(b) of the Act.**

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates *(check each that applies):*

☐ **section 1915(b)(1) (mandated enrollment to managed care)**

☐ **section 1915(b)(2) (central broker)**

☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**

☐ **section 1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under section 1932(a) of the Act.**

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

☐ **A program authorized under section 1915(i) of the Act.**

☒ **A program authorized under section 1915(j) of the Act.**

☐ **A program authorized under section 1115 of the Act.**
Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

☒ **This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The IRIS (Include, Respect, I Self-Direct) waiver is intended to provide persons with an ICF-IID level of care or nursing home level of care with a self-directed, fee-for-service alternative to enrolling in Family Care, which operates under an s. 1915 (b)(c) waiver and is the state's managed care long-term care program. This waiver will provide eligible participants the choice of a fully self-directed Medicaid home and community-based services (HCBS) waiver program.

The goals and objectives of this waiver include providing eligible participants with services that promote choice, independence, respect, dignity and community integration. The program is operational statewide and utilizes the self-direction service delivery model, which is a person-centered and cost-effective alternative to receiving long-term care services in institutional settings. The contracted organizations providing programmatic support to participants include the Fiscal Employer Agent (FEA) and IRIS Consultant Agency (ICA), which assist participants with financial management and self-direction.

Participants exercise decision-making authority over their waiver services and assume a direct role in managing their waiver services within a person-centered planning process. The Wisconsin Adult Long Term Care Functional Screen (LTCFS) is a functional screening tool that assesses a participant’s ability to complete activities of daily living and instrumental activities of daily living. Additionally, the LTCFS assesses the participant’s cognition, behaviors, diagnoses, medically oriented tasks and employment; as well as indicators for mental health issues, substance use issues, and other conditions that put an individual at risk of institutionalization in a nursing home or ICF-IID. The long-term care needs identified utilizing the LTCFS determine the amount of the participant’s individual budget allocation.

Based upon their identified long-term care needs and associated long-term care outcomes, participants choose which waiver services to include in their service plan. Participants hire and manage enrolled and qualified providers to provide the waiver services included in their service plan within their home or community. Because participants have increased choice about selecting their waiver services and assume a direct role in managing their service plan, they also accept the risk and increased responsibility for their spending choices. Participants are required to comply with all IRIS programmatic policies.

Participants coordinate with their designated IRIS Consultant (IC) to identify the types, quantities, and usual costs of the waiver services that are required to meet their long-term care needs and associated long-term care outcomes subject to the requirements of medical and functional necessity for home and community-based waiver services. When selecting waiver services, participants must ensure that the costs of their services do not exceed the determined amount of their participant-directed budget. Participants assume the required role of “budget authority”, which means that the participant exercises decision-making authority and assumes management responsibility for their spending choices. If a participant would like to make changes to their service plan, such as adding a new waiver service or increasing the amount of a waiver service, the changes must be based upon the participant’s identified long-term care needs and associated long-term care outcomes. To determine whether their changes are allowable, the participant must consult their IC, and the participant’s IC must ensure that the participant-requested change to their service plan is needs-based, allowable under program policies, and is effectively supporting the participant with achieving, maintaining, or obtaining their identified long-term care outcomes. Prior to initiating or receiving any changes to their waiver services, the participant is required to obtain authorization for the service and update their service plan with their IC.

Participants are the employers for the workers who provide their care. Participants must assume the required role of “employer authority”, which includes multiple responsibilities such as recruiting, hiring, training, supervising, and discharging their staff. If the participant chooses to employ Participant Hired Workers (PHWs), it is the participant’s responsibility to establish their PHWs’ work schedules to ensure that their PHWs do not work more than the participant's service plan will allow. It is the participant's responsibility to review, verify, and approve their PHWs' timesheets. To approve their PHWs’ timesheets, the participant must verify and ensure that their PHWs have accurately recorded the amount of time that they worked. To remain enrolled, the participant must fulfill the responsibilities included in the required “employer authority” role.

If the participant has a legal decision maker who has the authority to make decisions on their behalf, the legal decision maker is required to assume and fulfill the same required self-direction roles and accompanying responsibilities on behalf of the participant. The legal decision maker, on behalf of the participant, is required to comply with all IRIS programmatic policies.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver,

the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- (●) **No**
- ( ) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in section 1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make

participant-direction of services as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR § 441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR § 441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR § 441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR § 431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of section 1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight

and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

In July 2024, the SMA extended an invitation to all of its partners (contracted ICAs, FEAs, tribes, members of the long-term care community, advocates, providers, etc.) to provide any ideas they would like the SMA to consider in preparing this waiver renewal. The SMA received numerous submissions and conducted extensive review of the submissions.

Major Wisconsin newspapers contained public notices on 7/9/2025 that the draft IRIS (Include, Respect, I Self-Direct) 1915(c) waiver renewal application was available on the SMA's website for a 30-day public input period, at https://www.dhs.wisconsin.gov/iris/waiver-renewal.htm. The draft IRIS (Include, Respect, I Self-Direct) 1915(c) waiver renewal application was posted for a 30-day public input period. The public input period ended August 8, 2025. As described in the newspaper publications, members of the public could request paper copies of the waiver renewal application by calling (855) 885-0287. Comments on the waiver renewal could be submitted by mail or email:

Email: DHSDMSIRISRenewal@dhs.wisconsin.gov

Mail:
Wisconsin Department of Health Services
Division of Medicaid Services
Bureau of Programs and Policy
Attn: IRIS 1915(c) Waiver Renewal
PO Box 309
Madison, WI 53701-0309.

Wisconsin tribes received written notice that the draft IRIS (Include, Respect, I Self-Direct) waiver renewal application was available on the SMA's website for a 30-day tribal input period on 7/9/2025. The SMA also provided tribal consultation on 7/9/2025 at the Tribal Health Directors Meeting. The written notice, agendas, and meeting notes are included with this waiver renewal submission.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the state of the state's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name: Chartier

First Name: Amy

Title:

Section Manager, IRIS Policy Section

Agency: Department of Health Services/Division of Medicaid Services/Bureau of Programs and Policy

Address: One West Wilson Street, Room 518

Address 2: P.O. Box 309

City: Madison

State: **Wisconsin**

Zip: 53707-7851

Phone: (608) 267-7205 **Ext:** ☐ **TTY**

Fax: (608) 266-5629

E-mail: Amy.Chartier@dhs.wisconsin.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wisconsin**

Zip:

Phone: **Ext:** ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wisconsin**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- ☐ **Replacing an approved waiver with this waiver.**
- ☐ **Combining waivers.**
- ☐ **Splitting one waiver into two waivers.**
- ☒ **Eliminating a service.**
- ☐ **Adding or decreasing an individual cost limit pertaining to eligibility.**
- ☐ **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- ☐ **Reducing the unduplicated count of participants (Factor C).**
- ☐ **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- ☐ **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- ☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

This application serves as a renewal of the existing waiver, which incorporates the changes in the "Major Changes" section.

Several services have been modified to align with CMS technical instructions and address updates to the program, including:
• Fiscal Employer Agent (FEA) Services have been removed as a service category in Appendix C-1/C-3. FEA services were moved to an administrative function in this waiver renewal. FEA services will continue to be offered to participants and will remain otherwise unchanged, as contracted with the SMA and detailed in Appendix E.

• Interpreter Services have been removed as a service category and these services were merged into the Assistive Technology service category for more accurate service provision. This service will continue to be available to participants who demonstrate the service need.

• Live-in Caregiver services have been removed as a service category. The SMA determined that this service should be removed with the consideration that it has not been utilized by IRIS participants in recent years, and the service need is sufficiently met through other service categories, such as Supportive Home Care services.

• The service categories of Daily Living Skills Training and Consumer Education and Training have been combined into a single service category titled “Life Skills Training and Education.” The service scope remains unchanged, with the same coverage of individual services, providers, and existing limitations. This service will continue to be available to participants who demonstrate the service need.

These changes do not eliminate or limit coverage of existing services or supports within the program that are commonly utilized. Therefore, the SMA does not anticipate that these changes will result in any loss or reduction of services provided to participants. Participants will be notified of these changes during public comment, public forums/meetings, and/or their next required meeting with their IRIS Consultant Agency. These changes are effective with the new waiver start date of January 1, 2026.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

◉ **The waiver is operated by the state Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program *(select one)*:

◉ **The Medical Assistance Unit.**

Specify the unit name:

Division of Medicaid Services

(Do not complete item A-2)

○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Aging and Disability Resource Centers (ADRCs) (independent public entities):
1) Provide information and assistance;
2) Provide pre-admission pre-enrollment options counseling;
3) Conduct level of care evaluation activities using the SMA's automated Wisconsin Adult Long Term Care Functional Screen (LTCFS);
4) Coordinate other program eligibility activities on behalf of the SMA; and
5) Carry out prevention and community outreach activities (optional).

Tribal Aging and Disability Resource Specialist (TADRS):
1) Provide information and assistance;
2) Provide pre-admission pre-enrollment options counseling (optional);
3) Conduct level of care evaluation activities using the SMA's automated Wisconsin Adult Long Term Care Functional Screen (optional);
4) Make referral to other program eligibility activities on behalf of the SMA (optional); and
5) Carry out prevention and community outreach activities (optional).

Tribes may elect to do pre-admission and pre-enrollment activities, through the TADRS. If a tribe elects to perform these activities the completion of the LTCFS to determine eligibility is required. If a tribe does not elect to perform these activities, the ADRC where the tribal member is located performs the pre-admission and pre-enrollment options counseling instead.

External Quality Review Organization (EQRO):
1) Monitor, mediate, and evaluate participant appeals and grievances;
2) Conduct SMA appeal and grievance review process;
3) Staff, train, and provide a direct hotline for participant complaints;
4) Provide data, metrics, and reports to the SMA;
5) Collect, monitor, and file SMA responses to all Fair Hearing requests;
6) Complete, document, and deliver all record reviews and any accompanying adverse findings;
7) Validate, document, and communicate all remediation of individual negative findings;
8) Communicate all system level negative findings to SMA;
9) Review and validate performance measures to ensure waiver requirements are met; and
10) Assist the SMA in conducting training and technical assistance concerning waiver requirements.

IRIS Consultant Agency (ICA) waiver administrative and operational functions are governed by a provider agreement with the SMA and includes the following functions:
1) Assist participants to articulate goals, needs, and preferences, and identifying available supports;
2) Conduct in-home visits with assigned participants to collaboratively develop a comprehensive self-directed service plan and assess ongoing needs;
3) Perform prior authorization of waiver services per SMA guidelines;
4) Conduct periodic and annual level of care re-evaluation where the ICAs load the data into a state created, approved and monitored system, which makes the final eligibility determination. The State, through an ongoing process as described in performance measure #5 of this Appendix, monitors the accuracy of the data that is loaded by the ICAs as an administrative oversight activity;
5) Identify and respond to participant health and safety concerns through administrative monitoring; and
6) Conduct participant risk assessment and support mitigation planning.

Fiscal Employer Agents (FEA) waiver administrative and operational functions are governed by a contract with the SMA and includes the following functions:
1) Process worker enrollment, verify qualifications, and manage payroll, taxes, and insurance;
2) Collect and process timesheets, disburse funds, and track budget and expenditures;
3) Provide reports to participants and the SMA on financial activity;
4) Ensure compliance with federal wage, tax, and CMS fiscal standards; and
5) Support evolving financial management needs consistent with CMS guidance.

Gainwell Technologies Call Center:
1) Facilitate participant inquiries, including providing referrals to the appropriate contractors (i.e. ICAs, FEA, ADRCs, Ombudsman, etc.);

2) Maintain comprehensive contact management tracking system used to manage calls and other inquiries;
3) When necessary, communicate with ICAs and the FEA to address participant concerns; and
4) Document the contact with the participant in the SMA enterprise case management system.

Board on Aging and Long-Term Care Ombudsman services for participants 60 years old and above:
1) Provides information and education on participants' rights;
2) Investigates participants' complaints;
3) Attempts resolution to resolve participants' complaints through informal strategies (negotiation, and mediation, support of consumer self-advocacy, and work with internal advocates);
4) Assists participants' in filing grievances, complaints and appeals, and administrative hearing requests;
5) Assists participants' in filings related to administrative hearings; and
6) Provides individual case advocacy to participants in the grievance, appeal, and administrative hearing processes.

Disability Rights Wisconsin (DRW) Ombudsman Services for participants under 60 years old:
1) Provides information and education on participants' rights;
2) Investigates participants' complaints;
3) Attempts resolution to resolve participants' complaints through informal strategies (negotiation, and mediation, support of consumer self-advocacy, and work with internal advocates);
4) Assists participants' in filing grievances, complaints and appeals, and administrative hearing requests;
5) Assists participants' in filings related to administrative hearings; and
6) Provides individual case advocacy to participants in the grievance, appeal, and administrative hearing processes.

○ **No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

◉ **Not applicable**

○ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

☐ **Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Wisconsin Department of Health Services, Division of Medicaid Services (DMS)

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The State Medicaid Agency (SMA) ensures contracted entities adhere to policies and procedures through multiple oversight methods. Accordingly, the methods used to assess performance vary by agency type:

1) Complaints and grievance hotline – The SMA oversees the complaints/grievance system of the IRIS program, through a contract with an external quality review organization (EQRO). The EQRO facilitates a complaint and grievance hotline through which participants can report concerns, and if necessary, request SMA review.

2) Office of Inspector General (OIG) – The SMA's OIG responds and investigates fraud, waste, and abuse in public assistance programs administered by the SMA. This includes monitoring and auditing Medicaid providers. At the same time, OIG's internal audits protect the accountability of the SMA's programs and operations.

3) Wisconsin Aging and Disability Resource Centers (ADRC) and Tribal Aging and Disability Resource Specialists (Tribal ADRS) – ADRCs and Tribal ADRSs are the contracted local/regional non-state entities that perform waiver operational and administrative functions. ADRCs and Tribal ADRSs disseminate information regarding the waiver to potential participants using SMA provided materials, assist individuals in waiver enrollment, monitor enrollment processes on an ongoing basis, review ADRC-related grievances and appeals, and conduct level of care evaluation activities.
a) The SMA provides ADRCs and Tribal ADRSs with unbiased, person-centered enrollment counseling materials that meet CMS requirements for readability and are available in prevalent languages. The SMA reviews the provided materials annually.
b) The SMA provides technical assistance and oversight for ADRCs and Tribal ADRSs. Oversight mechanisms include: SMA Regional Quality Specialists centrally located to ADRCs and Tribes; monitoring quality of eligibility determinations (both functional and financial) and enrollment services; and ensuring ongoing training opportunities for ADRC staff and Tribal ADRSs. SMA oversight for Tribal ADRSs also includes desk reviews to ensure consistency and accuracy; ongoing technical assistance regarding the Tribal ADRS scope of work, including functional screen; and specialized training opportunities for Tribal ADRSs.
c) ADRC governing boards review complaints, grievances, and appeals received from individuals regarding the ADRCs. The SMA has instituted a statewide complaints, grievance, and appeals policy that is used to resolve complaints and to inform individuals of their grievance and appeal rights. Additionally, the SMA accesses ADRC and Tribal ADRSs client tracking databases for quality assurance reviews and independent investigations of complaints and grievances.
d) On an ongoing basis, the SMA conducts quality reviews of level of care evaluations using the automated Wisconsin Adult Long Term Care Functional Screen and provides feedback and remediation for the ADRCs and Tribal ADRSs. The SMA provides a variety of training and continuing knowledge activities for certified screeners. The SMA also conducts quarterly screen liaison calls and provides screen reviews upon request.
e) ADRCs operate under a contract with the SMA. They submit periodic reports to the SMA regarding information and assistance functions and monthly expenditures. ADRCs also submit annual reports to the SMA. On-site reviews are conducted annually by the SMA. ADRC customers are surveyed via a neutral third-party evaluator to evaluate their options and enrollment counseling experience.

4) Ombudsman – The SMA-Ombudsman contract has the following Ombudsman performance expectations:
a) Respond timely to participants' calls: 100% of all initial contacts must receive an attempted follow up call within two business days;
b) Provide informative written communication to members: 95% of brief cases and 100% of full cases must receive an opening and closing letter;
c) Be knowledgeable and professional: 100% of ombudsman must meet the ombudsman entity's core competency expectations as measured in annual performance reviews;
d) Maintain an effective relationship with the entity that provides ombudsman services to individuals aged 60 and older to identify issues and coordinate improvement efforts;
e) Maintain a collaborative relationship with the SMA: Ombudsman must meet at least annually with the SMA to discuss advocacy issues and promote collaboration on patterns of issues; and
f) Use informal means for case resolution when possible: Ombudsman must resolve at least 75% of cases informally.

Additionally, the SMA-Ombudsman contract requires a quarterly report to the SMA on the performance expectations and requires the Ombudsman to perform the following quality assurance activities:
a) Participate in and present data at meetings upon SMA request; and
b) Conduct ongoing internal quality assurance activities, including:
   i. Regular supervisory case progress reviews;

ii. Monthly team case rounds;
iii. Annual supervisory file reviews;
iv. Annual performance reviews of all staff.

The Ombudsman provides monthly, quarterly, and annual reports to the SMA.

5) Other performance issues may be reported by partners, advocates, and agencies that provide advocacy services.

6) IRIS Consultant Agency (ICAs) – The SMA assesses performance of waiver operational and administrative functions of ICAs through a certification and contract process. ICAs must demonstrate they meet certain requirements through the certification process. Once certified, they enter into a contract with the SMA. The contract details contractor responsibilities including, providing information and assistance to participants, enrollment and orientation of participants and care planning responsibilities, such as assessment, development and maintenance of the participant's service plan, creation of service authorizations, availability and applicability of waiver services, level of care re-evaluations, and assurance of participant rights. Participant health and welfare are also monitored by the SMA through ICA reporting and investigations of participant incidents and restrictive measure policies. The SMA contract is reviewed and renewed every two years.

For level of care re-evaluation where the ICAs load the data into a state created, approved and monitored system, which makes the final eligibility determination. The State, through an ongoing process as described in Appendix A performance measure #5, monitors the accuracy of the data that is loaded by the ICAs as an administrative oversight activity.

Additionally, the SMA assigns oversight team members to each ICA. These team members effectively monitor compliance with the contract through review of policies and procedures, monthly meetings, and complaint investigations. Quarterly, the SMA meets with each contractor to review the following, i) remediation activities for record review performance indicators below CMS required thresholds; ii) participant satisfaction survey results; iii) review of all substantiated cases of abuse, neglect, misappropriation and exploitation; and iv) review, if necessary, of any active contractor performance improvement plans (PIPS).

Annually, the SMA conducts recertification with each contractor. The recertification allows the SMA to confirm remediation of prior discovered problems and to identify potential areas of concern. The recertification also seeks to identify any potential areas of concern related to systemic problems or issues within the ICA or the overall program. The SMA and ICA remediate these issues accordingly. All activities related to contractor performance are documented and maintained within the SMA's Quality Management Plan document for each contractor.

Additionally, on a quarterly basis, the SMA's contracted EQRO conducts the record reviews which includes determinations of compliance and performance of all contracted entities, including each individual ICA. This record review encompasses performance measures included in this waiver in addition to other SMA-identified measures/reviews. The EQRO reports all concerns identified during the course of the record reviews to the SMA where they are addressed accordingly. The EQRO is responsible for completing, documenting, and reporting all resulting remediation activities for individual negative findings and reporting all system level negative findings to the SMA.

7) Fiscal Employer Agents (FEA) – The SMA assesses performance of waiver operational and administrative functions of the FEA through a contract process. The FEA contract details contractor responsibilities including, payroll processing and disbursement, tax reporting and withholdings, compliance and regulatory oversight, recordkeeping and documentation, and other financial management services. The SMA contract is reviewed annually.

Additionally, on a quarterly basis, the SMA's contracted EQRO conducts record reviews which includes determinations of compliance and performance of all contracted entities, including the FEA. This record review encompasses performance measures included in this waiver in addition to other SMA-identified measures/reviews. The EQRO reports all concerns identified during the record reviews to the SMA where they are addressed accordingly. The EQRO is responsible for completing, documenting, and reporting all resulting remediation activities for individual negative findings and reporting all system level negative findings to the SMA.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities

that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☒	☒
Waiver enrollment managed against approved limits	☒	☐
Waiver expenditures managed against approved levels	☒	☐
Level of care waiver eligibility evaluation	☒	☒
Review of Participant service plans	☒	☒
Prior authorization of waiver services	☒	☒
Utilization management	☒	☒
Qualified provider enrollment	☒	☒
Execution of Medicaid provider agreements	☒	☒
Establishment of a statewide rate methodology	☒	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐
Quality assurance and quality improvement activities	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver

- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of calendar quarters that indicate a statistically significant random sample (95%+/-) was pulled for each contractor based on participant enrollment. N/D: The number of calendar quarters that indicated the EQRO's sample was statistically significant based on the contractors enrollment over The total number of calendar quarters reviewed for each contractor.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: MetaStar	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SMA monitors level of care re-evaluations for efficacy to identify significant differences from initial evaluation. Numerator/Denominator: Total number of Long-term Care Functional Screens that did not have a change in the level of care from the original assessment of new enrollees over Total number of new enrollees who have been in the program greater than 365 days identified by SMA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Data Warehouse

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence

		Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The FEA must complete all Record Review remediation timely. Numerator/Denominator: Number of participant records that were remediated timely over Number of participant

records reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: MetaStar	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other**	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify:	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
IRIS Consultant Agencies (ICAs) remediate level of care evaluation errors within 90 days of notification of error by the SMA. Numerator/Denominator: Number of level of care evaluation errors remediated by ICA within 90 days of notification by SMA over Total number of level of care evaluation errors identified by SMA.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Data Warehouse

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: MetaStar	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
ICAs must complete all Record Review remediation timely. Numerator/Denominator: Number of participant records that were remediated timely over Number of participant records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: MetaStar	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of records reviewed by the EQRO within 90 days.
Numerator/Denominator: The number of records that the EQRO reviewed within 90 days over The total number of records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: MetaStar	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The SMA's online functional screen information access system (FSIA) determines the level of care (LOC). The FSIA calculates 8 distinct levels of care: intermediate care facility, level 2; intermediate care facility, level 1; skilled nursing facility; intensive skilled nursing services and developmental disability, levels 1A, 1B, 2 and 3. As an administrative oversight activity, the SMA monitors LOC re-evaluations for efficacy, by comparing LOC results of the individual's initial evaluation with the results of first LOC re-evaluation for new enrollees.

The SMA employs the following strategies to identify problems with LOC determinations that happen at the individual level. These include: (1) the ICA screener contacts the SMA about unexpected results of the functional screen; (2) the SMA discovers errors when reviewing screens with results that are under appeal; or (3) the SMA discovers errors during regular sampling of past screens. If errors are discovered, the SMA conducts desk reviews consisting of reviews of the affected screens as well as historical screens to look for consistency in screen selections as well as reasonableness of selections based on the whole person as depicted in the screen.

Some additional information is also obtained during the course of the contract administration of the external quality review organization (EQRO) and the record review process conducted by the EQRO.

On a continuous and ongoing basis information is obtained during the contract administration of the EQRO. For example, varied information is obtain during operational oversight activities and processes, including:

- operational meetings including meetings related to staffing proficiencies related to review activities,
- ad hoc communications to ensure potential issues are identified and remediated timely,
- when budgets are set for the FY as are work schedules and volumes,
- during SMA review and validation of invoices for line items before payment approval (including record reviews),
- during additional fiscal oversight where invoices are further validated by SMA financial oversight analysts before payment is issued,
- during review and validation of EQRO provided data and reports, and
- during the monitoring of the appropriate Code of Federal Regulations for statutory EQRO requirements updates and resulting contract compliance updates.

Quarterly, the EQRO conducts the record reviews which includes determinations of compliance for each contracted entity. The EQRO reports all concerns identified during the course of the record reviews to the SMA where they are addressed accordingly. The EQRO is responsible for completing, documenting, and reporting all resulting remediation activities for individual negative findings and reporting all system level negative findings to the SMA. Annually, as needed, the EQRO provides input relative to the annual revision of record review tools and instruction guides in order to align with changes in State statutory and administrative requirements.

Additionally, discovery information is obtained when the EQRO is validating reported performance measures required by the SMA and CMS. Information is also obtained when the EQRO is assessing the quality of services and support coordination functions, assessing compliance with quality standards, and other activities, such as administration or validation of consumer surveys of quality of care.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Some movement among the different levels of care is to be expected, but some moves between these levels of care may be an indicator of individual problems. If unexpected trends or patterns of change in the LOC are identified, the SMA's screen team will analyze the trends to determine appropriate next steps which may include a review of screens. The SMA maintains a record of individual level of care remediation activities.

Monthly, the SMA has meetings with individual contractors to discuss any performance and/or quality management concerns. The SMA remediates those concerns accordingly.

Quarterly, the SMA meets with each contractor to review the following:
• Remediation activities for Record Review performance indicators below the CMS required threshold;
• Review of all substantiated cases of abuse, neglect, misappropriation and exploitation cases; and
• Review of the contractor Performance Improvement Plans (PIPS) promulgated by the contractor to increase performance and address areas for improvement.

Annually, for each contractor, the SMA conducts a "Contractor Recertification Meeting" and also reviews their Participant Satisfaction Survey results with them. Following the meeting, the SMA provides the contractor with the outcome of the Annual Recertification and if necessary, determines next steps.

These processes allow the SMA to confirm remediation of discovered problems and to identify potential areas of concern. The recertification meetings and satisfaction survey results also seek to identify if discovered and potential areas of concern relate to systemic problems, issues within the contracted agency, or the overall program. The SMA remediates these issues accordingly. All activities related to contractor performance will be documented and maintained within the SMA's Quality Management Plan document for each contractor.

Also, a provider participating in the IRIS program is subject to sanctions that may be imposed by the SMA under Wis. Stat. § 49.45(2)(a)(13) and Wis. Admin. Code § DHS 106.08.

Remediation operations are continuously improved and updated so as to gain overall efficiencies within the program. Moreover, waiver amendments exist if systemic problems drastically hinder program operations.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: ICAs and FEA	☒ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☒ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☒	**Developmental Disability**	18		☒
	☒	**Intellectual Disability**	18		☒
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Participants in the “Disabled (Physical)” target subgroup who reach the age of 65 while participating in this waiver are considered to be part of the “Aged” target group. No other change occurs for the participant.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

  The limit specified by the state is *(select one)*

  - ○ **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ○ **Other**

    Specify:

- ○ **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver

participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

- ○ **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - ○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - ○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

- ○ **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- ○ **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	34593
Year 2	36703
Year 3	38815
Year 4	40925
Year 5	43037

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state *(select one)*:

- ◉ **Not applicable. The state does not reserve capacity.**
- ○ **The state reserves capacity for the following purpose(s).**

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

- ◉ **Waiver capacity is allocated/managed on a statewide basis.**
- ○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

All state defined regions will reach entitlement by July 1, 2021 for all eligible individuals.

Until July 1, 2021, the Aging and Disability Resource Centers (ADRCs) are responsible for managing waiver capacity by managing the wait list for enrollment during the transition period. One thirty-sixth of the number of people waiting for long-term care at the time IRIS starts in a state defined region are allowed to enroll in each of the first 36 months. After 36 months, all eligible individuals must be enrolled and there will no longer be a wait list. After July 1, 2021, there is no longer a role for ADRCs in managing waiver capacity.

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

All persons who have at least a nursing home or IDD level of care, as determined by the SMA's Adult Long Term Care Functional Screen (LTCFS) and are found to be financially eligible for Medicaid are entitled to entrance into this §1915(c) waiver.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (●) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.

Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR § 435.217)

- [x] **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- [x] **Pregnant Women (42 CFR § 435.116)**
- [x] **Infants and Children under Age 19 (42 CFR § 435.118)**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- [x] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in section 1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in section 1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in section 1902(a)(10)(A)(ii)(XVI) of the Act)**
- [x] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in section 1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR § 435.330)**
- [x] **Medically needy in 1634 States and SSI Criteria States (42 CFR § 435.320, § 435.322 and § 435.324)**
- [x] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

• Former Foster Care Youth (up to age 26) specified in 42 CFR § 435.150
• Transitional Medical Assistance specified in § 1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA
• Extended Medicaid Due to Spousal Support Collections specified in 42 CFR § 435.115
• Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increase since April, 1977 specified in 42 CFR § 435.135
• Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI specified in 42 CFR § 435.137
• Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security specified in 42 CFR § 435.138
• Disabled Adult Children specified in 1634(c) of SSA
• Targeted Low-Income Children specified in 42 CFR § 435.229
• Independent Foster Care Adolescents Under Age 21 specified in § 435.222
• Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash specified in 42 CFR § 435.210 and § 435.230
• Individuals eligible for Cash except for Institutionalized Status specified in 42 CFR § 435.211
• Institutionalized Individuals Eligible under a Special Income Level specified in 42 CFR § 435.236
• Individuals Receiving Hospice Care specified in 1902(a)(10(A)(ii)(VII) and 1905(o) of SSA
• Medically Needy Pregnant Women specified in 42 CFR § 435.301(b)(1)(i) and (iv)
• Medically Needy Children Age 18 through 20 specified in 42 CFR § 435.308
• Individuals Needing Treatment for Breast or Cervical Cancer (under age 65) specified in 42 CFR § 435.213
• Protected Medically Needy Individuals Who Were Eligible in 1973 specified in 42 CFR specified in 42 CFR § 435.133
• Institutionalized Individuals Continuously Eligible Since 1973 specified in 42 CFR § 435.132
• Individuals Who Lost Eligibility for SSI/SSP Due to an increase in OASDI Benefits in 1972 specified in 42 CFR § 435.134
• Individuals Who are Essential Spouses specified in 42 CFR § 435.131

Special home and community-based waiver group under 42 CFR § 435.217) *Note: When the special home and community-based waiver group under 42 CFR § 435.217 is included, Appendix B-5 must be completed*

○ **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.** *Appendix B-5 is not submitted.*

◉ **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217.**

Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR § 435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR § 435.236)**

Specify percentage: [ ]

○ **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42**

CFR § 435.320, § 435.322 and § 435.324)

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Medically needy (Group B Plus): For individuals who are aged or have a physical disability, the SMA will use the average monthly cost for private patients in nursing facilities as used for assessing a transfer of assets penalty to reduce an individual's income to an amount at or below the medically needy income limit. For individuals with an intellectual disability, the SMA will use the average of the monthly rates charged for inpatient care in a State Center for the Developmentally Disabled to reduce an individual's income to an amount at or below the medically needy income limit.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR § 435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR § 435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under section 1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or section 1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time period after September 30, 2027 (or other date as required by law).

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under section 1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under section 1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR § 435.726 (Section 1634 State/SSI Criteria State) or under § 435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under section 1924 of the Act are not used to determine eligibility of individuals**

with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules at 42 CFR § 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in ?1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage:

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

◉ **The following formula is used to determine the needs allowance:**

Specify:

A personal maintenance allowance equal to the sum of the following, but not to exceed 300% of the SSI federal benefit rate:
1. A basic needs allowance equal to 100% of the SSI federal benefit rate, plus the state supplement payment (SSP), plus the state SSI-E payment rate, rounded to the nearest whole dollar.
2. For employed members, an allowance equal to the first $65 of earned income and one-half of remaining earned income.
3. A special housing amount that includes housing costs over $350 per month.

Additional income deductions may include:
Special exempt income, which includes court-ordered support payments, expenses associated with a guardianship or an SSA-approved PASS plan, impairment related work expenses, and some costs associated with real property listed for sale.

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in section 1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**

◉ **AFDC need standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a

family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR § 435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*

◉ **The state does not establish reasonable limits.**

○ **The state establishes the following reasonable limits**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under section 1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

  The basic needs allowance is the state's SSI-E payment; plus an allowance for employed members equal to the first $65 of earned income and one-half of remaining earned income; plus special exempt income, including court ordered support amounts (child or spousal support) and court ordered attorney and/or guardian fees; plus a special housing amount that includes housing costs over $350 per month. The total of these four allowances cannot exceed 300% of the SSI federal benefit. The basic needs allowance is published in the Wisconsin Medicaid Eligibility Handbook.
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR § 435.726 or 42 CFR § 435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- ◉ **Allowance is the same**
- ○ **Allowance is different.**

  Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR § 435.726 or 42 CFR § 435.735:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ○ **Not Applicable (see instructions)** *Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ◉ **The state does not establish reasonable limits.**
- ○ **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State – January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State ? January 1, 2014 through September 30, 2027 (or other date as required by law).

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules – January 1, 2014 through September 30, 2027 (or other date as required by law).

The state uses the post-eligibility rules of section 1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

Level of care determinations for new applicants are made by the SMA screening tool, the Adult Long Term Care Functional Screen (LTCFS), which are determined through information input and assessment performed by Aging and Disability Resource Centers (ADRC) or Tribal Aging and Disability Resource Specialists (ADRS). The ICAs are responsible for performing reevaluations.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Evaluation of level of care is performed by individuals who have a license to practice as a registered nurse in Wisconsin, pursuant to Wis. Stat. § 441.06, or a Bachelor of Arts or Science degree in a health or human services related field (e.g. social work, rehabilitation, psychology), and a minimum of one year experience working with at least one of the target populations. Individuals permitted to perform level of care evaluations are certified as screeners after confirming that they have the required education/experience and passing an online course, which includes tests of their knowledge of instructions and criteria for level of care determination. To maintain their certification, the SMA requires each screener to undergo a review to evaluate knowledge and skills at least once every two years. The SMA maintains electronic records of these test results.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and

the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care criteria for Nursing Home level of care are the same as the criteria for Medicaid reimbursement of nursing facility care in Wisconsin. The specific nursing home levels of care are intensive skilled nursing, skilled nursing facility, and intermediate care facility 1 and 2. The level of care criteria for the ICF/IID level of care are the same as the criteria for Medicaid reimbursement for ICF/IID facility care in Wisconsin. The level of care tool used is the LTCFS.

e. Level of Care Instrument(s). Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

The LTCFS is an automated tool developed by the SMA to determine the appropriate nursing home or ICF/IID level of care for waiver applicants. The LTCFS was developed with SMA registered nurses who evaluated Physician Plans of Care to determine Medicaid eligibility for nursing home residents. It has been evaluated by the SMA and determined to be valid, reliable, and to result in a comparable level of care.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Information used in level of care assessments for new applicants is gathered by certified screeners at the ADRC or Tribal ADRS. The screener gathers information during an in-person meeting with the applicant using the SMA's automated LTCFS, which returns a level of care for the prospective participant. Information for annual re-evaluations of level of care is gathered by the ICA through the same process. The State, through an ongoing process as described in Appendix A, monitors the accuracy of the information provided by the ICA.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

Within 365 days

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

Annual reevaluation of level of care is an ICA responsibility. Each ICA uses an internal tracking system to ensure that a participant's level of care is reevaluated at least every 365 days.

LTCFS results are sent from the functional screen electronic system to the Medicaid Management Information System (MMIS) and the Medicaid eligibility system. MMIS also verifies both Medicaid and functional eligibility for all participants on a monthly basis and disenrolls participants who do not meet eligibility requirements.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

All functional screens are maintained electronically by the SMA in its automated long-term care functional screen computer system.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
All applicants enrolled in IRIS must have a valid IRIS level of care based on an evaluation using the SMA's Long-Term Care Functional Screen.
Numerator/Denominator: Number of applicants newly enrolled in the IRIS program who have an eligible level of care during the waiver year over All the new applicants enrolled during the waiver year

Data Source (Select one):
Other
If 'Other' is selected, specify:
Functional Screen Information Access System (FSIA), SMA Enterprise Care Management System, and Medicaid Management Information System (MMIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Waiver participants must receive an annual Long-Term Care Functional Screen within 365 days of their last Long-Term Care Functional Screen.
Numerator/Denominator: Number of participants with their most recent Long-Term Care Functional Screen within 365 days of the previous Long-Term Care Functional Screen over Number of Long-Term Care Functional Screens reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System, Functional Screen Information Access System (FSIA), and Medicaid Management Information System (MMIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Typical reasons for errors in level of care (LOC) evaluation include misinterpretation of the written level of care instructions that are provided by the SMA to the evaluator and human error in keying selections in the SMA's online level of care Functional Screen Information Access System (FSIA) application. The SMA uses a combination of LOC data generated by the online LOC FSIA application and evidence gathered during direct audit of the evaluator's LOC records to identify errors. Under contracts between the SMA and LOC evaluators, evaluators are required to remediate all errors identified by the SMA during quality assurance audits. The SMA verifies that all remediation has occurred prior to providing the reviewer with written approval of remediation.

Additionally, the SMA Enterprise Care Management System and Medicaid Management Information System (MMIS) editing and disenrollment processing was implemented in August 2024 to prevent IRIS applicants from being enrolled without a valid level of care and to automatically disenroll participants that have not completed an annual Long-Term Care Functional Screen. If SMA contracted entities cannot enroll new applicants or have a participant disenrolled for level of care reasons, they must contact the SMA to remediate any related level of care issues.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Individual problems with level of care determinations are typically discovered by the SMA in one of three ways:
(1) the screener contacts the SMA about unexpected results of the functional screen;
(2) the SMA discovers errors when reviewing screens with results that are under appeal;
or (3) the SMA quality reviewers discover errors during regular sampling of past screens.

In all cases, the SMA contacts the Aging and Disability Resource Center, Tribal Aging and Disability Resource Specialist, or ICA to ascertain the correct facts and to direct correction of the screen. Correction is verified via observation of the corrected screen in the functional screen information access system. The SMA maintains a record of individual level of care remediation.

If SMA contracted entities cannot enroll new applicants or have a participant disenrolled for level of care reasons, they must contact the SMA to remediate any related level of care issues.

Remediation operations are continuously improved and updated to gain overall efficiencies within the program. Moreover, waiver amendments exist if systemic problems drastically hinder program operations.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The ADRC or Tribal ADRS must inform the potential enrollee about the available services and enrollment options, specific to institutional service options and home and community-based services offered through the waiver. A potential participant will document their choice by signing an enrollment form, which is maintained by the ADRC or Tribal ADRS.

Once a participant enrolls, the ICA informs the participant a second time about: 1) the choice between institutional care and home and community-based services, 2) the choice of waiver services, including various community and residential care settings, and 3) the choice of qualified providers during the initial plan development process.

These discussions are documented on the service plan and verified by the participant. The participant verifies this by signing the document which will be maintained in the participant's record and will be verified during the SMA's Record Review.

b. Maintenance of Forms. Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Participant choices are documented in the ADRC tracking system. The ADRC specialist or Tribal ADRS indicates what options the participant was given, what the participant chose, and details regarding reasons for the option that was chosen, if provided. Participant choices are also stored in the participant's record which is accessible to the SMA.

Copies of SMA enrollment forms are maintained by the ADRC or Tribal ADRS. Copies of service plans and related participant records are maintained by the SMA.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

ADRCs and Tribal ADRSs are required to have SMA-developed forms and other materials related to long-term care services available in the prevalent non-English languages spoken in Wisconsin. ADRCs are also required to obtain interpreters or telephonic interpretation services when needed by an applicant or participant.

The SMA requires that the materials provided to the participant by the ICA and Fiscal Employer Agent (FEA) be available in paper form, unless the participant prefers electronic materials, when electronic materials are both available and meet the requirements for electronic media detailed by the SMA in the provider agreement.

All materials produced and/or used by the ICA and FEA must:
• Use easily understood language and format;
• Use a font size no smaller than 12-point; and
• Be available in alternate formats and through the provision of auxiliary aids and services upon request and at no cost.

During hours of operation, the ICA and FEA must have staff and/or subcontractor(s) available for language translation, transliteration, and interpreter services in person, by phone, and/or virtually. The ICAs and FEA must offer an interpreter, such as a primary non-English language or a sign language interpreter or a translator, in all crucial situations requiring language assistance as soon as it is determined that the participant is of limited English proficiency or needs other interpreter services. Provision of interpreter services must be in compliance with Title VI of the Civil Rights Act of 1964.

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service
Statutory Service	Adult Day Care
Statutory Service	Day Habilitation
Statutory Service	Individual Supported Employment
Statutory Service	Life Skills Training and Education
Statutory Service	Prevocational Services
Statutory Service	Respite
Extended State Plan Service	Nursing Services
Supports for Participant Direction	IRIS Consultant Agency (ICA) Services
Other Service	Assistive Technology
Other Service	Community Transportation
Other Service	Competitive Integrated Employment (CIE) Exploration
Other Service	Consultative Clinical and Therapeutic Services for Caregivers
Other Service	Counseling, Therapeutic, and Wellness Services
Other Service	Environmental Accessibility Adaptations (Home Modifications)
Other Service	Home Delivered Meals
Other Service	Housing Counseling
Other Service	Individual Directed Goods and Services
Other Service	Relocation - Community Transition Services
Other Service	Residential Services (1-2 Bed AFH)
Other Service	Residential Services (Other)
Other Service	Small Group Supported Employment
Other Service	Specialized Medical Equipment and Supplies
Other Service	Support Broker Services
Other Service	Supportive Home Care
Other Service	Training Services for Unpaid Caregivers
Other Service	Vehicle Modifications
Other Service	Virtual Monitoring and Emergency Response Systems
Other Service	Vocational Futures Planning and Support

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult Day Care services are the provision of services for part of a day in a non-residential group setting to participants who need an enriched social or health-supportive experience or need assistance with activities of daily living, supervision, and/or protection. The number of hours being utilized must be specified in the participant's service plan.

Adult day care services may include personal care, supervision, light meals, and medical care. Meals provided as part of adult day care may not constitute a full nutritional regimen (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).

Personal care services and transportation between the participant's place of residence and the adult day care setting may be provided as a component of this service (transportation between the service setting and any community site is always included in this service and provider's rate). The cost of these services is included in the rate paid to providers of these services.

Adult day care services must be provided in a non-institutional, community-based setting.

Adult day care services may only be funded through the waiver when otherwise not available through the State Plan, Medicare or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult day care is limited to a maximum of 8 hours per day.

Service Delivery Method *(check each that applies)*:

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**
- [ ] **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Adult Day Care Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 105.14

Other Standard *(specify):*

HCBS Compliant per 42 CFR § 441.301(c)(4)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04020 day habilitation

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Day habilitation provides activities and supports to foster the acquisition of generalized skills and opportunities for the participant to actively participate in integrated community-based activities that build on the participant's interests, preferences, gifts, and strengths. Day habilitation reflects the participant's person-centered goals regarding community connections and involvement. This service promotes maximum participation in integrated community life while facilitating meaningful relationships, friendships, and social networks with participants of the broader community who share similar interests and goals for community participation. Services are aimed at supporting participants to reach the highest level of independence and, where possible, reducing or eliminating the need for paid supports to engage in personally meaningful community activities. Services provided must be consistent with the participant's service plan.

Day Habilitation includes:
• Development of an inventory to establish baseline levels of skills and independence;
• Activities focused on the development, retention, and improvement of self-help, socialization, and adaptive skills;
• Daily opportunities to engage in community life and interact with participants of the broader community who do not receive waiver services;
• Community mapping;
• Supports and opportunities designed to foster, through experiential and adult learning, the acquisition of positive social skills, interpersonal competence, greater independence, and the ability to exercise and communicate personal choices and preferences;
• Coordination with needed therapies in the participant's service plan, such as physical, occupational, or speech therapy;
• For participants with degenerative medical conditions, supports and community involvement opportunities that are designed to maintain skills and functioning and to prevent or slow regression, rather than acquiring new skills or improving existing skills;
• Retirement activities;
• Supports to participate in volunteer opportunities not related to vocational goals;
• Skills in arranging and using transportation; and
• Completion of the six-month day habilitation report.

Day habilitation may be provided in a variety of settings in the community and must be provided separately from the participant's private residence or other residential living arrangement. When this service is provided in community settings, the service is expected to be provided in small groups no larger than three (3).

Meals may be provided as a part of day habilitation but shall not constitute a full nutritional regimen (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).

Personal care services and transportation between the participant's place of residence and the day habilitation setting may be provided as a component of this service (transportation between the facility and one or more community site is always included in this service and provider's rate). The cost of these services is included in the rate paid to providers of these services.

This service may be provided in a disability-specific, provider owned and controlled (facility-based) setting or a non-disability-specific (community-based) setting. When this service is provided in a provider owned or controlled setting for any portion of the service delivery, the setting is considered facility-based. However, a portion of facility-based setting services must involve community-based service opportunities for participants. When this service is provided in a community setting 100% of the time, the setting is considered community-based. Community-based service delivery may use a provider owned or controlled setting as a primary address but cannot provide services in that setting.

Participants who receive day habilitation may also receive educational, supported employment, and prevocational services separately. However, different types of non-residential services may not be billed for the same period of the day.

Day habilitation may not include the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services). This service also cannot include volunteering for the day habilitation provider.

Day habilitation may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Day Habilitation Agency
Agency	Facility-Based Day Habilitation Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Community-Based Day Habilitation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Service delivery is 100% community-based, and

At least one of the following:
• Accreditation by a nationally recognized accreditation agency, or
• A minimum of two years of experience working with the target population in providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services.

If transportation services are provided, the provider must meet the qualifications for Community Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Day Habilitation

Provider Category:

Agency

Provider Type:

Facility-Based Day Habilitation Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Facility is HCBS compliant per 42 CFR § 441.301(c)(4), and

At least one of the following:
• Accreditation by a nationally recognized accreditation agency, or
• A minimum of two years of experience working with the target population in providing this service, daily living skills training, supportive home care, personal care, home health care, skilled nursing, supported employment or similar services.

If transportation services are provided, the provider must meet the qualifications Community Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

Individual Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03021 ongoing supported employment, individual
Category 2:	**Sub-Category 2:**
03 Supported Employment	03010 job development
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Individual Supported Employment services that consist of six separate service components which assist participants with obtaining and maintaining competitive integrated employment (CIE). CIE is defined in the SMA program resources. For each service covered under this category, the completion of all applicable documentation is a requirement of service provision as detailed in SMA policy.

1. CIE Discovery
CIE discovery is a time-limited practice for participants who have decided to pursue CIE. This service is appropriate when a participant requires further assessment to guide successful job development efforts after they have determined they would like to pursue CIE. The decision to pursue CIE must be documented in the plan prior to utilizing this service category.
CIE Discovery includes:
a. Person-centered discovery assessment process as part of CIE planning;
b. An application to the Division of Vocational Rehabilitation (DVR) for assistance with obtaining CIE, including sharing the participant’s completed assessment profile with their DVR counselor;
c. Clarifying specific conditions necessary for the participant to achieve a successful CIE outcome by:
i. Observing the participant in familiar and novel situations with an emphasis on familiar situations and activities where participant’s specific interests, skills, and competencies will be most apparent;

ii. Interviews with family, friends, and others with close relationships to the participant to gain additional understanding of the participant's specific interests, skills, strengths, abilities, and conditions for success in CIE;
iii. Translating interests, skills, and strengths exhibited in the participant's daily life into possibilities for CIE;
iv. Completion of an individualized summary of the CIE discovery process and outcomes; and
v. Documentation of each date of service, the activities performed, and the duration of each activity in the CIE discovery service.
d. Determining participant interest toward aspects of the labor market;
e. Recognizing skills, strengths, and other contributions valuable to employers or to the community; and
f. Identify and effectively match participant's interests, skills, strengths, personality, and conditions for success to a prospective employer and job.

2. CIE Job Development
CIE Job Development is designed to support a participant through job development with the goal to obtain CIE. CIE resulting from job development must be consistent with the participant's person-centered employment outcomes, including type of work, preferred hours, and income desired. Job development includes:
a. Written goals, preferences, and conditions for success prior to the start of the service;
b. Obtaining sufficient knowledge from the participant's CIE Discovery process to effectively match their interests, skills, strengths, personality, and conditions for success to a prospective employer and job;
c. Direct and indirect time networking with businesses on behalf of the participant to find and create CIE opportunities;
d. Job duty negotiation and representation on behalf of the participant with prospective employers; and
e. Assessing and negotiating the types of assistance and accommodations a participant may need to fully perform and maintain their job.
CIE Job Development may not be authorized for a participant already engaged in CIE, except when specific criteria is met, as detailed in policy.

3. CIE Job Coaching
CIE job coaching consists of job training and performance-related supports for a participant. CIE job coaching includes:
a. Task analysis of the job;
b. Structured intervention techniques, including job site training via systematic instruction, to assist the participant in learning to perform job tasks;
c. Teaching and modeling appropriate work ethics, interpersonal skills, and other soft skills necessary to ensure success in CIE, including travel and mobility skills;
d. Engagement with the participant's supervisor and co-workers;
e. Evaluation and facilitation of necessary job accommodations;
f. Performance assessments to measure progress in learning tasks and skills required to successfully sustain CIE;
g. Assisting the participant to develop self-advocacy skills at work; and
h. A job coach fading plan.

4. Workplace Personal Assistance (WPA)
Workplace personal assistance provides on-going employment supports and personal assistance at the workplace for the participant to sustain CIE when job coaching for independence is no longer needed. This service is used to assist a participant in tasks where independent mastery has been determined not possible due to physical, behavioral health, and/or emotional challenges. CIE Workplace Personal Assistance includes:
a. Assistance with personal care while at work;
b. Assistance during paid and unpaid breaks;
c. Motivational and behavioral supports;
d. Physical supports using the concept of partial participation;
e. Supervision supports to maintain safety in the workplace;
f. Assisting the participant to maintain employment by working with the employer and co-workers on scheduling, performance expectations, transportation, communication, and promoting skill acquisition; and
g. Check-ins with the employer regarding work performance and expectations.
Workplace personal assistance can be provided in addition to CIE job coaching only when a participant has a portion of their job where they are expected to become independent through assistance from a job coach and has another portion of the job where they are not expected to be able to become independent. Job coaching and WPA services may not be provided for the same unit of time.

5. Partners with Business (PwB)
PwB enables a participant to maintain CIE with a combination of informal and paid employment supports provided directly by their employer. The supported employment provider reimburses the employer for the co-worker(s) support that is beyond what is typically available to workers without disabilities filling the same or similar positions. PwB includes:

a. Facilitating and establishing the PwB arrangement, including:
i. Utilization of the PwB support analysis;
ii. Negotiation of PwB supports with the employer;
iii. Implementation of co-worker background checks;
iv. Implementation of a PwB agreement; and
v. Development of a co-worker support plan, that outlines the direct support provided by a co-worker that a job coach/WPA would otherwise provide.
b. Training for the co-worker(s) providing PwB support, including:
i. Training specific to the participant, including the support plan, communication style, learning style, and specific needs related to performing and maintaining their job; and
ii. Ensuring the co-worker completes the DHS WPA web-based training if providing assistance with personal care.
c. Supporting the employer, supervisor, and co-workers supporting the participant, including:
i. On and off-site follow-along back-up supports;
ii. Providing assistance with supports typically provided by the co-worker when temporarily unavailable; and
iii. Monthly check-ins with the employer and participant, at minimum.
d. Fading expectations should be in place to maximize the independence of the employed participant while also ensuring that the participant can successfully maintain CIE.
The employer may only be reimbursed for supports identified through the PwB support analysis that would otherwise be provided by a job coach or WPA. Reimbursement is based on units of service that would otherwise need to be provided by a Supported Employment provider, as determined through the PwB support analysis. Informal supports for the participant, already negotiated with, and provided by, the employer prior to the implementation of PwB are not reimbursable under PwB.

6. Work Incentive Benefits Counseling (WIBC)
WIBC provides the participant individualized information about their benefits and how earnings could affect them. The information offers the participant guidance to make informed choices about employment. WIBC services includes:
a. Verifying the participant’s current benefits;
b. Identifying benefits that may change as a result of increased work earnings;
c. Identifying options and costs for health and long-term care benefits;
d. Predicting foreseeable points of benefit changes;
e. Providing contact information for agencies to which the participant will need to report earnings;
f. Providing accurate and appliable information regarding Social Security work incentives;
g. Developing a written summary of an individualized person-centered work incentive benefits analysis;
h. Holding an in-person meeting with the participant to explain the individualized written work incentive benefits analysis; and
i. Providing follow-along services for up to one year for questions and clarifications about benefits.

Individual supported employment services may be provided only in non-disability-specific settings in the community, which are not leased, owned, operated, or controlled by a service provider. The only exceptions are during the observation element of the CIE discovery component, where a disability-specific setting is a familiar place for the participant.

Individual supported employment services may not be provided in a small-group format. The ratio is always 1:1 for this service. Supported employment services may not include volunteer work, regardless of the setting. These services do not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers in similar positions at their place of employment.

Participants working, regardless of what individual supported employment services are selected or provided, shall be compensated in accordance with applicable Federal and State laws and regulations and shall earn no less than the federal minimum wage or a higher minimum wage if established in the locality where the participant works. Individual supported employment services do not include incentive payments, subsidies, or unrelated vocational training expenses, such as: (a) incentive payments made to an employer to encourage or subsidize the employer’s participation in supported employment, or (b) wages or other payments that are passed through to users of supported employment services.

Personal care services and transportation between the participant's place of residence and the setting may be provided as a component of this service (transportation between the service setting and any community site is always included in this service and provider’s rate). The cost of these services is included in the rate paid to providers of these services.

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

to authorizing this service, the participant's record documents that this service is not otherwise available to the participant through a program funded by Vocational Rehabilitation under section 110 of the Rehabilitation Act of 1973, as amended, and, for participants ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

Individual supported employment services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Work Incentive Benefits Specialist
Individual	On-the-Job Support Person or Job Developer
Agency	Supported Employment Agency
Agency	Work Incentive Benefits Counseling Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Individual Supported Employment

Provider Category:

Individual

Provider Type:

Work Incentive Benefits Specialist

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• DVR contracted provider of Work Incentive Benefits Services, or
• Community Work Incentive Coordinator (CWIC) certification or completion of a similar comprehensive training program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Individual Supported Employment

Provider Category:

Individual

Provider Type:

On-the-Job Support Person or Job Developer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• A DVR contracted provider of Supported Employment or Customized Employment services; or
• CESP certification from National APSE; or
• ACRE Basic Employment Certificate in Supported Employment, Community Employment or Customized Employment; or
• At least 2 years of experience working with the target population providing employment-related services.

If transportation services are provided, the provider must meet the qualifications for Community Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Individual Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

At least one of the following:
• Division of Vocational Rehabilitation (DVR) contracted provider of Supported Employment or Customized Employment; or
• Accreditation by a nationally recognized accreditation agency; or
• A minimum of two years of experience working with the target population providing employment-related servicesin the community.

If transportation services are provided, the provider must meet the qualifications for Community Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Individual Supported Employment

Provider Category:

Agency

Provider Type:

Work Incentive Benefits Counseling Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

DVR contracted provider of Work Incentive Benefits Services

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Education

Alternate Service Title (if any):

Life Skills Training and Education

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08010 home-based habilitation
Category 2:	**Sub-Category 2:**
13 Participant Training	13010 participant training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Life Skills Training and Education services provides training and education designed to assist a participant in developing, practicing, and acquiring life skills necessary for independence, self-determination, and self-advocacy. This service supports the development of knowledge and skills to independently perform routine daily activities, including skills to increase the participant's independence and participation in community life. All training and education being provided under this category are required to be unique to the participant’s support needs and service plan goals.

Training and skill development services provided under this category include:
• An inventory to establish baseline levels of skills and independence;
• Task analysis and systematic instruction in:
o Money management, organizational skills, safety and situational awareness, and routine daily activities;
o Health and self-care skills;
o Home care maintenance, shopping, nutrition, and food preparation;
o Mobility and travel training;
o Driving lessons (for participants who have already acquired their instruction permit);
o General information technology skills (unrelated to assistive technology); and
o The skills necessary for accessing and using community resources.

Training services are designed to allow a participant to meet assessed long-term care related outcomes in a time frame necessary to learn the identified skill and is not intended to provide substitute task performance.

Education services provided under this category include:
• Enrollment or registration fees for education and training courses, workshops, or conferences regarding:
o Self-advocacy and self-determination skills;

o Sexual wellness education and training;
o Exercising civil rights; and
o Skills or knowledge needed to exercise responsibility over services and supports.
• Books and other educational materials;
• Transportation expenses incurred by the participant to attend the courses, workshops, or conferences being accessed; and
• Education and training for a participant's paid or unpaid caregivers and/or legal decision makers that are directly related to the services being provided.

This service can only be provided in the participant's residence or in integrated community settings. This service cannot be provided in a non-residential, facility-based setting.

While the participant works towards the skill or knowledge identified on their service plan, it is anticipated that there will be a gradual decrease of service hours to allow the participant more opportunities for community participation and generalized skill development. The participant's progress towards obtaining the skill(s) and outcome(s) identified on the participant's service plan may be monitored by both the SMA and the participant's IRIS Consultant Agency. Monitoring ensures the efficacy of the training or education services.

Life skills training and education excludes all forms of tuition, payment for lodging and meals, and educationally related services available under Individuals with Disabilities Education Act (IDEA) (20 U.S.C. §1401 et seq). This service also excludes training the member to use assistive technology or communication devices, which is covered under the assistive technology service category.

Life skills training and education may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service, if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Training services may not exceed 40 hours per participant weekly (and no more than 8 hours in a calendar day). Additionally, the participant must demonstrate that they can acquire the skill(s) and outcome(s) identified on their plan within 365 days. If it may reasonably take more than a year, the participant needs to demonstrate plans to obtain the skill(s) and outcome(s) within 365 days.

Education expenses cannot exceed $3000 per participant annually.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Sexual Wellness Education or Training Provider
Agency	Daily Living Skills Training Agency
Individual	Sexual Wellness Educator or Trainer
Individual	Daily Living Skills Trainer
Agency	Education and Training Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Life Skills Training and Education

Provider Category:

Agency

Provider Type:

Sexual Wellness Education or Training Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agency staff providing the training and education must meet at least one of the following qualifications:

• Sexual Wellness Educator, Counselor, or Sex Therapist certified by the American Association of Sexuality Educators, Counselors, and Therapists (AASECT), or
• Any of the following professionals with specialized training in sexual education:
o Psychologist;
o Licensed Clinical Social Worker;
o Licensed Professional Counselor;
o Applied Behavior Analyst;
o Other licensed or certified professionals approved by the SMA to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Life Skills Training and Education

Provider Category:

Agency

Provider Type:

Daily Living Skills Training Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Accreditation by a nationally recognized accreditation agency, or

• The scope of provider standards described in SMA program policy: IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards (P-03071).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Life Skills Training and Education

Provider Category:

Individual

Provider Type:

Sexual Wellness Educator or Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Sexual Wellness Educator, Counselor, or Sex Therapist certified by the American Association of Sexuality Educators, Counselors, and Therapists (AASECT), or
• Any of the following professionals with specialized training in sexual education:
o Psychologist;
o Licensed Clinical Social Worker;
o Licensed Professional Counselor;
o Applied Behavior Analyst;
o Other licensed or certified professionals approved by the SMA to provide the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Life Skills Training and Education

Provider Category:

Individual

Provider Type:

Daily Living Skills Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The scope of the required provider standards for this service is described in SMA program policy: IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards (P-03071).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Life Skills Training and Education

Provider Category:

Agency

Provider Type:

Education and Training Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Competent and qualified providers of education and training with expertise in problem solving, self-advocacy skills development, self-determination, community integration, financial management, and decision-making.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
04 Day Services	04010 prevocational services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Prevocational services are designed to create a person-centered path for participants to achieve or maintain at least part-time participation in competitive integrated employment (CIE). CIE is defined in the SMA program resources. This service involves community-based learning, paid work training experiences, and community-based volunteering where the participant can develop general, non-job-task-specific strengths, skills, knowledge, and experience that contribute to employability within CIE. Services are expected to occur over a defined period of time as determined by the participant and their IRIS consultant. The expected outcome of this service is measurable gains in knowledge, skills, personal strengths, and experiences that contribute to the member's engagement to obtain or maintain CIE with the highest possible wage. When this service is authorized for a participant already working in CIE, the service must focus on goals related to ensuring the member's success in, and ability to sustain CIE. Any participant who utilizes this service must have a documented outcome of CIE on their service plan. This service cannot be authorized or reauthorized for a participant who has indicated that they do not wish to pursue CIE.

Prevocational services include:
• Community-based exploration and experiential opportunities that facilitate a participant's desire for, and ongoing participation in CIE at the highest possible wage;
• Services and skill-building opportunities that are matched to the participant's interests, strengths, priorities, abilities, and conditions for success in CIE (including programs such as Project SEARCH);
• Development of general skills that lead to CIE, including:
o Communicating effectively with supervisors, co-workers, and customers;
o Expressing and understanding expectations;
o Adhering to generally accepted community workplace conduct;
o Following directions and completing tasks;
o Utilizing workplace problem-solving skills and strategies;

o Learning to network;
o Developing interview skills;
o Creating resumes and portfolios;
o Managing conflicts;
o Learning and applying general workplace safety; and
o Mobility training.
• Volunteering opportunities; and
• Completion of a six-month progress report and service plan documentation. The purpose of this is to ensure and document that prevocational services are assisting the participant in progressing toward a goal of at least part-time, integrated employment. Timely completion of this document is required for reauthorization of prevocational services.

Unless used to support Project SEARCH, community-based prevocational services are expected to be provided in small groups no larger than three (3). This service can be provided on an individual basis as appropriate for participant's needs.

Personal care services and transportation between the participant's place of residence and the prevocational setting may be provided as a component of this service (transportation between the service setting and any community site is always included in this service and provider's rate). The cost of these services is included in the rate paid to providers of these services.

This service may be provided in a disability-specific, provider owned and controlled (facility-based) setting or a non-disability-specific (community-based) setting. When this service is provided in a provider owned or controlled setting for any portion of the service delivery, the setting is considered facility-based. However, a portion of facility-based setting services must involve community-based service opportunities for participants. When this service is provided in a community setting 100% of the time, the setting is considered community-based. Community-based service delivery may use a provider owned or controlled setting as a primary address but cannot provide services in that setting.

Waiver funding is not available for vocational services (paid work as opposed to time-limited paid training) delivered in facility-based settings where participants are supervised for the primary purpose of producing goods or performing services.

When a participant's service plan includes a prevocational service, there must be documented opportunities for participation in community-based activities consistent with the intended outcome of this service and which facilitate the participant's interactions with people from the broader community who are not receiving waiver services. This includes opportunities and support specific to pursuing CIE in the community.

Prevocational services are not considered outcomes in and of themselves, nor is any prevocational service, including paid training, considered to be employment if service authorization is required to ensure the continued availability for the participant's participation in the paid training.

Participation in prevocational services is not a prerequisite for participation in CIE or authorization of any other employment services provided under the waiver. Participants who receive prevocational services may also receive educational services, supported employment, and/or day services. The participant's service plan may include two or more types of non-residential services. However, different types of non-residential services may not be billed for the same period of time. These services also may not overlap or be blended with other employment services or residential services.

Prevocational services may be provided to supplement, but not duplicate services that are available and provided to a participant as part of an approved Individualized Plan for Employment (IPE), funded under the Rehabilitation Act of 1973, as amended, or under an approved Individualized Education Plan (IEP), under the Individuals with Disabilities Education Act (IDEA). Prior to authorizing this service, the participant's record documents that this service is not otherwise available to the participant through a program funded by Vocational Rehabilitation under section 110 of the Rehabilitation Act of 1973, as amended, and, for participants ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

Participants who participate in paid training as part of prevocational services shall be compensated in accordance with applicable Federal and State laws and regulations. Compensation at sub-minimum wage shall comply with the Fair Labor Standards Act and the Workforce Investment and Opportunity Act (WIOA) including WIOA provision for youth with disabilities under age 26. If a member's calculated wage for paid training in this service under Section 14(c) of the FLSA is minimum wage or higher, the member is not eligible to receive facility-based prevocational services during the time this paid training is occurring. This service cannot involve volunteering for a service provider on their service plan or volunteering in situations where a participant must be paid under state and federal labor laws.

Prevocational services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Community-Based Prevocational Services Provider
Agency	Facility-Based Prevocational Services Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Community-Based Prevocational Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Service delivery is 100% community-based, and

At least one of the following:
- Accreditation by a nationally recognized accreditation agency, or
- A DVR contracted provider of Supported Employment Services, or
- A minimum of two years of experience working with the target population providing employment-related services.

If transportation services are provided, the provider must meet the qualifications for Community Transportation.

The provider must comply with all applicable occupational health and safety standards of the Federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

Facility-Based Prevocational Services Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Facility is HCBS compliant per 42 CFR § 441.301(c)(4), and

At least one of the following:
• Accreditation by a nationally recognized accreditation agency, or
• A DVR contracted provider of Supported Employment Services, or
• A minimum of two years of experience working with the target population providing employment-related services.

If transportation services are provided, the provider must meet the qualifications for Community Transportation.

The provider must comply with all applicable occupational health and safety standards of the Federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite services are provided for a participant on a temporary, short-term basis to ease the participant's primary caregiver(s) from daily stress and care demands. These services provide compensation for substitute care and supervision appropriate to the participant's needs while the primary caregiver(s) are temporarily relieved from providing care. In this service category, a "primary caregiver" is defined as a paid or unpaid caregiver that provides more than fifty percent of the care and support on the participant's service plan.

Respite services may be provided in an institution such as a certified Medicaid setting or other licensed facility. Respite services may also be provided in a residential facility such as a certified or licensed adult family home, licensed community-based residential facility, certified residential care apartment complex, in the participant's own home, or the home of a respite service provider. The respite provider may not also be the primary caregiver of the participant's supportive home care, and they may not also share a residence with the participant.

Respite care may not be furnished for the purpose of compensating relief or substitute staff for residential service providers or supportive home care provider agencies who provide greater than eight (8) consecutive hours of service in a day. The costs of such staff must be addressed through the provider's rate covered under the applicable waiver service.

When a participant requires assistance to train newly hired support staff, additional staff coverage may be authorized to permit existing staff to provide onboarding training to new support staff. Onboarding training coverage is not available for agency providers. The requirements regarding onboarding training are further detailed in SMA policy.

The receipt of respite services precludes the participant from receiving other waiver services such as adult day care, nursing services, and supportive home care on the same day the participant receives respite services, unless clear documentation exists that service delivery occurred at distinct times from respite services, regardless of how the respite payment is structured.

The cost of room and board is excluded for this waiver service, regardless of service setting or location. This service may not be utilized in lieu of other, more applicable support or care services, such as supportive home care.

Respite may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite service limits are only applied to specific service providers, as detailed in the applicable service provider's credentialing authorities (see provider specifications below for credentialing authorities).

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Residential Care Apartment Complex (RCAC)
Agency	1-2 Bed Adult Family Home
Agency	Personal Care Agency
Individual	Individual Worker
Agency	Supportive Home Care Agency
Agency	Hospital
Agency	Community-Based Residential Facility (CBRF)
Agency	3-4 Bed Adult Family Home
Agency	Nursing Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Residential Care Apartment Complex (RCAC)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code ch. DHS 89

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

1-2 Bed Adult Family Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes (AFH)

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Personal Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 105.17

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Individual

Provider Type:

Individual Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The scope of the required provider standards for this service is described in SMA program policy: IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards (P-03071).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Supportive Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The scope of the required provider standards for this service is described in SMA program policy: IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards (P-03071).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Hospital

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DHS 124

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Community-Based Residential Facility (CBRF)

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DHS 83

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

3-4 Bed Adult Family Home

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DHS 88

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Nursing Home

Provider Qualifications

License *(specify):*

Wis. Admin. Code chs. DHS 132 and DHS 134

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Extended State Plan Service

Service Title:

Nursing Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
05 Nursing	05020 skilled nursing
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

◉ **Service is included in approved waiver. There is no change in service specifications.**

○ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Nursing Services is also known as “professional nursing” as defined in Wisconsin’s Nurse Practice Act, Wis. Stat. ch. 441. Nursing services are medically necessary, skilled nursing services that may only be provided safely and effectively by an advanced practice nurse, a registered nurse, or a licensed practical nurse who is working under the supervision of a registered nurse.

The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act (NPA). This includes the specific roles and prescribed tasks of a skilled nurse, according to the NPA. All nursing services being provided must also be consistent with the participant's identified needs and documented on their service plan.

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

These services are provided when nursing services identified as needed in a participant’s plan of care and furnished under the approved Medicaid State Plan or through Medicare and plan limits are exhausted or when nursing services are not covered under the Medicaid State Plan or through Medicare.

The statewide IRIS Self-Directed Personal Care (IRIS SDPC) oversight agency reviews the need for nursing services to ensure the participant’s needs exceed the Medicaid State Plan benefit limitations. Results of the analysis serve as the prior authorization for this service.

Nursing services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-directed Registered Nurse/LPN
Individual	Individual RN or LPN

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service

Service Name: Nursing Services

Provider Category:

Agency

Provider Type:

Agency-directed Registered Nurse/LPN

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 441

Certificate *(specify):*

Agency is certified by Medicare per Wis. Admin. § DHS 105.16

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Nursing Services

Provider Category:

Individual

Provider Type:

Individual RN or LPN

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 441

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):

IRIS Consultant Agency (ICA) Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-directio
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

IRIS Consultant Agency (ICA) services are resources, information, and services provided to the participant by an ICA to assist the participant in identifying immediate and long-term needs and outcomes, developing options to meet those needs and outcomes, and gain access to needed waiver and other State plan services and supports. Additionally, the ICA also provides assistance with accessing other identified medical, social, rehabilitation, vocational, educational, and other services as needed, regardless of the funding source for the services to which access is gained.

To assist the participant in self-directing and accessing services within the program, the ICA carries out the following activities:
a. Providing comprehensive IRIS program orientation and skills training regarding self-direction, provider and participant-hired worker selection, and participant spending and individual budget management;
b. Providing assistance and oversight to the participant as determined by the SMA, including federal HCBS requirements per 42 CFR § 441.301(c).
c. Providing assistance with regards to the self-directed planning process and its application;
d. Creating and maintaining the participant’s service plan and associated service authorizations in collaboration with the

participant;
e. Monitoring and effectively assuring participant health and welfare;
f. Performing routine level of care re-evaluations, annually and as needed, where the ICAs load the data into a state created, approved, and monitored system that makes the final eligibility determination;
g. Providing resources and content necessary to assist participants with maintaining long-term care and Medicaid eligibility;
h. Explaining participant's rights and the appeals and grievance processes;
i. Facilitating between the participant and the financial management services provider;
j. Providing insights to the participant about problem solving, conflict resolution, hiring, managing, and terminating participant-hired workers; and
k. Recognizing, remediating, and reporting critical events.

To ensure participants are provided effective information and assistance related to self-direction, ICAs ensure all staff meet competency requirements defined by the SMA.

ICA services do not include direct coordination of services or the hiring, management, scheduling, training, or termination of service providers, as this is the participant's role in exercising their employer authority.

Except Indian Health Care Providers (IHCP), ICA service providers cannot also provide other Wisconsin long-term care HCBS waiver services to the same participant.

ICA services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Indian Health Care Provider (IHCP)
Agency	IRIS Consultant Agency (ICA)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: IRIS Consultant Agency (ICA) Services

Provider Category:

Agency

Provider Type:

Indian Health Care Provider (IHCP)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Indian Health Care Provider (IHCP) as defined by the American Recovery and Reinvestment Act of 2009

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency (SMA)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: IRIS Consultant Agency (ICA) Services

Provider Category:

Agency

Provider Type:

IRIS Consultant Agency (ICA)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies must be certified by the State Medicaid Agency as an ICA

Other Standard *(specify):*

Certified ICAs must have a current contract with the SMA

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency (SMA)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Assistive technology is an item, piece of equipment, software, application, service dog, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants in their communities. This service category includes assistive technology typically referred to as adaptive or communication aids. Assistive technology services directly assist a participant in the selection, acquisition, or use of an assistive technology device. This service category also includes warranties, cost of maintenance, ancillary supplies, software, and equipment necessary for the proper functioning of assistive technology.

Assistive technology also includes services that directly assist a participant in the acquisition or use of assistive technology, such as:
A. The evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;
B. Services consisting of purchasing, leasing/renting, or otherwise providing for the acquisition of assistive technology for participants;
C. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology;
D. Coordination and use of necessary therapies, interventions, or services with assistive technology, including therapies, interventions, or services associated with other services in the service plan;
E. Training or technical assistance for the participant, or, where appropriate, the family members, legal decision makers, advocates, or authorized representatives of the participant; and
F. Training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of the participant.

Service Dogs:
Assistive technology includes the purchase of a fully trained service dog. A service dog is defined as a dog that is

individually trained by a reputable provider experienced in providing structured training for service dogs to do work or perform tasks for the participant that are directly related to the participant's disability. Costs are limited to the following:
• Purchase of a fully trained service dog from a reputable provider with experience providing structured training for service dogs;
• Post-purchase training with a reputable provider experienced in providing structured training for service dogs to partner a service dog with the participant owner; and
• Ongoing maintenance costs of a fully trained service dog that include preventative, acute, and primary veterinary care and items necessary for the service dog to perform its task or work.

Service dog costs must be consistent with program policy. This includes the requirement that service dog expenses can only be for a dog that has been individually trained by a reputable provider experienced in providing structured training for service dogs to do work or perform tasks for an individual with a disability. The task(s) performed by the dog must be directly related to the participant's disability.

This service excludes costs related to a dog that does not meet the definition of a service dog (i.e. emotional support dog, therapy dog, dog training to become a service dog, household pet).

Interpreter Services:
Assistive technology also includes interpreter services, which are provided to participants who have hearing, speech, or vision impairments and require interpretation to communicate with people in the community, employees, or others.

This service excludes interpreter services that are otherwise available or are the responsibility of another entity, including for communication with the SMA-contracted entities, service providers, or other health care professionals that are required to provide interpreter services as part of their rate.

This service does not supplant the responsibility of SMA-contracted entities, service providers, or other health care professionals to take reasonable steps to provide meaningful access to their services by persons with limited English proficiency (LEP). Providers must provide language assistance services in order to comply with Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act of 1973.

Devices and Equipment for Remote Service Delivery:
Assistive Technology also covers devices and equipment for remote service delivery. This is the purchase of devices and equipment required to facilitate access to waiver services being delivered remotely to increase, maintain, or improve the participant's functional capabilities at home, work, and in the community. All devices and equipment covered for the purpose of remote service delivery require the participant to have an authorization for a remote-eligible service on their plan. Additionally, prior to remote service delivery, the participant and remote service provider must have a service provider agreement in place indicating that remote services will be provided following the installation and setup of the devices and equipment. When devices or equipment are being issued and billed by the remote service provider as a part of their remote service rate, they may not be billed separately under this service category.

Devices, equipment, software, or communication and monitoring technology covered by this service may only be used in the context of remote monitoring and support services. Devices and equipment covered under this service category are:
• Radio frequency identification devices;
• Live audio or video feed equipment;
• Web-based monitoring systems; and
• Devices or equipment that facilitate live two-way communication.

All devices and equipment must be purchased for the participant by a qualified vendor. This service also includes installation, upkeep, and maintenance of devices or equipment, as appropriate. Devices or equipment not working properly and requiring repair must be repaired by a qualified vendor. If a participant has multiple services being remotely delivered on their service plan, the participant and their consultant must work to ensure devices or equipment may be utilized to address as many of the remote services as possible, with no duplicative purchases of devices or equipment.

Devices and equipment for remote service delivery excludes the purchase of any device or equipment for recreational or diversional purposes. Payment of recurring costs for the same or similar equipment is not allowable unless it is determined that the item or device has exhausted its useful life or has been rendered unsafe or unusable due to damage or defect.

Acquisition of all assistive technology, including the use of assessments, is subject to program policy consistent with this service definition. Services under this category which are in addition to assistive technology services available through the State Plan require a documented decision from State Plan Medicaid prior to acquisition. All assistive technology services

require a qualified health care professional's order demonstrating medical or behavioral necessity (except interpreter services and devices and equipment for remote service delivery).

Assistive technology may be purchased, new or used, or leased to the participant. All assistive technology must meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory (UL) and Federal Communication Commission (FCC).

This service category excludes the coverage of internet services. The participant must have access to internet services before devices requiring internet connection can be authorized or acquired.

Assistive technology and services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Qualified Health Professional Agency
Individual	Service Dog Trainer or Provider
Agency	Veterinary Clinic
Individual	Independent Practice Veterinarian
Individual	Qualified Health Professional
Agency	Service Dog Training or Provider Agency
Agency	Assistive Technology Vendor or Assessor
Agency	Technology Vendor
Agency	Durable Medical Equipment and Medical Supply Vendor
Individual	Interpreter, Facilitator, or Translator
Agency	Interpretation, Facilitation, or Translation Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Qualified Health Professional Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employing or contracting with professionals with current state licensure or certification in their field of practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agency

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Service Dog Trainer or Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable provider with experience providing structured training for service dogs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Veterinary Clinic

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employing or contracting with licensed veterinarians (Wis. Stat. § 89.06)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Independent Practice Veterinarian

Provider Qualifications

License *(specify):*

Wis. Stat. § 89.06

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Qualified Health Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Professionals with current state licensure or certification in their field of practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Service Dog Training or Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable provider with experience providing structured training for service dogs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Assistive Technology Vendor or Assessor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

UL or FCC standards for electronic devices

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Technology Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

UL or FCC standards for electronic devices

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Durable Medical Equipment and Medical Supply Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 105.40

Other Standard *(specify):*

UL or FCC standards for electronic devices

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Interpreter, Facilitator, or Translator

Provider Qualifications

License *(specify):*

If providing translation for the deaf or hard of hearing, provider must be licensed under Wis. Stat. § 440.032

Certificate *(specify):*

Other Standard *(specify):*

• Ability to interpret effectively, accurately, and impartially both receptively and expressively, using necessary specialized vocabulary.
• Participants may further specify qualifications and requirements for Interpreter Service providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Interpretation, Facilitation, or Translation Agency

Provider Qualifications

License *(specify):*

If providing translation for the deaf or hard of hearing, provider must employ or contract with interpreters licensed under Wis. Stat. § 440.032

Certificate *(specify):*

Other Standard *(specify):*

• Ability to interpret effectively, accurately, and impartially both receptively and expressively, using necessary specialized vocabulary.
• Participants may further specify qualifications and requirements for Interpreter Service providers.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transportation

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Transportation is the transport of a participant to and from a waiver service, place of employment, or community service, activity, or resource as specified in the participant's service plan. The cost of community transportation is reimbursed in accordance with the Internal Revenue Service federal mileage reimbursement rate and is outlined in the participant's service plan. This service may consist of items such as public transit tickets, fare cards, or other fare media or services where the provider directly transports a participant (and the participant's attendant, if any) to destinations.

Community Transportation is offered in addition to medical transportation required under 42 CFR § 431.53 and transportation services under the State Plan, defined in 42 CFR § 440.170(a) (if applicable) and does not replace them. Transportation service may only be funded through the waiver when the services are not provided by a legally responsible third-party, such as a school, private insurance, or a public entity. Whenever possible, family, neighbors, friends, community agencies, or local government programs that can provide this service without charge will be prioritized and utilized.

Community transportation may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Excludes emergency (ambulance) medical transportation covered under the Medicaid State plan service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**
- ☒ **Relative**
- ☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Transportation Provider
Individual	Individual Worker
Agency	Taxi or Common Motor Carrier
Agency	Transportation Network Agency
Agency	Mass Transit Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Agency

Provider Type:

Specialized Transportation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Wis. Admin. Code ch. Trans 301
• And one of the following:
o Wis. Stat. § 85.21; or
o Wis. Stat. § 85.22; or
o Wis. Stat. § 85.215.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Individual

Provider Type:

Individual Worker

Provider Qualifications

License *(specify):*

Provider must have a valid operator’s license from the WI Department of Transportation

Certificate *(specify):*

Other Standard *(specify):*

Provider must have liability insurance, with a vehicle in good repair including all operating and safety systems functioning.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Agency

Provider Type:

Taxi or Common Motor Carrier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Stat. § 194.04

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Agency

Provider Type:

Transportation Network Agency

Provider Qualifications

License *(specify):*

Wis. Stat. §§ 440.41 and 440.415

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Community Transportation

Provider Category:

Agency

Provider Type:

Mass Transit Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Stat. § 85.20(1)(e)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Competitive Integrated Employment (CIE) Exploration

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ◉ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Competitive integrated employment (CIE) Exploration is intended to help participants make an informed choice about whether they would like to pursue CIE, including self-employment. CIE is defined in the SMA program resources. CIE Exploration is appropriate for a participant who is not currently employed in CIE and needs more information to make informed choice about whether they want to pursue CIE, including self-employment.

CIE Exploration includes:
• Arrangement of career exploration opportunities and assistance in participation of at least 3 business tours, informational interviews, and/or job shadows;
• Debriefing with the participant after career exploration experiences;
• Introductory education on supported employment services;
• An initial conversation about work incentives available to minimize the impact of CIE on public benefits and identification of need for personalized, in-depth Work Incentives Benefits Analysis;
• Documentation in the participant's plan regarding their choice about pursuing CIE following the completion of the service;

• Person-centered exploration planning; and
• Completion of the required reporting documentation related to this service, as detailed in SMA policy.

CIE Exploration may not be provided in a small group format. The ratio is always 1:1 for this service.

CIE Exploration may only be provided in non-disability specific settings typically found in the community or the participant's residence, which is not a provider-controlled setting. The only exception is if the participant lives in a residential setting that is leased, owned, operated, or controlled by a provider and this setting is the most appropriate setting for this service.

Participants who are receiving CIE exploration services may not receive individual supported employment services or vocational futures planning and support services. This service does not include Work Incentives Benefits Analysis, which is

covered under individual supported employment.

CIE Exploration services may be provided to supplement, but not duplicate, services that are available and provided to a participant as part of an approved Individualized Plan for Employment (IPE), funded under the Rehabilitation Act of 1973, as amended, or under an approved Individualized Education Plan (IEP), under the Individuals with Disabilities Education Act (IDEA). Prior to authorizing this service, the participant's record documents that this service is not otherwise available to the participant through a program funded by Vocational Rehabilitation under section 110 of the Rehabilitation Act of 1973, as amended, and, for participants ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

Transportation between the participant's place of residence and the service setting may be provided as a component of this service (transportation between the service setting and any community site is always included in this service and provider's rate). The cost of these services is included in the rate paid to providers of these services.

CIE Exploration may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

CIE Exploration may not be authorized on a participant's service plan for longer than a 365-day period and only when the participant is not actively receiving service(s) to obtain CIE or already engaged in CIE.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	CIE Exploration Provider
Agency	Supported Employment Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Competitive Integrated Employment (CIE) Exploration

Provider Category:

Individual

Provider Type:

CIE Exploration Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• A DVR contracted provider of Supported Employment or Customized Employment services; or
• CESP certification from National APSE; or
• ACRE Basic Employment Certificate in Supported Employment, Community Employment or Customized Employment; or
• At least 2 years of experience working with the target population providing employment-related services.

If transportation services are provided, the provider must meet the qualifications for Community Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Competitive Integrated Employment (CIE) Exploration

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• A DVR contracted provider of Supported Employment or Customized Employment services; or
• Accreditation by a nationally recognized accreditation agency; or
• A minimum of two years of experience working with the target population providing employment-related services.

If transportation services are provided, the provider must meet the qualifications for Community Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consultative Clinical and Therapeutic Services for Caregivers

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11030 medication assessment and/or management
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Consultative clinical and therapeutic services assist unpaid caregivers and/or paid support staff in carrying out the participant's treatment/support plans, are not covered by the Medicaid State Plan, and are necessary to improve the participant's independence and inclusion in their community. The purpose of these services is to improve the ability of unpaid caregivers and paid providers to carry out therapeutic interventions.

The service includes assessments, development of home treatment/support plans, intervention plans, training and technical assistance to carry out the plans, consultation with providers and potential providers, and monitoring of the participant and the provider in the implementation of the plans. This may be provided in the individual’s home or in the community, as described in the participant’s service plan. This service may also include consultation with service providers and potential providers to assess whether they can meet the unique needs of the participant, as well as to identify all supports necessary for caregivers to perform therapeutic interventions.

Services are provided by state licensed or certified professionals that deliver services limited to their areas of formal education and training, and as directed by their professional code of ethics.

This service must be directly related to a therapeutic need assessed and documented on the participant’s service plan. Consultative clinical and therapeutic services for caregivers is a short-term service, only authorized so long as it is necessary to educate, train, or provide initial support to the caregiver(s).

Consultative clinical and therapeutic services for caregivers may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Counseling or Therapy Agency
Individual	Counselor or Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consultative Clinical and Therapeutic Services for Caregivers

Provider Category:

Agency

Provider Type:

Counseling or Therapy Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employing or contracting with professionals with current state licensure or certification in their field of practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Consultative Clinical and Therapeutic Services for Caregivers

Provider Category:

Individual

Provider Type:

Counselor or Therapist

Provider Qualifications

License *(specify):*

Professionals with current state licensure in their field of practice

Certificate *(specify):*

Professionals with current state licensure in their field of practice

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Counseling, Therapeutic, and Wellness Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11130 other therapies
Category 2:	**Sub-Category 2:**
10 Other Mental Health and Behavioral Services	10090 other mental health and behavioral services
Category 3:	**Sub-Category 3:**
17 Other Services	17990 other

Category 4: **Sub-Category 4:**

10 Other Mental Health and Behavioral Services | 10060 counseling

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Counseling, therapeutic, and wellness services is the provision of professional, treatment-oriented services, resources, or interventions to address a participant's identified long-term care need, specifically related to their personal, social, physical, medical, behavioral, emotional, cognitive, mental, or substance abuse treatment needs. The outcome of these services is the maintenance or improvement of the participant's health, welfare, or general functioning in the community. Counseling, therapeutic, and wellness services must meet clearly defined outcomes, be effective for the participant's condition or desired outcome, and be cost effective, as demonstrated on the participant's service plan.

Counseling, therapeutic, and wellness services include:
• Aging or disability adjustment and adaptation counseling;
• Interpersonal counseling;
• Recreational therapy, music therapy, art therapy, and aquatic therapy;
• Culturally appropriate complementary medicine and wellness services;
• Massage therapy,
• Behavioral counseling;
• Grief counseling;
• Health club memberships and fitness classes; and
• Camps.

Costs directly associated with counseling, therapies, or wellness services received are also included in this service category. Services and expenses covered under this category may not be only recreational or diversional in nature. It must be demonstrated on the participant's service plan that the authorized service or expense serves an applicable counseling, therapeutic, or wellness purpose.

Any services provided must be recommended by a qualified health care or mental health professional. Additionally, this service may only be authorized when there is an unmet need identified and documented, and when State Plan services have been exhausted. When this service is being requested through the SMA additional funding request process, a participant may not already have more than one of these services authorized on their plan to meet the same need.

This service category excludes the following:
• Experimental or prohibited treatments, goods, and services;
• Inpatient services;
• Services provided by a physician; and
• Attendant costs, to assist participants in attending counseling and therapeutic sessions (which is covered under Supportive Home Care services).

Counseling, therapeutic, and wellness services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Wellness Provider
Agency	Wellness Provider Agency
Individual	Personal Trainer
Agency	Camp
Agency	Counseling or Therapy Agency
Individual	Counselor or Therapist
Agency	Fitness Center

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling, Therapeutic, and Wellness Services

Provider Category:

Individual

Provider Type:

Wellness Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider must have licensure, certification, registration, accreditation, experience, or training appropriate to the service being provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling, Therapeutic, and Wellness Services

Provider Category:

Agency

Provider Type:

Wellness Provider Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Provider must employ staff who have licensure, certification, registration, accreditation, experience, or training appropriate to the service being provided.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling, Therapeutic, and Wellness Services

Provider Category:

Individual

Provider Type:

Personal Trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED) certification; and
• National certification from an accredited agency

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling, Therapeutic, and Wellness Services

Provider Category:

Agency

Provider Type:

Camp

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. ATCP 78

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling, Therapeutic, and Wellness Services

Provider Category:

Agency

Provider Type:

Counseling or Therapy Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Employing or contracting with professionals with current state licensure or certification in their field of practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling, Therapeutic, and Wellness Services

Provider Category:

Individual

Provider Type:

Counselor or Therapist

Provider Qualifications

License *(specify):*

Professionals with current state licensure in their field of practice

Certificate *(specify):*

Professionals with current state licensure in their field of practice

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Counseling, Therapeutic, and Wellness Services

Provider Category:

Agency

Provider Type:

Fitness Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Stat. § 100.178 and Wis. Stat. § 100.177(1)(c)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Environmental Accessibility Adaptations (Home Modifications)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Environmental accessibility adaptations, commonly referred to as home modifications, are physical adaptations to the private residence of a participant or participant's family that ensure the health, welfare, and safety of the participant and enable the participant to function with greater independence in their home. These are generally permanent fixtures and/or changes to the physical structure of the home. This service category also includes cost of materials, services, permits and inspections, maintenance, and warranties necessary for a modification.

Modifications covered under this waiver service include:
• Accessible alerting systems for smoke/fire/carbon monoxide;
• Adaptive doorbells, locks, and/or security items, systems, or devices;
• Adaptive doorknobs and door openers;
• Adaptive lighting;
• Bathroom adaptations for bathing, showering, toileting, and personal care needs;

• Fences;
• Flush entries and leveled thresholds;
• Installation of specialized electric and plumbing systems that are necessary to accommodate the participant's medical equipment and supplies;
• Kitchen counter and sink modifications;
• Railings to safely access the home;
• Raised electrical switches and sockets;
• Ramps from street, sidewalk, or house;
• Wheelchair accessible and slip-resistant flooring;
• Stair gliders and stair lifts;
• Surface protection;
• Swing-clear and expandable offset door hinges;
• Track lift systems;
• Vertical lifts; and
• Widened doorways, landings, and hallways.

Modifications may be made up to 180 days prior to leaving the institutional setting and enrolling in the waiver but cannot be paid for until the participant is enrolled in the waiver.

Acquisition of all modifications, including use of SMA-conducted accessibility assessments, is subject to program policy consistent with this service definition and must be cost-effective. Modifications of permanent or structural nature are further defined in SMA program resources. Non-permanent or non-structural changes are allowed when another entity (i.e. landlord or residential provider) is not responsible for making the needed adaptation(s).

This service category excludes:
• Modifications or improvements that are of general home maintenance and upkeep, including those that are exclusively for the purpose of bringing the home up to local and state housing or building code requirements (i.e. roof repair, flooring replacement, sidewalks, etc.);
• Modifications to the home which are of general utility and are not of direct medical or remedial benefit to the participant (e.g., household appliances, whole house generators, or central air conditioning systems);
• Modifications made to living arrangements that are owned or leased by agency providers of other waiver services;
• Permanent or structural modifications to rented living arrangements;
• Modifications that do not meet standards of manufacture, design, and installation;
• Funding for the installation and/or monthly cost of internet services (when necessary, this service may only be authorized for participants who already have access to necessary internet services);
• Residential elevators or enclosed vertical platform lifts;
• Materials that exceed the industry standards or are for cosmetic benefit only;
• Modifications within a home that is not yet constructed or has been built within the last five years;
• Modifications within a home that is found to be not structurally sound, as determined by assessor or contractor; and
• Modifications that add to the total square footage of the home, except when necessary to complete a modification and shown to be the most cost-effective option.

All modifications are required to comply with applicable local and state housing or building codes and are subject to inspections required by the municipality responsible for administering the codes.

Home modifications may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Technology Vendor
Agency	Carpenters, Electrical Contractors, Electricians, Elevator Contractors, General/Dwelling Contractor, HVAC Contractors, Plumbers, Professional Engineers
Individual	Carpenter, Electrical Contractor, Electrician, Elevator Contractor, General/Dwelling Contractor, HVAC Contractor, Plumber, Professional Engineer

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations (Home Modifications)

Provider Category:

Agency

Provider Type:

Technology Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

UL or FCC standards for electronic devices

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

At time of authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations (Home Modifications)

Provider Category:

Agency

Provider Type:

Carpenters, Electrical Contractors, Electricians, Elevator Contractors, General/Dwelling Contractor, HVAC Contractors,

Plumbers, Professional Engineers

Provider Qualifications

License *(specify):*

Provider must employ staff who have the required state license.

Certificate *(specify):*

Provider must employ staff who have the required state certification.

Other Standard *(specify):*

Provider must employ staff who have the required state registration and adhere to industry set standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

At time of authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Environmental Accessibility Adaptations (Home Modifications)

Provider Category:

Individual

Provider Type:

Carpenter, Electrical Contractor, Electrician, Elevator Contractor, General/Dwelling Contractor, HVAC Contractor, Plumber, Professional Engineer

Provider Qualifications

License *(specify):*

Provider must obtain required state license.

Certificate *(specify):*

Provider must obtain required state certificate.

Other Standard *(specify):*

Provider must obtain required state registration and adhere to industry set standards.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

At time of authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

Meals must align with USDA Dietary Guidelines for Americans standards, be medically appropriate for the participant, and must provide a minimum of one-third of the estimated daily calorie needs for the participant’s age group.

This service may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home delivered meals may not constitute a full nutritional regimen (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Hospitals
Agency	Restaurants
Agency	Aging Network Agency
Agency	Indian Health Care Provider (IHCP)
Agency	Nursing Homes
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Hospitals

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DHS 124

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Restaurants

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. ATCP 75

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Aging Network Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Stat. § 46.82(1)(a)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Indian Health Care Provider (IHCP)

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Indian Health Care Provider (IHCP) as defined by the American Recovery and Reinvestment Act of 2009

Verification of Provider Qualifications

Entity Responsible for Verification:

State Medicaid Agency (SMA)

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Nursing Homes

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DHS 132
Wis. Admin. Code ch. DHS 134

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code § DHS 105.16

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Housing Counseling

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Housing counseling is the provision of information and assistance for participants who are looking to acquire and maintain safe, affordable, and accessible housing in the community. Housing counseling includes exploring home ownership and rental options and individual and shared housing options, including options where the participant lives with his or her family. This service provides supports to preserve the most independent living arrangement and/or assist the participant in locating the most integrated option appropriate to the participant. The purpose of housing counseling is to elevate participant choice and control, increase access to affordable housing, and promote community integration.

Housing counseling services include:
• Conducting a community integration assessment to identify the participant's preferences related to housing and needs for support to maintain community integration, including:
o Type and location of housing desired;
o Preference for living alone or with others;
o Identification of a roommate, if applicable;
o Accommodations and modifications needed;
o Identification of the type of setting that works best for the individual;
o Assistance in obtaining or accessing sources of income necessary for community living;
o Assistance in establishing credit and meeting obligations of tenancy; and
o Other important needs and preferences.
• Identifying financial resources, determining affordability, and assisting in access to financing, including:
o Securing supporting documents/records;
o Completing/submitting applications;
o Securing deposits; and
o Locating funding for furnishings.
• Locating and securing available housing;
• Explaining the rights and responsibilities of a tenant with disabilities, including how to ask for reasonable accommodations and modifications and how to file a complaint;
• Supports to assist the participant in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager; and
• Planning for ongoing management and maintenance of housing.

This service may not be provided by an agency that also provides residential support services, service coordination, or information and assistance as a function of this waiver to the participant.

Housing counseling may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Housing Counseling Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Housing Counseling

Provider Category:

Agency

Provider Type:

Housing Counseling Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Must have expertise in housing issues;
• Must have housing counseling or assistance as a part of its mission or regular activities; and
• Must not have a direct or indirect financial interest in the property or housing the participant selects.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Individual Directed Goods and Services refers to services, equipment, or supplies that addresses or enhances the participant's opportunity to achieve their long-term support need but is not already coverable under another service category. The service, equipment, or supply must not be included under an exclusion of another service category.

Any service, equipment, or supply covered must be cost-effective and clearly address a participant's identified long-term care need, be documented in their service plan, and meet the additional following requirements:
• The participant is reasonably unable to obtain the good or service from another source; and
• At least one of the following:
o The good or service must decrease the need for other Medicaid services (Medicaid State Plan or other waiver services); or
o Promote or maintain inclusion in the community; or
o Increase or maintain the participant's safety in their home environment.

Individual Directed Goods and Services are purchased from the participant-directed budget. Any service, equipment, or supply included under this service definition must be verified by the SMA prior to service authorization and utilization.

Individual Directed Goods and Services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Experimental or prohibited treatments, goods, and services are excluded.

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Care Agency, Supportive Home Care Agency, Aging Network Agency, Education and Training Agency, Other Merchants or Contractors
Individual	Individual Worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Home Health Care Agency, Supportive Home Care Agency, Aging Network Agency, Education and Training Agency, Other Merchants or Contractors

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets applicable industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets applicable industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Relocation - Community Transition Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Relocation – Community Transition Services are non-recurring set-up expenses for participants who are transitioning from an institution or a provider-operated living setting to a community living setting in a private residence where the person is directly responsible for their own living expenses. Allowable expenses are those that are necessary to enable the participant to establish a basic household, excluding room and board. Only initial costs to prepare the living arrangement are covered by this service. Relocation expenses may be covered up to 180 days prior to leaving the institutional setting and enrolling in the waiver but cannot be paid for until the participant is enrolled in the waiver.

Relocation services include:
a. Activities to assess need, as well as arrange for and procure the other services in this list;
b. Security deposits that are required to obtain a lease on an apartment or home;
c. Essential household furnishings, supplies, and appliances not included in the community living arrangement, such as furniture, window coverings, food preparation items, and bed/bath linens;
d. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
e. One-time general cleaning and household organization needed to prepare the selected community living arrangement for occupancy; and
f. Moving expenses.

This service category excludes:
• Housekeeping services provided after occupancy (which are considered a supportive home care service);
• Regular rental or mortgage expenses;
• Expenses for ongoing room and board (food, rent, etc.);
• Regular utility charges;
• Household appliances or items that are intended for diversional/recreational purposes;
• Service agreements or extended warranties for appliances or home furnishings;
• Furnishing of living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing; and
• Home modifications necessary to address safety and accessibility in the participant’s living arrangement (which may be provided under the waiver’s home modification service).

Relocation services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Landlord
Individual	Individual Mover

Provider Category	Provider Type Title
Agency	Public Utilities
Agency	Moving Company
Agency	Home Furnishing Vendor
Agency	Real Estate Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Relocation - Community Transition Services

Provider Category:

Individual

Provider Type:

Individual Landlord

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Relocation - Community Transition Services

Provider Category:

Individual

Provider Type:

Individual Mover

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Relocation - Community Transition Services

Provider Category:

Agency

Provider Type:

Public Utilities

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Relocation - Community Transition Services

Provider Category:

Agency

Provider Type:

Moving Company

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Relocation - Community Transition Services

Provider Category:

Agency

Provider Type:

Home Furnishing Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Relocation - Community Transition Services

Provider Category:

Agency

Provider Type:

Real Estate Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable agency that meets industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Residential Services (1-2 Bed AFH)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02013 group living, other
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 4:	**Sub-Category 4:**
02 Round-the-Clock Services	02021 shared living, residential habilitation

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential services are a combination of individually tailored supports, services, treatment, and care provided within a community-integrated residential setting above the level of room and board. These services are designed to support a participant in the most integrated residential setting appropriate to meet their needs. Residential services include supervision, social development, behavior supports, medication administration, and ongoing daily support. The scope of residential services also includes other waiver services such as personal care, supportive home care, and daily living skills; however, such activities may not comprise the entirety of the service. Residential services also include collaboration with health care, vocational, or day service providers.

The residential service provider and participant must maintain an agreement which specifies the nature and scope of the services provided. All services performed by the provider are included in the residential provider's rate.

Participants may purchase individual services from separate providers. In these cases, residential service providers must also coordinate with those external service providers. Supportive home care may only be provided by an external party when the care takes place outside of the residential setting.

This service category excludes the cost of room and board, items of comfort or convenience, or costs related to building maintenance, upkeep, or improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix I-5.

Provider-controlled settings must be certified or licensed according to their setting and service provision. Provider-controlled settings that act as providers of residential services are excluded from providing separate support services; all support-related services must be included in the provider's rate under the correct residential service category.

A provider-controlled setting is a setting in which participants who are not related to the provider or operator reside and receive support and services above the level of room and board, and:
a. The provider has a direct or indirect financial relationship with the property owner but does not lease or own the property, or
b. The property owner or provider has influence over which service providers the participant uses, or
c. The provider has influence over whether a participant is accepted for residency, or
d. The provider holds the lease or title to the home in which the participant resides.

Residential service providers may also be eligible to receive retainer payments, in accordance with the SMA retainer payment policy. See the supportive home care waiver service for additional details regarding allowable retainer payments and applicable requirements.

The residential provider must immediately report to the local Adult Protective Services unit and/or local law enforcement regarding any incident, situation, or condition that endangers the health or safety of the participant living in the residential setting. All providers of residential services must also communicate with the certifying or licensing agency, the participant's ICA, and applicable providers, within confidentiality laws, about any critical incidents that occur in the residential setting, as soon as practicable.

Residential services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified 1-2 Bed Adult Family Home
Individual	Certified 1-2 Bed Adult Family Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Residential Services (1-2 Bed AFH)

Provider Category:

Agency

Provider Type:

Certified 1-2 Bed Adult Family Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes (AFH)

Other Standard *(specify):*

HCBS compliant per 42 CFR § 441.301(c)(4)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Residential Services (1-2 Bed AFH)

Provider Category:

Individual

Provider Type:

Certified 1-2 Bed Adult Family Home

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wisconsin Medicaid Standards for Certified 1-2 Bed Adult Family Homes (AFH)

Other Standard *(specify):*

HCBS compliant per 42 CFR § 441.301(c)(4)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Residential Services (Other)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**
02 Round-the-Clock Services	02013 group living, other
Category 3:	**Sub-Category 3:**
02 Round-the-Clock Services	02031 in-home residential habilitation
Category 4:	**Sub-Category 4:**
02 Round-the-Clock Services	02023 shared living, other

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Residential services are a combination of individually tailored supports, services, treatment, and care provided within a community-integrated residential setting above the level of room and board. These services are designed to support a participant in the most integrated residential setting appropriate to meet their needs. Residential services include supervision,

social development, behavior supports, medication administration, and ongoing daily support. The scope of residential services also includes other waiver services such as personal care, supportive home care, and daily living skills; however, such activities may not comprise the entirety of the service. Residential services also include collaboration with health care, vocational, or day service providers.

The residential service provider and participant must maintain an agreement which specifies the nature and scope of the services provided. All services performed by the provider are included in the residential provider's rate.

Unless the residential setting is required to provide a service, the participants may purchase individual services from separate providers. In these cases, residential service providers must also coordinate with those external service providers. Supportive home care may only be provided by an external party when the care takes place outside of the residential setting.

This service category excludes the cost of room and board, items of comfort or convenience, or costs related to building maintenance, upkeep or improvement. The method by which the costs of room and board are excluded from payment for Residential Services is specified in Appendix I-5.

All providers of this service category are considered to be provider-controlled settings. Provider-controlled settings must be certified or licensed according to their setting and service provision. Provider-controlled settings that act as providers of residential services are excluded from providing separate support services; all support-related services must be included in the provider's rate under the correct residential service category.

A provider-controlled setting is a setting in which participants who are not related to the provider or operator reside and receive support and services above the level of room and board, and:
a. The provider has a direct or indirect financial relationship with the property owner but does not lease or own the property, or
b. The property owner or provider has influence over which service providers the participant uses, or
c. The provider has influence over whether a participant is accepted for residency, or
d. The provider holds the lease or title to the home in which the participant resides.

Residential service providers may also be eligible to receive retainer payments, in accordance with the SMA retainer payment policy. See the supportive home care waiver service for additional details regarding allowable retainer payments and applicable requirements.

The residential provider must immediately report to the local Adult Protective Services unit and/or local law enforcement regarding any incident, situation, or condition that endangers the health or safety of the participant living in the residential setting. All providers of residential services must also communicate with the certifying or licensing agency, the participant's ICA, and applicable providers, within confidentiality laws, about any critical incidents that occur in the residential setting, as soon as practicable.

Residential services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified Residential Care Apartment Complex
Agency	Licensed Adult Family Home

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Residential Services (Other)

Provider Category:

Agency

Provider Type:

Certified Residential Care Apartment Complex

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Wis. Admin. Code ch. DHS 89

Other Standard *(specify):*

HCBS compliant per 42 CFR § 441.301(c)(4)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Residential Services (Other)

Provider Category:

Agency

Provider Type:

Licensed Adult Family Home

Provider Qualifications

License *(specify):*

Wis. Admin. Code ch. DHS 88

Certificate *(specify):*

Other Standard *(specify):*

HCBS compliant per 42 CFR § 441.301(c)(4)

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Small Group Supported Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03022 ongoing supported employment, group
Category 2:	**Sub-Category 2:**
03 Supported Employment	03010 job development
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Small group supported employment services provide a combination of person-centered career exploration, career planning, and employment training activities in integrated community settings. This service is provided alongside the general workforce in regular business or industry for groups of two to six workers. Small group supported employment must be provided in a manner that promotes integration into the workplace and integration between participants and people without disabilities in those workplaces. Examples include mobile crews, enclaves, and other business-based workgroups who

employ small groups of workers with disabilities in a community setting. Small group supported employment does not include services provided in facility-based work settings.

Participants must have a goal or outcome of at least part-time competitive integrated employment (CIE) in their service plan to receive this service. The expected outcome of this service includes gains in knowledge, skills, personal strengths, and experiences, which contribute to the participant pursuing, achieving, or sustaining CIE. CIE is defined in the SMA program resources.

Small group supported employment services include:
• Career exploration and development leading to at least part-time participation in CIE. Career exploration activities must be provided in integrated community settings where such activities typically take place for individuals not receiving waiver services. Activities include:
o Business tours and informational interviews;
o Small group discovery;
o Meeting with prospective employers;
o Small group educational opportunities focused on key aspects of CIE;
o Division of Vocational Rehabilitation (DVR) orientation;
o Soft skill education and training opportunities;
o Developing transportation and mobility skills; and
o Identification of need and referral for work incentive benefits analysis.
• Work experiences matched to a participant's interest, strengths, skills, abilities, and conditions for success while being transferable to CIE;
• Supports expected to maximize participant independence and skill acquisition, utilizing systematic instruction based on job analysis, along with individualized assistive or adaptive devices and support; and
• Other workplace support services that are not specifically related to job skill training that enable the participant to be successful in work and other community settings where this service is provided.

Small group supported employment does not include payment for supervision, training, support, or adaptations that are typically available to workers without disabilities who fill similar positions in the business.

Small group supported employment services may only be provided in non-disability-specific settings in the community, which are not leased, owned, operated, or controlled by a service provider. These services may not include volunteer work.

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

These services may be provided to supplement, but not duplicate services that are available and provided to a participant as part of an approved Individualized Plan for Employment (IPE), funded under the Rehabilitation Act of 1973, as amended, or under an approved Individualized Education Plan (IEP), under the Individuals with Disabilities Education Act (IDEA). Prior to authorizing this service, the participant's record documents that this service is not otherwise available to the participant through a program funded by Vocational Rehabilitation under section 110 of the Rehabilitation Act of 1973, as amended, and, for participants ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

This service does not include incentive payments, subsidies, or unrelated vocational training expenses, including the following:
• Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment, or
• Wages or other payments that are passed through to users of supported employment services.

Participants engaged in elements of this service that involve work shall be compensated in accordance with applicable Federal and State laws and regulations.

Personal care services and transportation between the participant's place of residence and the setting may be provided as a component of this service (transportation between the service setting and any community site is always included in this service and provider's rate). The cost of these services is included in the rate paid to providers of these services.

Small group supported employment services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is

provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Small Group Supported Employment

Provider Category:

Agency

Provider Type:

Supported Employment Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Setting is HCBS compliant per 42 CFR § 441.301(c)(4), and

At least one of the following:
• Division of Vocational Rehabilitation (DVR) contracted provider of Supported Employment or Customized Employment; or
• Accreditation by a nationally recognized accreditation agency; or
• A minimum of two years of experience working with the target population providing employment-related servicesin the community.

If transportation services are provided, the provider must meet the qualifications for Community Transportation.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized medical equipment and supplies include items, devices, equipment, or supplies necessary to maintain the participant's health, manage a medical or physical condition, improve or maintain functioning, or enhance independence. The costs of routine maintenance and applicable warranties for such medical equipment and supplies are also included. Any item, device, equipment, or supply provided must be of direct medical or remedial benefit to the participant and must not be otherwise available to the participant through the Medicaid State Plan.

Items, devices, equipment, and supplies covered under this service category include:
• Over the counter medications with a National Drug Code (NDC) if not covered under the State Plan drug benefit and when prescribed by any licensed and authorized prescriber;
• Medically necessary prescribed skin conditioning lotions and lubricants;
• Prescribed Vitamin D, a prescribed multivitamin, and prescribed calcium supplements;
• Electronic medication management devices;

• Books and other therapy aids that are designed to augment a professional therapy or treatment plan; and
• Room air conditioners, humidifiers, and water treatment systems, when needed to support a participant's health and safety outcomes.

Acquisition of all specialized medical equipment and supplies is subject to program policy consistent with this service definition and must be cost-effective. Items, devices, equipment, and supplies under this service category are in addition to medical supplies and equipment available under the State Plan, and therefore require a documented decision from State Plan Medicaid prior to acquisition. All specialized medical equipment and supplies require a qualified health care professional's order demonstrating medical or behavioral necessity.

Items not regulated by the federal Food and Drug Administration (FDA) as nutritional or dietary supplements are excluded unless specifically covered under the Medicaid state plan.

All specialized medical equipment and supplies must meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory (UL) and Federal Communication Commission (FCC).

Specialized medical equipment and supplies may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated and bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment and Medical Supply Vendor
Agency	Licensed Pharmacy
Agency	Other Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment and Medical Supply Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Wis. Admin. Code § DHS 105.40

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Licensed Pharmacy

Provider Qualifications

License *(specify):*

Wis. Stat. ch. 450

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

Other Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Reputable vendor that meets industry standards

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Support Broker Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A support broker is an individual who assists a participant by providing them with individualized support in maintaining a variety of public assistance benefits (i.e., energy assistance programs, FoodShare, etc.).

Support brokers must be knowledgeable of public benefit programs, of the general support needs of individuals in a participant's target group, and of other local community-integrated services and resources available to the participant. The participant is responsible for assuring that a support broker has the applicable knowledge.

Support brokers must be independent of any other waiver service provider.

This service may not duplicate the role of the IRIS Consultant Agency (ICA) or Fiscal Employer Agent (FEA) as defined by the program. This service may not operate as a case management service.

Participant employer authority and budget authority responsibilities may not be delegated to this service.

Support broker services may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Support Broker
Agency	Support Broker Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Support Broker Services

Provider Category:

Individual

Provider Type:

Individual Support Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual may be considered a qualified support broker only when they demonstrate adequate knowledge of the unique needs/preferences of the participant and the participant's specific target group, and they have knowledge of the local service delivery system and local resources available to the participant. The participant decides the amount and type of training they require of the support broker.

Knowledge of the unique needs/preferences of the participant and the service system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Support Broker Services

Provider Category:

Agency

Provider Type:

Support Broker Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual may be considered a qualified support broker only when they demonstrate adequate knowledge of the unique needs/preferences of the participant and the participant's specific target group, and they have knowledge of the local service delivery system and local resources available to the participant. The participant decides the amount and type of training they require of the support broker.

Knowledge of the unique needs/preferences of the participant and the service system.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supportive Home Care

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
08 Home-Based Services	08040 companion
Category 3:	**Sub-Category 3:**
08 Home-Based Services	08050 homemaker
Category 4:	**Sub-Category 4:**
08 Home-Based Services	08060 chore

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supportive home care (SHC) is the direct and indirect assistance with daily functions and individualized needs, to assure adequate functioning and safety in a participant's home and community. SHC services are comprised of supports or tasks, such as:

• Companion or attendant supports necessary for participant safety at home and in the community. This may include observation or indirect assistance with the following: verification of appropriate self-administration of medications, meal preparation, bill payment, communication, schedule and/or appointments attendance; completion of activities detailed in occupational or physical therapy treatment plans; arrangement and/or usage of transportation; and personal assistance in non-employment related community activities.
• Chore services that assist the participant to maintain their home environment in a clean, sanitary, and safe manner. Intermittent major household tasks that must be performed seasonally or in response to some natural or other periodic event are also covered.
• Routine care services that perform direct care services, such as physical assistance or personal care. However, personal care activities may not comprise the entirety of this service category. When personal care is available to the participant through the Medicaid State Plan, it must be utilized prior to the authorization of any personal care under this service category.

When a participant requires assistance to train newly hired support staff, additional staff coverage may be authorized to permit existing staff to provide onboarding training to new support staff. Onboarding training coverage is not available for agency providers. The requirements regarding onboarding training are further detailed in SMA policy.

This service also covers the cost of community involvement supports. Community involvement supports assist the participant with engagement in community-integrated events and activities, through the coverage of expenses for support staff to accompany a participant, specifically when a participant's attendance is dependent on staff accompaniment. Coverable expenses include the cost of transportation, attendance or admittance expenses, and meal expenses. This is limited to participant-hired worker's expense only; the participant portion of the expense is the responsibility of the participant. Community involvement support is not available for agency providers.

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

The participant shall determine the amount of the per diem retainer payment, not to exceed 75% of the authorized rate amount, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member. Retainer payments may be made under the following medically related and non-medically related circumstances as applicable to the participant:

Medically Related
• Hospitalization;
• Nursing home or ICF-I/ID admission;
• Receipt of medical or rehabilitative care entailing at least an overnight absence; or
• Participation in a therapeutic rehabilitative program as defined in Wis. Admin. Code § DHS 101.03(175).

Non-Medically Related
• Planned vacation entailing at least an overnight absence and unaccompanied by the worker;
• Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence;
• Obtaining education, employment, or job, habilitative or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or
• Recreational activities unaccompanied by the worker entailing at least an overnight absence.

Provider-controlled settings must be certified or licensed according to their setting and service provision. Provider-controlled settings that act as providers of residential services are excluded from providing separate support services; all support-related services should be included in the provider's rate under the correct residential service category.

A provider-controlled setting is a setting in which participants who are not related to the provider or operator reside and receive support and services above the level of room and board, and:
a. The provider has a direct or indirect financial relationship with the property owner but does not lease or own the property, or
b. The property owner or provider has influence over which service providers the participant uses, or
c. The provider has influence over whether a participant is accepted for residency, or
d. The provider holds the lease or title to the home in which the participant resides.

Supportive Home Care may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supportive Home Care Agency
Individual	Individual Worker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Home Care

Provider Category:

Agency

Provider Type:

Supportive Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The scope of the required provider standards for this service is described in SMA program policy: IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards (P-03071).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supportive Home Care

Provider Category:

Individual

Provider Type:

Individual Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The scope of the required provider standards for this service is described in SMA program policy: IRIS (Include, Respect, I Self-Direct) Support Services Provider Training Standards (P-03071).

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Training Services for Unpaid Caregivers

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

Training services includes instruction about treatment regimens and other services that are included in the participant's service plan, use of equipment specified in the service plan, and supports required to safely maintain the participant within the community. This service includes online or in-person training, conferences, and educational resources on the specific disabilities, illnesses, or conditions that affect the participant. Training services must provide the caregiver with more information about the participant's condition, what to expect, and how to provide the best care and support for someone with that specific condition.

Training services must assist the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the service plan and must directly relate to the individual's role in supporting the participant to meet their identified long term care needs.

Training services includes registration costs and fees associated with formal instruction in areas that are relevant to the needs identified in the participant's service plan.

This service excludes:
• Training services provided to paid caregivers/providers;
• Services provided to or expenses incurred by a participant; and
• Payment for lodging and meal expenses.

Training services for unpaid caregivers may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Trainer
Agency	Training/Service Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training Services for Unpaid Caregivers

Provider Category:

Individual

Provider Type:

Individual Trainer

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

This training must be provided by accredited professionals who maintain current credentials in their field of practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Training Services for Unpaid Caregivers

Provider Category:

Agency

Provider Type:

Training/Service Agency

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

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

Other Standard *(specify):*

This training must be provided by accredited professionals who maintain current credentials in their field of practice.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Vehicle modifications are physical adaptations to the vehicle which is the participant's primary means of transportation. Vehicle modifications accommodate the specialized needs of a participant and enable the participant to function with greater independence in the community. This service category also includes the cost of materials, services, inspections, and maintenance necessary for a vehicle modification.

Vehicle modifications covered under this waiver service include:
• Customized devices necessary for the participant to be transported safely in the community, including tie-downs and wheelchair docking systems;
• Driver control devices, including hand controls and pedal adjusters;
• Safety inspections required for a modification (at time of purchase and annually);

• Interior alterations to seats, head and leg rests, and belts;
• Modifications needed to accommodate a participant's sensitivity to sound, light, or other environmental conditions;
• Portable ramps when the sole purpose of the ramp is for the participant to access the vehicle;
• Raising the roof or lowering the floor to accommodate wheelchairs; and
• Vehicular lifts, platforms, carriers, and curbsiders.

Acquisition of all modifications, including use of SMA conducted accessibility assessments, is subject to program policy consistent with this service definition and must be cost-effective.

This service category excludes:
• Modifications to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the participant;
• Modifications to vehicles that are owned or leased by agency providers of waiver services;
• Modification costs that exceed the value of the vehicle to be modified;
• Materials that exceed the industry standards or are for cosmetic benefit only, including autonomous vehicle technology;
• Purchase or lease of a vehicle (however, this service category can be used to fund the portion of a new or used vehicle purchase that directly relates to the cost of accessibility adaptations); and
• Regularly scheduled upkeep and maintenance of a vehicle or of any modifications made, regardless of funding source.

All vehicle modifications must meet all the applicable standards of manufacture, safety, design and installation such as Underwriters Laboratory (UL) and Federal Communication Commission (FCC).

Vehicle modifications may only be funded through the waiver when otherwise not available through the State Plan, Medicare, EPSDT (for participants ages 18-21), or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☐ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Motor Vehicle Modifier

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:
Agency
Provider Type:
Motor Vehicle Modifier

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Provider must be registered as a “vehicle modifier” with the National Highway Traffic Safety Administration (49 CFR § 595.6);
• Provider must meet requirements outlined in 49 CFR § 595.7; and
• Provider must install equipment according to the manufacturer’s requirements and instructions.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

At time of authorization

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Virtual Monitoring and Emergency Response Systems

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
17 Other Services	17990 other
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Virtual monitoring and emergency response systems is the provision of real-time monitoring services by trained professionals providing support from a secondary location and the provision of systems that allow participants to access emergency response services. This service ensures a participant's ability to safely remain in their home and community with the least invasive level of support necessary, while decreasing reliance on paid on-site staff and avoiding placement in a more restrictive environment.

Virtual Monitoring:
This service provides virtual monitoring and support provided through non-invasive monitoring technology, such as devices, sensors, and communication systems that allow staff operating from a secondary location to monitor and communicate with participants who do not require physical assistance or support. This service also includes communication with back-up supports when needed in the event of an equipment malfunction or when the participant needs unplanned in-person assistance, or with EMS in the event of an emergency. All equipment necessary for the provision of virtual monitoring must be supplied by the provider, including installation, upkeep, and maintenance of equipment.

The participant and any individuals living with the participant must be fully informed of what virtual monitoring is being provided and must consent in writing to the use of virtual monitoring systems, including for the types, locations, and schedule of use of remote monitoring systems, prior to use. The participant and/or individuals living with the participant may retract their consent at any time. If consent is retracted, the systems/equipment must be turned off and removed and back-up or necessary in-person supports authorized as soon as possible. Additionally, the participant has a right to turn off monitoring equipment at any time and must be provided with instructions on how to turn off the equipment.

Personal Emergency Response Systems (PERS):
This service also includes PERS which are electronic devices or systems that provide a direct telephonic or other electronic communications link between someone living in the community and health professionals to secure immediate response and assistance in the event of a physical, emotional, or environmental emergency. This service includes devices and services necessary for operation of PERS when those devices and services are otherwise not available. This service also includes installation, upkeep, and maintenance of devices or systems as appropriate.

This service category includes initial training and technical assistance specific to all virtual monitoring and emergency response systems. This training and technical assistance will be provided to the participant, family members, and any individuals living with the participant, as applicable. This includes:
• Informing the participant of the control they will have over the equipment, including how the participant can turn off any monitoring systems or equipment present.
• A description or tour of where devices or monitors will be placed, including the locations of monitors and scheduled times of use.

Before authorizing virtual monitoring and emergency response systems, the participant, service provider, and ICA must develop and document a back-up support plan in the event of an emergency, equipment malfunction, or if the participant otherwise requires unplanned in-person assistance.

This service excludes:
• Funding for the installation and/or monthly cost of landline service;
• Funding for the installation and/or monthly cost of internet services (this service may only be authorized for participants who already have access to necessary internet services);
• Any monitoring systems or equipment with audio or video feed that is being placed in bedrooms or bathrooms; and
• Monitoring services that are evaluated to be functionally inequivalent to the service's in-person modality for the requesting participant, as further defined in SMA policy.

Virtual monitoring and emergency response systems may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

☒ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Virtual Support Provider
Agency	PERS Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Virtual Monitoring and Emergency Response Systems

Provider Category:

Agency

Provider Type:

Virtual Support Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

• Provider follows UL or FCC standards for electronic devices, if applicable.
• Provider maintains a secure network system compliant with 45 C.F.R. Part 164.
• Provider has written policies and procedures that define emergency situations and detail how virtual support staff will respond.
• Provider has safeguards or emergency back-up systems, such as batteries or generators, at the virtual support center and for use in the participant's home.
• Provider trains staff on the ability to recognize and respond to emergencies, first-aid, participant health, safety, and welfare, privacy and confidentiality, participant rights, and participant-specific information and individual needs.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Virtual Monitoring and Emergency Response Systems

Provider Category:

Agency

Provider Type:

PERS Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

UL standards for electronic devices or FCC regulations for telephonic devices

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Prior to authorization (and annually, if applicable)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vocational Futures Planning and Support

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Vocational Futures Planning and Support (VFPS) is a person-centered, team-based comprehensive employment planning and support service that assists the participants to obtain, maintain, or advance in competitive integrated employment (CIE), including self-employment and microenterprise. CIE is defined in the SMA program resources. This service assists a participant in identifying a pathway to CIE and addresses barriers to employment due to the participant's disability, benefits, or life circumstances. The expected outcome of this service includes measurable gains in knowledge, skills, personal strengths, and experiences that contribute to the participant obtaining and sustaining CIE with the highest possible wage. This service may not be authorized for a participant who has already obtained CIE outside the VFPS process or does not have a goal to advance in CIE.

VFPS includes the development of an employment plan based on these seven elements:
• Coordination of the VFPS process;
• Development of a written employment plan based on an individualized person-centered determination of the participant's strengths, assets, needs, interests, conditions for success, and barriers to CIE;
• An employment-focused assistive technology pre-screen or in-depth assessment;
• Work incentive benefits analysis;
• Career exploration and goal validation;
• Job seeking support, including customized job negotiation or business plan development and launch; and,
• Job coaching, including systematic instruction to stabilize the participant in CIE or workplace personal assistance (WPA) support to maintain CIE.

This service may not be provided in small group format. The ratio is always 1:1 for this service. This service may not be used to support volunteering, regardless of where the service takes place.

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

Personal care services and transportation between the participant's place of residence and the setting may be provided as a component of this service (transportation between the service setting and any community site is always included in this service and provider's rate). The cost of these services is included in the rate paid to providers of these services.

These services may be provided to supplement, but not duplicate services that are available and provided to a participant as part of an approved Individualized Plan for Employment (IPE), funded under the Rehabilitation Act of 1973, as amended, or under an approved Individualized Education Plan (IEP), under the Individuals with Disabilities Education Act (IDEA). Prior to authorizing this service, the participant's record documents that this service is not otherwise available to the participant through a program funded by Vocational Rehabilitation under section 110 of the Rehabilitation Act of 1973, as amended, and, for participants ages 18-22, not available through a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq).

VFPS may only be funded through the waiver when otherwise not available through the State Plan, Medicare, or a responsible private or public entity. Waiver funds may not be used to purchase this service if it is otherwise provided to the

general public for free. This service may not be duplicated or bundled with any service that is provided under another waiver service category, such as prevocational or supported employment services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service Delivery Method *(check each that applies)*:

- ☒ **Participant-directed as specified in Appendix E**
- ☒ **Provider managed**
- ☒ **Remote/via Telehealth**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Vocational Futures Planning and Support Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vocational Futures Planning and Support

Provider Category:

Agency

Provider Type:

Vocational Futures Planning and Support Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Vocational Futures Planning and Support agency must offer all seven elements of the service, and

At least one of the following:
• A DVR contracted provider of Supported Employment and/or Customized Employment services; or
• Accreditation by a nationally recognized accreditation agency; or
• A minimum of two years of experience working with the target population providing employment-related services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Fiscal Employer Agent

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

Service
Individual Supported Employment
Life Skills Training and Education
Respite
Assistive Technology
Competitive Integrated Employment (CIE) Exploration
Consultative Clinical and Therapeutic Services for Caregivers
Counseling, Therapeutic, and Wellness Services
Housing Counseling
Individual Directed Goods and Services
Relocation - Community Transition Services
Small Group Supported Employment
Support Broker Services
Supportive Home Care
Training Services for Unpaid Caregivers
Virtual Monitoring and Emergency Response Systems
Vocational Futures Planning and Support

1. Will any in-person visits be required?

- ○ **Yes.**

◉ **No.**

2. *By checking each box below, the state assures that it will address the following when delivering the service remotely/via telehealth.*

☒ **The remote service will be delivered in a way that respects privacy of the individual especially in instances of toileting, dressing, etc.** ***Explain:***

Remote service delivery and the placement of devices for this service delivery method must respect the privacy of the participant, especially in instances of toileting, dressing, and other personal cares. Remote services must be conducted using encrypted, HIPAA compliant video infrastructure to ensure privacy and security with all communications.

Devices or equipment for remote service delivery with audio or video feed functionality may not be placed in bedrooms or bathrooms. However, devices or equipment for remote service delivery without audio or video feed functionality may be placed in bedrooms or bathrooms if all the following requirements are discussed with the participant and documented in the participant's service plan to determine why placement in the bedrooms or bathrooms are necessary:
a. Identification of a specific and individualized assessed need.
b. Positive interventions and supports used prior to any modifications to the person-centered service plan.
c. Less intrusive methods of meeting the need that have been tried but did not work.
d. A clear description of the condition that is directly proportionate to the specific assessed need.
e. Regular collection and review of data to measure the ongoing effectiveness of the device or equipment for remote service delivery.
f. Established time limits for periodic reviews to determine if the device or equipment for remote service delivery is still necessary or can be terminated.
g. Include written, informed consent of the participant.
h. An assurance that interventions and supports will cause no harm to the participant.

☒ **How the telehealth service delivery will facilitate community integration.** ***Explain:***

Remote service delivery allows participants greater accessibility to services and supports previously limited by geographic distance, while also encouraging participant independence and access to care with flexibility and minimization of barriers to access the community. To ensure remote service delivery facilitates community integration, the participant and the ICA determine if remote service delivery is functionally equivalent to in-person service delivery and complements, not replaces, an in-person support or service. It also assessed whether the remote services and support enhances the participant's ability to live, work, and meaningfully participate in the community. With proper functional equivalence, remote service delivery provides participants an alternative to more restrictive settings while promoting access to services and providers in the broader community.

☒ **How the telehealth will ensure the successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service can be rendered without someone who is physically present or is separated from the individual.** ***Explain:***

Remote service delivery enhances or increases a participant's independence and ability to live, work, or meaningfully participate in the community by providing real-time support using two-way communication and non-invasive monitoring technology. Non-invasive monitoring technology allows participants to communicate with offsite, remote staff who communicate with participants without providing direct, physical assistance. Services are provided by trained off-site professionals and staff who deliver live support offsite, decreasing reliance on paid on-site professionals and staff and avoiding placement in a more restrictive environment. For participants who determine a clear and proper functional equivalence, remote service delivery enhances successful delivery of services when hands-on, in-person, physical assistance is not required. Without clear functional equivalence, services cannot be delivered remotely.

☒ **How the state will support individuals who need assistance with using the technology required for telehealth delivery of the service.** ***Explain:***

Before implementation of remote service delivery, the service provider must demonstrate a comprehensive training to the participant, family members, all required team members, and any individuals living with the participant, as applicable. This training must include providing all necessary user guides and tutorials on how to use the remote service platforms, devices, and technologies.

Training and technical assistance must also include:
• Informing the participant of the control they will have over the equipment, including how the participant can turn off any monitoring systems or equipment present.
• A description or tour of where devices or monitors will be placed, including the locations of monitors and scheduled times of use.

Additionally, before the authorization of remote service delivery, the participant must develop and document a back-up plan in the event of an emergency or equipment malfunction, which includes back-up power sources, alarms, additional resources to assist, or if the participant requires in-person assistance in the absence of the remote service.

☒ **How the telehealth will ensure the health and safety of an individual.** ***Explain:***

During each in-person visit and annual plan review performed by the ICA, the health and safety of the participant utilizing remote service delivery will be evaluated by the ICA and participant. They will assess whether the service continues to meet the participant's goals and ensure that the services being provided continue to maintain functional equivalence. Additionally, the participant's back up plan is also reviewed and updated, if necessary, to ensure it continues to safely support the participant in the event of an emergency or equipment malfunction.

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

○ **No. Criminal history and/or background investigations are not required.**

◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a. In accordance with SMA IRIS program policy, it is a program requirement that all Medicaid-reimbursed participant-hired workers and individual providers aged 18 years of age or older pass the IRIS background check, which requires passing a criminal background check and a caregiver background check as described in the IRIS SMA program policy: https://www.dhs.wisconsin.gov/publications/p0/p00708a.pdf.

b. The program's scope of the required criminal and caregiver background checks includes a review of any applicable employment settings for the care, safety, and security of program participants, as well as a review of any criminal conviction record. The criminal background check includes a search of a predetermined set of criteria from the records of the Wisconsin Department of Justice. If the applicant or ongoing participant-employed provider resided outside of Wisconsin or outside of the United States within the last three years, the criminal history search will include that state and/or country. The caregiver background check includes a search of the Wisconsin Caregiver Misconduct Registry, which is maintained by the Wisconsin Department of Health Services. The scope of the required criminal and caregiver background checks is defined in the SMA IRIS program policy as described here: https://www.dhs.wisconsin.gov/publications/p0/p00708a.pdf.

c. To be qualified to receive reimbursement from Medicaid, it is a program requirement that participant-hired workers and individual providers aged 18 years of age or older pass criminal and caregiver background checks. The Fiscal Employer Agent (FEA) is required by contract to ensure that individuals aged 18 years of age or older who are applying to work as a participant-hired worker or individual provider pass the criminal and caregiver background checks prior to providing Medicaid-reimbursed services to the participant. During a participant-hired worker's or individual provider's subsequent ongoing employment with the IRIS participant, the FEA is required by contract to ensure that all participant–hired workers and individual providers aged 18 years of age or older pass subsequent criminal and caregiver background checks every four years and on an ad hoc basis throughout the duration of employment to remain qualified to receive reimbursement from Medicaid. The FEA is required by contract to establish and utilize a tracking process to ensure that subsequent ongoing background checks are conducted within 60 days prior to each four-year anniversary of employment. Upon participant request, the FEA is required to provide the criminal and caregiver background check results to the participant in their entirety. The FEA is required to notify the participant of the applicant's and/or ongoing participant-employed provider's Medicaid reimbursement qualification status by mail within three business days of the FEA's receipt of the criminal and caregiver background check results in their entirety. FEA notification to the participant by mail is required to include identification and disclosure of conviction(s) and/or caregiver misconduct finding(s) that are categorized as Serious Crimes, Mandatory Disclosure Crimes, and Caregiver Misconduct Findings in the SMA IRIS program policy. Additionally, there are escalated FEA participant notification requirements described in the SMA IRIS program policy if the participant is required to inform the participant-employed provider that the FEA will not process any future payment for services because the participant-employed provider did not pass the four-year or ad hoc background checks and is unqualified to receive reimbursement from Medicaid. The SMA IRIS program policy is available at https://www.dhs.wisconsin.gov/publications/p0/p00708a.pdf. The SMA will verify that agency providers comply with background check requirements by ensuring the agency's attestation that the background checks were completed. The SMA will conduct reviews of samples of participant-hired workers to ensure the completion of these background checks.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; (c) the process for ensuring that mandatory screenings have been conducted; and (d) the process for ensuring continuity of care for a waiver participant whose service provider was added to the abuse registry. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a. The SMA, as required under Wis. Stat. § 146.40 and Wis. Admin. Code §§ DHS 13, maintains a registry of caregivers as an official record of persons found to have abused or neglected a client or misappropriated a client's property. The ICAs, FEA, and all other entities that are licensed by, certified by, or registered with the SMA to provide direct care or treatment services to clients, are required to report to the SMA any allegation of abuse, neglect, or misappropriation of client's property committed by any person who is employed by or under contract with the entity if the person is under the control of the entity.

b. Positions for which caregiver misconduct registry screenings must be conducted include all waiver service providers included in the service plan who have regular, direct contact with waiver participants and all persons employed by or under contract with an entity that is licensed or certified by or registered with the SMA to provide direct care or treatment services to clients.

c. The FEA is required by contract to ensure that individuals aged 18 years of age or older that are employed by the participant as participant-hired workers or individual providers pass required caregiver misconduct registry checks. The FEA will conduct caregiver misconduct registry checks for participant-hired workers and individual providers and will verify that agency providers comply with caregiver misconduct registry check requirements. The SMA conducts reviews of the providers' performance to ensure required caregiver misconduct registry checks are completed and ensures a related performance measure is in place to report compliance with this activity.

d. If a waiver participant's provider is added to the Caregiver Misconduct Registry, continuity of care will be maintained by the participant utilizing and implementing their individualized IRIS back-up plan, which is a required comprehensive document that addresses contingencies such as emergencies, including instances when the participant's primary caregiver or other service or support provider, excluding an agency provider, is not available for a short period of time. Additional information for participant implementation of the back-up plan is described in both the IRIS Background Check Policy and the IRIS Service Plan Policy as described here: https://www.dhs.wisconsin.gov/publications/p0/p00708a.pdf.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Certified Residential Care Apartment Complex

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Individual Directed Goods and Services	☐
Assistive Technology	☐
Environmental Accessibility Adaptations (Home Modifications)	☐
Adult Day Care	☐
Individual Supported Employment	☐
Life Skills Training and Education	☐
Residential Services (Other)	☒
Home Delivered Meals	☐

Waiver Service	Provided in Facility
Consultative Clinical and Therapeutic Services for Caregivers	☐
Training Services for Unpaid Caregivers	☐
Small Group Supported Employment	☐
Respite	☐
Supportive Home Care	☐
Counseling, Therapeutic, and Wellness Services	☐
Nursing Services	☐
Prevocational Services	☐
Community Transportation	☐
IRIS Consultant Agency (ICA) Services	☐
Vehicle Modifications	☐
Vocational Futures Planning and Support	☐
Relocation - Community Transition Services	☐
Day Habilitation	☐
Specialized Medical Equipment and Supplies	☐
Support Broker Services	☐
Competitive Integrated Employment (CIE) Exploration	☐
Residential Services (1-2 Bed AFH)	☐
Housing Counseling	☐
Virtual Monitoring and Emergency Response Systems	☐

Facility Capacity Limit:

No limit (See c.ii.)

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒

Standard	Topic Addressed
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Certified 1-2 Bed Adult Family Home

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Individual Directed Goods and Services	☐
Assistive Technology	☐
Environmental Accessibility Adaptations (Home Modifications)	☐
Adult Day Care	☐
Individual Supported Employment	☐
Life Skills Training and Education	☐
Residential Services (Other)	☐
Home Delivered Meals	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Training Services for Unpaid Caregivers	☐
Small Group Supported Employment	☐
Respite	☐
Supportive Home Care	☐
Counseling, Therapeutic, and Wellness Services	☐
Nursing Services	☐
Prevocational Services	☐
Community Transportation	☐
IRIS Consultant Agency (ICA) Services	☐
Vehicle Modifications	☐
Vocational Futures Planning and Support	☐
Relocation - Community Transition Services	☐

Waiver Service	Provided in Facility
Day Habilitation	☐
Specialized Medical Equipment and Supplies	☐
Support Broker Services	☐
Competitive Integrated Employment (CIE) Exploration	☐
Residential Services (1-2 Bed AFH)	☒
Housing Counseling	☐
Virtual Monitoring and Emergency Response Systems	☐

Facility Capacity Limit:

1 or 2 residents

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

Licensed Adult Family Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Individual Directed Goods and Services	☐
Assistive Technology	☐
Environmental Accessibility Adaptations (Home Modifications)	☐
Adult Day Care	☐
Individual Supported Employment	☐
Life Skills Training and Education	☐
Residential Services (Other)	☒
Home Delivered Meals	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Training Services for Unpaid Caregivers	☐
Small Group Supported Employment	☐
Respite	☐
Supportive Home Care	☐
Counseling, Therapeutic, and Wellness Services	☐
Nursing Services	☐
Prevocational Services	☐
Community Transportation	☐
IRIS Consultant Agency (ICA) Services	☐
Vehicle Modifications	☐
Vocational Futures Planning and Support	☐
Relocation - Community Transition Services	☐
Day Habilitation	☐
Specialized Medical Equipment and Supplies	☐
Support Broker Services	☐
Competitive Integrated Employment (CIE) Exploration	☐
Residential Services (1-2 Bed AFH)	☐
Housing Counseling	☐
Virtual Monitoring and Emergency Response Systems	☐

Facility Capacity Limit:

4 residents

Scope of Facility Sandards. For this facility type, please specify whether the state's standards address the following topics (*check each that applies*):

Scope of State Facility Standards

Standard	Topic Addressed

Scope of State Facility Standards

Standard	Topic Addressed
Admission policies	☒
Physical environment	☒
Sanitation	☒
Safety	☒
Staff : resident ratios	☒
Staff training and qualifications	☒
Staff supervision	☒
Resident rights	☒
Medication administration	☒
Use of restrictive interventions	☒
Incident reporting	☒
Provision of or arrangement for necessary health services	☒

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

a. For the purpose of this waiver program, legally responsible person refers to the spouse of a participant. The spouse of a participant may be paid to provide personal care or similar services as necessary and if they are identified on the participant's service plan. However, personal care and similar services may only be provided as components of adult day care, day habilitation, supportive home care, respite, supported employment, nursing services, and residential services.

b. The spouse may only be paid for services that are above and beyond the ordinary spousal caregiving responsibilities, and only if:
i. The service is identified as necessary, and it is included on the participant's service plan;
ii. The participant's preference is for the spouse to provide the service;
iii. The spouse meets the provider qualifications and standards for the service to be provided and there is a properly executed provider agreement between the FEA and the spouse for providing this service; and
iv. The spouse will either: 1) Provide an amount of service that exceeds the normal care giving responsibilities for a spouse who does not have a disability; or 2) Forego other paid employment options in order to provide the service and is not receiving a pension (including Social Security retirement benefits).

c. The ICA is responsible to ensure that the purchase of service meets the following criteria, which are intended to ensure that the provision of services by a spouse is in the best interest of the participant:
i. The service to be provided meets identified needs and outcomes on the participant's service plan, as well as assures the health, safety, and welfare of the participant;
ii. Purchase of services from the spouse is cost-effective in comparison to purchase of services from another provider; and
iii. Real or potential conflicts of interest for the provider are identified, monitored, and reviewed by the ICA. The ICA's review also assures the participant is able to successfully participate in the self-direction process.

d. For the purposes of this waiver, only spouses are identified as legally responsible persons who can provide waiver services. When a spouse is also a legal decision maker, they are no longer considered a legally responsible person, but rather the legal decision maker of that participant. In these instances, they must follow general state law and program policy regarding substituted decision making.

e. There are no additional limitations specific to legally responsible persons, beyond general service limits that are listed within Appendix C-1/C-3 of this waiver.

f. ICAs are responsible to monitor and document that authorized services are rendered by the spouse in accordance with the participant's service plan. ICAs conduct Fraud Allegation Review and Assessment (FARA) and if necessary, mitigate associated risks, when concerns are raised about potential payment for unworked hours to the participant. When risks or conflicts are identified, the ICA and participant will work together to develop an effective risk agreement. ICAs also conduct announced and unannounced visits, as well as other mitigation strategies. The SMA and its contracted external quality review organization (EQRO) monitor ICAs oversight of all service providers, including legally responsible caregivers. In situations wherein the spouse is the one committing the fraud, the participant will be required to mitigate and/or may be disenrolled from the IRIS program.

g. SMA oversight in the form of accountability and compliance are facilitated in a number of ways: 1) Through the SMA's contractor oversight process which includes ICAs; 2) Through a contract with an external quality review organization (EQRO) that facilitates discovery and remediation activities for ICAs; 3) Monthly meetings with ICAs to discuss performance and/or quality management concerns; and 4) if needed, corrective action plans or performance improvement projects may be initiated.

Additionally, the ICA is responsible for ensuring the accuracy of service authorizations. Service authorizations must be within the scope and duration of the participant's service plan and issued only to providers who meet IRIS program and policy requirements, as well as any additional standards defined in the contract between the SMA and the ICA. The contract outlines expectations and prescribes sanctions for violations and non-compliance. To ensure that payments are made solely for services rendered and to support broader compliance with waiver requirements, the SMA implements a comprehensive oversight framework for all services. This includes verifying that all services are authorized in accordance with assessed needs and do not exceed established service limits. Provider eligibility is confirmed prior to service authorization, ensuring that all providers meet licensure, training, and background check requirements, as well as any contractual obligations. The SMA also uses the Medicaid Management Information

System (MMIS) to validate that submitted claims align with authorized services in both scope and timing.

These integrated procedures and others, serve as critical controls to ensure that services are provided appropriately, by qualified providers, and within the parameters of the participant's approved service plan.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- ○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ○ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ◉ **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

  a. For the purposes of this waiver, a relative is defined as a person related by blood, adoption or marriage, to the participant. Legal guardian is defined in state statute and referred to as a "legal decision maker" in this waiver.

  b. Services are rendered by relatives or legal decision makers when:
  i. The service is identified as necessary and included on the participant's service plan;
  ii. The participant's preference is for the individual to provide the service;
  iii. There is a properly executed provider agreement between the participant and the individual providing the service;

  iv. The individual meets the provider qualifications and standards for the service;
  v. When the legal decision maker is also a spouse, they may be paid only for services that that exceeds the normal caregiving responsibilities for a spouse who does not have a disability or who foregoes paid employment in order to provide the service.

  c. Additionally, ICAs are responsible to monitor and document that authorized services are rendered by the relative or legal decision maker in accordance with the participant's service plan. ICAs conduct FARA reviews and if necessary, mitigate associated risks, when concerns are raised about potential payment for unworked hours to the individual(s). ICAs also conduct announced and unannounced visits, as well as other mitigation strategies. The SMA and its compliance contractor, monitor ICAs oversight of all service providers including relatives and legal decision makers. In situations wherein the relative or legal decision maker is the one committing the fraud, the participant will be required to mitigate and/or may be disenrolled from the IRIS program as a result.

- ○ **Other policy.**

  Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

a. All willing providers who demonstrate evidence of meeting eligibility requirements for provider qualifications and/or standards for the desired Appendix C-1/C-3 service, are eligible to serve IRIS participants. The SMA contracts with the ICAs and FEA and require that those organizations be familiar with provider enrollment procedures, timelines, and responsibilities relative to the verification of provider qualifications and standards.

b. IRIS participants identify the providers that they would like to provide services. The participant's ICA provides the necessary tools, resources, information, and support to assist participants in locating providers. The FEA verifies that the provider meets all applicable requirements.

c. ICAs provide participants the necessary supports and services in support of self-direction by assisting the identified providers to accurately and thoroughly complete provider enrollment and qualification verification, including all required criminal and caregiver background checks. The SMA's enterprise care management system maintains information on providers, including individual workers that are already registered and have had their qualifications including applicable criminal and caregiver background checks verified. In these cases, the provider is immediately available to be selected during the development of the participant's service plan in the SMA's enterprise care management system.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

- (●) **No, the state does not choose the option to provide HCBS in acute care hospitals.**
- ( ) **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*
  - [ ] **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**
  - [ ] **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**
  - [ ] **The HCBS must be identified in the individual's person-centered service plan; and**
  - [ ] **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

And specify: **(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Active participant-hired workers (PHW) must have the appropriate criminal background and caregiver registry checks as verified by the Fiscal Employer Agent (FEA). Numerator/Denominator: Number and percent of active participant-hired workers with appropriate criminal background and caregiver registry checks over Number of active participant-hired workers checked.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System and Fiscal Employer Agent Information System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:

	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Active providers (non-participant-hired worker) must meet the provider verification requirements. Numerator/Denominator: Number of active providers (non-participant-hired workers) who met the provider verification requirements over Number of active providers (non-participant hired worker).

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System and Medicaid Management Information System (MMIS)

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Participants must have a completed IRIS Participant Education Manual: Acknowledgement (F-01947) form. Numerator/Denominator: Number and percent of participants who have a completed IRIS Participant Education Manual: Acknowledgement (F-01947) form over Number of participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

To ensure waiver and program compliance by the contracted FEA and ICAs, the SMA developed performance indicators that aligns with CMS assurances outlined within this Appendix. Discovery and remediation information primarily comes from the Record Review process which is administered through a contract with an external quality review organization (EQRO).

Quarterly, the EQRO conducts the Record Reviews for each contracted entity. The EQRO is responsible for completing all resulting remediation activities and reporting the findings to the SMA. Additionally, the Record Review process allows the SMA to gather information about complaints, appeals and grievances, participant incident reports, and requests for the use of restrictive measures.

Additionally, discovery information is obtained when the EQRO is validating reported performance measures required by the SMA and CMS. Information is also obtained when the EQRO is assessing the quality of services and support coordination functions, assessing compliance with quality standards, and other activities, such as administration or validation of consumer surveys of quality of care.

Contractor oversight operations also provide valuable discovery information. Monthly, the SMA has meetings with individual contractors to discuss any performance and/or quality management concerns.

The SMA expects that by transitioning the provider certification process to the Medicaid Management Information System (MMIS), participant authorizations will be limited to Medicaid certified provider agencies. This shift is expected to enhance quality management by ensuring all participating providers meet established standards, ultimately leading to improved service delivery and better health outcomes.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Quarterly, the SMA meets with each contractor to review the following:
• Remediation activities for Record Review performance indicators below the CMS required threshold;
• Review of all substantiated cases of abuse, neglect, misappropriation and exploitation cases; and
• Review of the contractor Performance Improvement Plans (PIPS) promulgated by the contractor to increase performance and address areas for improvement.

Monthly, the SMA has meetings with individual contractors to discuss any performance and/or quality management concerns. The SMA remediates those concerns accordingly.

Annually, for each contractor, the SMA conducts a “Contractor Recertification Meeting” and also reviews their Participant Satisfaction Survey results with them. Following the meeting, the SMA provides the contractor with the outcome of the Annual Recertification and if necessary, determine next steps.

These processes allow the SMA to confirm remediation of discovered problems and to identify potential areas of concern. The recertification meetings and satisfaction survey results also seek to identify if discovered and potential areas of concern, relate to systemic problems or issues within the contracted agency or the overall program. The SMA remediates these issues accordingly. All activities related to contractor performance will be documented and maintained within the SMA’s Quality Management Plan document for each contractor.

Additionally, a provider participating in the IRIS program is subject to sanctions that may be imposed by the SMA under Wis. Stat. § 49.45(2)(a)(13) and Wis. Admin. Code § DHS 106.08.

Remediation operations are continuously improved and updated so as to gain overall efficiencies within the program. Moreover, waiver amendments exist if systemic problems drastically hinder program operations.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: FEA, ICAs	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

◉ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit,

including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☒ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

IRIS Individual Budget Allocations (IBAs) are established through a model based on historic cost data. The SMA's contracted actuaries develop target group specific regression models to determine which attributes from the SMA's Adult Long-Term Care Functional Screen (LTCFS) are most predictive of a participant's costs as well as the amount of funding predicted by each attribute. An IRIS participant's IBA is calculated by seeing which attributes the member has on the LTCFS, and adding up the funding the regression model has associated with those attributes. Further adjustments, such as for regional cost variance, are applied to the IBA as appropriate to maintain an equitable and cost-effective funding model. This calculation is completed automatically as part of the LTCFS system. The SMA updates the IBA calculation annually.

All services in Appendix C-1/C-3 are funded by this individual budget allocation with the exception of IRIS Consultant Agency (ICA) Services, which is a requirement of participation in the IRIS program and is therefore not funded by the participant's budget.

The participant's LTCFS is completed annually, which will adjust the IBA according to any changes in attributes (e.g., changes in needs with cost-driving factors) that are captured. Participants are notified of their IBA by their ICA following the completion of their LTCFS.

If the participant's IBA is insufficient to meet the needs of the participant, a budget amendment (BA) or one-time expense (OTE) request can be made to the SMA. The SMA reviews all BA/OTE requests and determines if those requests are fully approved, partially approved, or denied. This review is done based on the participant's existing service plan, their identified long-term care needs, and the specific funding request. The review also takes various program requirements into consideration, including cost-effectiveness, medical necessity, maximization of informal supports, utilization of Medicaid State Plan services, and all other funding sources available to the participant.

If a person needs additional services as the result of a change in condition, the participant will report the change in condition to the ICA and a change in condition LTCFS will be administered. Any change in budget will be considered prior to determining the need for a BA or OTE. Participants may exercise their State Fair Hearing rights in cases where BA or OTE requests are denied.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

1) The SMA has assessed and determined that the following settings meet the requirements of 42 CFR § 441.301(c)(4):

1. The SMA has determined that these settings are not provider-owned or provider-controlled residential settings; are integrated in the greater community or, in the case of residences in rural settings, are the participant's choice and are consistent with the characteristics of such communities; does not segregate or isolate participants receiving Medicaid HCBS from the broader community of non-participants not receiving Medicaid HCBS, except with respect to private residences in rural areas where such is the participant's preference; provides opportunities for regular interaction in daily activities with non-participants; facilitates participant's choice in services, daily activities, and assumption of typical, age-appropriate social roles; and supports rights to dignity, respect, autonomy, and freedom from coercion. More details regarding means by which the SMA ascertains that these waiver settings meet federal HCBS Setting requirements, at the time of this submission and ongoing, are included in answer #2 below.

a. Settings where the individual will reside:

i. Participant's private residences; whether owned or rented, including when voluntarily shared with family, friends, or chosen residence mates; that are not regulated residential settings for persons with disabilities.

b. Settings that the individual will receive services:

i. Places of integrated, competitive employment. Per the SMA-DWD joint definition of Competitive Integrated Employment (CIE) (https://dwd.wisconsin.gov/dvr/partners/cie/definition.htm), a CIE location must be "a location where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons" and "must [be] typically found in the community." To be "typically found in the community", an employment setting location should be found in the competitive labor market and not formed for the purposes of employment for individuals with disabilities."

ii. Community sites predominantly used by the general public for typical community activities, unless specifically prohibited by 42 CFR § 441.301(c)(5), including, but not limited to, retail establishments; schools; recreational and entertainment facilities; libraries; places of religious worship; public and private transportation settings, such as buses, trains, and private vehicles; restaurants; community centers; service establishments; streets; and other public accommodations.

2. The second category of settings are settings that are subject to further review to determine if they are in compliance with the HCBS Settings requirements. The following settings are reviewed for compliance with the HCBS Settings Rule on an ongoing basis by the SMA or by contracted entities under the direction of the SMA. In order to accept Medicaid waiver funding and prior to rendering services or supports, the setting must be initially determined to be compliant with the HCBS Settings requirements and must continue to maintain compliance throughout their time providing services or supports. More details regarding means by which the SMA ascertains these waiver settings meet federal HCBS Setting requirements, at the time of this submission and ongoing, are included in answer #2 below.

a. Settings where the individual will reside:

i. Licensed 3-4 bed adult family homes (AFHs): Residences where three or four adults not related to the operator or administrator of the facility live together in a community setting.

ii. Certified 1-2 bed adult family homes (AFHs): Residences where up one or two adults live together in a community setting.

iii. Certified Residential Care Apartment Complexes (RCAC): Homelike, community-based setting where 5 or more adults reside in their own living units that are separate and distinct from each other.

b. Settings where the individual will receive services:

i. Adult day care centers: A nonresidential group setting that provides services for part of a day to adults who need an enriched social or health supportive experience or who need assistance with activities of daily living, supervision, and/or protection.

ii. Day habilitation- facility based service settings: A non-residential setting, separate from the member's private residence or other residential living arrangement, that provides activities and supports to foster the acquisition of generalized skills and opportunities for the member to participate in integrated community-based activities. Day habilitation settings are considered facility-based (as opposed to community-based) when the provider uses a provider owned or controlled setting for any portion of the service delivery.

iii. Prevocational- facility based service settings: A center-based site where individuals receive pre-vocational services intended to enable progression to competitive integrated employment. Prevocational services are considered facility-

based (as opposed to community-based) when the provider uses a provider owned or controlled setting for any portion of the service delivery.

iv. Group-supported employment settings: A setting where a small group of workers receives a combination of person-centered career exploration, career planning, and employment training activities in integrated community settings. Small group employment support does not include services provided in facility-based work settings, but sites are reviewed to ensure compliance.

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

2) The SMA ascertains that all waiver settings meet federal HCBS Setting requirements, at the time of this submission and ongoing, through the following means:

1. Integrated community settings or private residences from #1:
While these settings are viewed as integrated in the community, the SMA does not assume that in each instance they meet the HCBS settings rule requirements. To ensure these settings meet requirements at the time of submission and ongoing, as part of the ongoing person-centered planning process used by ICAs, all settings in which waiver services are delivered, including those described above, will be reviewed by the ICA or assessed by another entity delegated by the SMA, to ensure that the setting is not designed in such a way that it isolates the individual from the greater community. This review occurs at the time of development of the initial person-centered plan and at reviews of that plan on, at least, an annual basis. The review includes periodic face-to-face meetings with the participant in home and community settings.

2. Compliance for RCACs and 3-4 Bed AFHs:
To ensure initial compliance, every RCAC and 3-4 bed AFH receiving Medicaid waiver funding for residential services completes a self-assessment to attest to compliance with the HCB Settings requirements. If the reviewer identified internal inconsistencies or other ambiguous responses, the setting is contacted by phone or email and is interviewed regarding any unclear responses. If remediation requirements are identified during the desk review or subsequent follow-up, the setting is required to submit verification of remediation before an HCBS Settings Compliance determination is made. Settings that meet all compliance criteria, both with and without remediation, receive a letter from the SMA confirming their compliance and the HCBS compliance designation is included on the SMA Division of Quality Assurance (DQA)'s public-facing Provider Search (https://www.dhs.wisconsin.gov/guide/provider-search.htm). This same process will be used for future settings requesting HCBS compliance.

Licensed settings and settings that are certified by the state licensing authority, the Division of Quality Assurance, (DQA) (3-4 bed AFHs, RCACs, and adult day care providers) are subject to periodic compliance site visits (at least every 3 years for 3-4 bed AFHs and RCACs) by DQA. To ensure ongoing compliance with the HCBS Settings Requirements, as part of these periodic licensing or certification reviews, DQA also reviews the setting for continued HCBS compliance. Settings found to have deficiencies in licensing or certification requirements are required to implement corrective actions and can lose their license or certification when noncompliance continues or is egregious. Any provider that loses its license or certification cannot continue to be a qualified waiver service provider regardless of their HCBS compliance status. Providers are required to address any HCBS rule deficiencies. Failure to adequately remediate results in removal as an HCBS waiver provider.

3. Compliance for 1-2 bed AFHs:
Certified 1-2 bed AFHs are certified by contracted staff under the direction and supervision of the SMA. . The HCBS requirements are incorporated into the Wisconsin Medicaid Standards for Certified 1-2 Bed AFH. To ensure initial compliance, the certification entity is required to review compliance with the state standards for any setting that intends to serve HCBS waiver members. In order to receive Medicaid funding, each setting completes an initial review of compliance by contracted staff under the direction and supervision of the SMA. If a setting is found to not meet requirements, they are required to submit verification of remediation before an HCBS Settings Compliance determination is made. To ensure ongoing compliance, these settings are recertified on an annual basis. The recertification process includes verification of the HCBS Settings Requirements and remediation of any items not successfully remediated. If an AFH application for certification or recertification has been denied or if an AFH certification has been revoked, the AFH is no longer eligible to serve as an HCBS waiver provider. A list of 1-2 bed AFHs that have been found compliant with the HCBS settings rule is maintained on the Current list of certified 1-2 bed AFH found on the DHS webpage for 1-2 bed Certified AFHs (https://www.dhs.wisconsin.gov/regulations/afh/1-2bed/certified-1-2bed-afh.xlsx).

4. Compliance for Non-residential settings (Day habilitation- facility based service settings, Prevocational- facility based service settings, adult day care centers, and group supported employment settings):

Contracted staff under the direction and supervision of the SMA complete desk reviews consisting of materials submitted and a validation visit to ensure that all HCBS Settings requirements are in place. For current and future adult day care center settings requesting review, the responsibility for conducting the reviews has transition to DQA. DQA follows the same process followed by the contracted staff under the direction and supervision of the SMA. If during the review for a non-residential setting, a setting is found to not meet requirements, the provider is required to submit verification of remediation before an HCBS Settings Compliance determination is made. Settings that meet all compliance criteria, both with and without remediation, receive a letter from the SMA. A list of nonresidential settings that have been found

compliant with the HCBS settings rule is on the HCBS Nonresidential Settings Compliance List found on the SMA HCBS webpage (https://www.dhs.wisconsin.gov/hcbs/nonres-compliance-list.xlsx) for all non-residential providers other than adult day care centers. The compliance status for adult day care centers is included on the DQA public-facing Provider Search (https://www.dhs.wisconsin.gov/guide/provider-search.htm). To ensure ongoing compliance, these settings have their compliance status verified at least once every three years. The ongoing verification process includes verification of the HCBS Settings Requirements and remediation of any items not successfully remediated. The review process for all new and existing providers will include an off-site review of provider documents and an onsite visit. Settings that are not found to be compliant with the HCBS settings rule, are required to submit acceptable remediation plans. If the non-residential provider fails to achieve compliance with the HCBS settings rule within the designated timeframe, the provider is no longer eligible to serve as an HCBS waiver provider.

5. Additional steps taken by the SMA to ascertain initial and ongoing compliance for all settings include:
a. Requirements in the SMA – Fiscal Employer Agent (FEA) and IRIS Consultant Agency (ICA) contract ensure the ongoing assessment of settings in which waiver services are provided have been determined to be compliant with the HCBS Settings Rule;
b. Informing participants, through participant materials, of the HCBS Settings requirements and how to report any concerns in regard to the settings in which they receive services; and
c. Adding review of HCBS Settings Rule related person-centered planning requirements to the External Quality Review Organizations record reviews.

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

☒ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**

☒ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.** ***(see Appendix D-1-d-ii)***

☒ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**

☒ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**

☒ **Facilitates individual choice regarding services and supports, and who provides them.**

☒ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings.*)

○ **No, the waiver does not include provider-owned or controlled settings.**

◉ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):

☒ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**

☒ **Each individual has privacy in their sleeping or living unit:**

☒ **Units have entrance doors lockable by the individual.**

☒ **Only appropriate staff have keys to unit entrance doors.**

☒ **Individuals sharing units have a choice of roommates in that setting.**

☒ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☒ **Individuals have the freedom and support to control their own schedules and activities.**

☒ **Individuals have access to food at any time.**

☒ **Individuals are able to have visitors of their choosing at any time.**

☒ **The setting is physically accessible to the individual.**

☒ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

IRIS Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☐ **Social Worker**
Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are

employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- (●) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

a) Participants receive information and assistance relating to self-directing and actively engaging in the person-centered service plan development process, at a minimum, during orientation and quarterly thereafter. The participant has the freedom to request information and support from the IRIS Consultant Agency (ICA) or Fiscal Employer Agent (FEA) at any other time.

The participant is educated and provided support to help direct and actively engage in the service plan development process. Participant education and support includes information about:
• The ISP (service plan) planning process;
• Role of legal and non-legal representatives in the service plan development process;
• Strategies for developing a service plan that addresses all aspects of the participant's life;
• Role and responsibilities of the participant as a self-director of their waiver supports and services;
• Available supports and services;
• Strategies for finding, training, and managing service providers, including participant-hired workers;
• Differences between participant-hired workers, individual providers, and agency providers;
• Strategies for managing their individual budget allocation (IBA);
• Processes for changing supports and services; and
• Role and responsibilities for HCBS Settings Rule requirements.

b) The participant has the right to include anyone they choose in the service plan development process including family members, medical or behavior professionals, and other sources of support.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The self-directed, person-centered IRIS Service Plan (service plan) reflects the life the participant wants to live, their culture, as well as their functional, medical, and social needs to successfully live in the community. The self-directed, person-centered service planning process supports the participant's efforts to develop as much independence as possible in their daily life and in achieving goals by meeting their long-term care support needs. IRIS program participants exercise decision-making authority over their waiver services and assume a direct role in managing their waiver services within a person-centered planning process. Because participants have increased choice about selecting their waiver services and assume a direct role in managing their person-centered service plan, they also accept the risk and increased responsibility for their spending choices. If the participant has a legal decision maker who has the authority to make decisions on their behalf, the legal decision maker is required to assume and fulfill the same required self-direction roles and accompanying responsibilities on behalf of the participant.

a) Upon enrollment, the participant and any optional support individuals of their choosing, leads the service planning process with the guidance of the IRIS Consultant Agency (ICA). During these in-person meetings, the initial service plan is developed. The ICA facilitates the completion of the requisite paperwork and back-office processing related to the completion of the service plan. The participant's start date in the IRIS program is the date of implementation of the initial service plan. For new enrollments, the initial service plan is developed and implemented during the 60-day IRIS program orientation period.

The service plan is agreed to, completed, and signed by the participant. Signatures from essential service providers responsible for the service plan implementation must also be obtained. Essential service providers are defined under program policy. For non-essential service providers, a copy of the provider's signed service contract, agreement, or authorization will be added to the service plan. The signed service plan will then be distributed to the participant and all essential service providers responsible for the implementation of the service plan.

b) Information used in level of care assessments for new enrollees is gathered by Aging and Disability Resource Center (ADRC) screeners during an in-person meeting with the participant by using the state's automated Wisconsin Adult Long-Term Care Functional Screen (LTCFS).

The SMA, using information from the resulting LTCFS, identifies the participant's long-term care needs relative to the participant's abilities to complete activities of daily living (ADLs), instrumental activities of daily living (IADLs), as well as any medical or behavior needs. If behavioral needs are identified, a behavioral support plan (BSP) is created which includes the regular collection and review of behavioral data.

Additionally, an IRIS participant needs assessment is completed to further identify and address the participant's long-term care needs. For participants in a residential provider-owned or provider-controlled setting, long-term care needs may include any applicable, appropriately documented HCBS Settings Rule Modification.

To create the participant's initial service plan, the ICA uses the results of the LTCFS, the IRIS participant needs assessment, and any created behavioral support plan, in conjunction with exploratory discussions with the participant to comprehensively assess and identify the participant's health status, needs, risk factors, and long-term care outcomes, strengths, preferences, and informal supports. The ICA reviews and identifies any ongoing conditions that require a course of treatment or regular care monitoring and other factors that may impact the participant's health and welfare.

c) Participants are first informed about the services available under the waiver at the ADRC during enrollment options counseling. Tribal Aging and Disability Specialist (TADRS) must follow this provision if they elect to perform eligibility and enrollment functions for the tribe(s) they work with. Upon enrollment and during program orientation, participants are also provided with SMA-approved materials which describe the services available under the waiver. At minimum, the ICA meets with the participant quarterly to formally review, reassess, and update the service plan, if necessary. During quarterly reassessment meetings, the ICA, if requested, provides information to the participant about the services available under the waiver. All SMA-approved IRIS program materials are readily accessible on the IRIS program website along with general information about the IRIS program and the available services offered.

d) The participant's service plan is developed using a self-directed, person-centered planning process that assesses, identifies, and documents the participant's long-term care needs; achievable long-term care outcomes; and the services and supports, consistent with the assessment, that will be sufficient to assure the participant's health, safety,

and well-being. The participant's involvement in their self-directed service plan development process ensures their goals, needs, and preferences are identified and addressed. The service plan development process encourages the active involvement of the participant and their chosen supports within their decision-making process.

To ensure that the service plan is understandable to the participant, it is written in plain language and in a manner that is accessible to participants with disabilities (through the provision of auxiliary aids and services at no cost to the participant) and participants with Limited English Proficiency (through the provision of language services at no cost to the participant).

ICAs are required to ensure that the service plans developed by their ICA staff meet the needs of the participant. Accordingly, the SMA conducts record reviews that evaluate a sample of participant service plans to ensure that the service plans created adequately meet the participant's needs and achievable long-term care outcomes. ICAs are required to remediate any individual negative findings as well as complete quality management templates to improve insufficient performance.

e) The participant receives information and individualized assistance from the ICA. The amount of support provided by the ICA varies based upon the participant's needs, however, at a minimum, the ICA assures that the participant's long-term care needs are assessed, achievable long-term care outcomes are developed, and the participant's related services and supports are identified. The ICA also ensures there are no immediate or long-term health and safety risks or risk of hospitalization or institutionalization for the participant.

The ICA provides the necessary tools, resources, and information to locate and retain providers. The participant is responsible for identifying and retaining participant-hired workers (PHW), individual providers, agency providers or a combination of providers . The ICA, in tandem with coordination from the Fiscal Employer Agent (FEA), ensures that the participant's service plan and subsequent service authorizations, and other back-office processes are in place to support the participant. The participant is responsible for communicating any change of condition to the ICA so level of care reassessments can be coordinated, and subsequent changes are made to the service plan to address the changes in condition. The ICA, at a minimum, is required to meet the participant quarterly to discuss the progress on implementation of the service plan. However, the participant may contact the ICA at any time about waiver services and support coordination matters.

f) The service plan utilizes the most cost-effective waiver and non-waiver funded resources available to bridge the gap between the needs identified in the LTCFS, needs assessment, and achievable long-term care outcomes. The participant and ICA, collaboratively, are responsible for the development of the participant's service plan. During the service plan development process, the ICA uses the results of the most recent LTCFS, the IRIS participant needs assessment, and any created behavioral support plan, in conjunction with exploratory discussions with the participant to comprehensively assess and identify the participant's needs, achievable long-term care outcomes, strengths, preferences, informal supports, and identify any ongoing participant conditions that require a course of treatment or regular care monitoring.

The ICA is required to ensure the participant has the resources and information needed to implement the service plan. The participant is responsible for implementing, monitoring, and reporting service delivery of their service plan. Additionally, the ICA is required to complete periodic phone and face-to-face visits with the participant to monitor implementation of the service plan, check on the participant's overall health and safety, and review and revise the service plan, as needed. The participant may contact their ICA at any time if they are concerned about the implementation of their service plan.

g) At least quarterly, the ICA meets with the participant to review, reassess, and, if necessary, update the service plan which includes the participant's long-term care needs and achievable long-term care outcomes. If necessary, the ICA conducts another LTCFS. The participant and ICA collaborate to ensure the new service plan accurately reflects the participant's needs and achievable long-term care outcomes. The service plan must be reviewed and updated whenever the participant's preferences change, there is a significant change in the condition of the participant, the service plan no longer meets the participant's needs or associated outcomes, or at the participant's request. After any change or renewal of the service plan, all essential service providers, both new and existing, sign and receive an updated copy of the service plan.

h) The participant takes an active role in engaging in and directing their person-centered service planning process

during initial plan development discussions as well as throughout their enrollment in the IRIS program.

i) The SMA documents consent of the person-centered service plan from the participant with a signature captured on the participant's service plan.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☒ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☒ **For provider owned or controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan and the following will be documented in the person-centered service plan:**

- ☒ **A specific and individualized assessed need for the modification.**
- ☒ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☒ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☒ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☒ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☒ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☒ **Informed consent of the individual.**
- ☒ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The participant and their IRIS Consultant Agency (ICA) collaborate to identify and discuss risks that may arise with participant self-direction of services and supports. After identifying potential risks, the participant and ICA work together to develop effective strategies to mitigate risks to the greatest extent possible using the participant's available resources. Identified risks are documented in the needs assessment component of the service plan, addressed during the development of the service plan, and reassessed throughout the participant's enrollment in the IRIS program.

One mitigation strategy is the completion of a comprehensive, individualized back-up plan. The individualized back-up plan is participant-focused and developed with the participant's unique needs and circumstances. The participant and ICA are required to develop an individualized back-up plan to address contingencies such as emergencies, including the absence of the participant's primary caregiver. The individualized back-up plan must include a back-up caregiver that is able to provide requisite care and maintain the participant's health and safety. Individualized back-up plans must contain the following components:
a. Medical needs, as applicable;
b. Behavior needs, as applicable;
c. Medication and medical equipment needs, as applicable;
d. General overview of the participant's schedule;
e. Contact information for emergency back-up providers;
f. Contact information for service providers including medical providers and the ICA; and
g. Other pertinent, participant-specific information.

The participant and the ICA review the accuracy and effectiveness of the individualized back-up plan at least quarterly during regular contacts or more frequently, as needed. The participant is responsible for notifying the ICA of any changes that may impact their individualized back-up plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The IRIS participant selects their own qualified service providers. During development of the service plan and throughout the participant's enrollment, the ICA is the main resource and support for service provider and vendor information. The ICA is required to have localized knowledge and provide participants with the tools, resources, and information consistent with each participant's needs.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

Once the participant and ICA complete and submit the service plan into the SMA's enterprise care management system, then the ICA has the responsibility of approving the participant's service plan through a secondary approval process. If any changes occur or are required, it is the ICA's responsibility to work with the participant to modify, review, and approve the service plan. As described in Appendix C, select services may require SMA approval prior to being included on the approved service plan.

To verify that the services in the participant's service plan are furnished using a written person-centered service plan that is based on a person-centered approach and subject to the approval of the SMA, the SMA contracts with an External Quality Review Organization (EQRO) to complete a retrospective review of participant service plans on a quarterly basis.

To conduct the review, the EQRO reviews a sample (95% confident interval) of each ICA's total service plans from the past year, which includes provider-owned or provider-controlled settings. The random sample is reviewed to ensure that those service plans:
• Address all the participant's identified long-term care needs, including mitigation of health and safety risks (see performance measure at the end of this appendix);
• Have participant-driven long-term care outcomes;
• Have adequately supported long-term care outcomes; and
• Have complete service authorizations including service or support type, scope, amount, description, and frequency (see performance measure at the end of this appendix).

If any insufficient findings arise from this retrospective review, the SMA is notified, and the ICA must remediate the findings (non-compliant service plans) immediately. In addition, the SMA and ICA discuss performance on these review indicators at quarterly meetings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

a. The participant and the IRIS Consultant Agency (ICA) are jointly responsible for assuring the participant's health and welfare; the effective delivery of waiver services, active, continuous monitoring of the implementation of the service plan in a cost-effective manner ; as well as the adherence to the HCBS Settings requirements. If the participant has a legal decision maker who has the authority to make decisions on their behalf, the legal decision maker is required to assume and fulfill the same required self-direction roles and accompanying responsibilities on behalf of the participant.

b. The ICA regularly meets with the participant to ensure that selected services and supports continue to meet the participant's needs, are furnished in accordance with the service plan, and are accessible to the participant.

The regular meetings allow the ICA to monitor the participant's choice of qualified provider(s) and the effectiveness of their individualized back-up plan. The ICA may mitigate risk of threats to health and safety by connecting the participant with resources for addressing their own health and safety risks. If a threat to health or safety arises, the ICA reports such critical incidents to appropriate parties, which may include Adult Protective Services or law enforcement. This is further defined in Appendix G. If the participant refuses or is unable to address their own health and safety, or refuses the assistance of the ICA, the ICA has the responsibility to recommend program requested disenrollment.

The participant's service plan is a dynamic document that reflects significant changes in the participant's outcomes, health status, furnished waiver supports and services, non-waiver services, and the participant's life.

In addition to regular meetings between the ICA and participant, the SMA has developed performance indicators for monitoring the ongoing implementation of the service plan. The External Quality Review Organization (EQRO) reviews, on a quarterly basis, a random sample (95% confidence interval) of each ICA's service plans, which includes provider-owned or provider-controlled settings, to ensure that each service plan:
i. Continues to address all of the participant's long-term care needs, including mitigation of health and safety risks (see performance measure at the end of this appendix);
ii. Continues to have participant-driven long-term care outcomes;
iii. Continues to have adequately supported long-term care outcomes; and
iv. Continues to have complete service authorizations including service or support type, scope, amount, description, and frequency (see performance measure at the end of this appendix).

c. The participant and ICA meet frequently for thorough, in-person consultations during the initial service plan planning and implementation phase. After the service plan is implemented, the ICA, at minimum, contacts the participant monthly and meets in-person every 90 days to monitor the implementation of the participant's service plan.

b. Monitoring Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

- ☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**
- ☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**
- ☐ **Direct oversight of the process or periodic evaluation by a state agency;**
- ☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**
- ☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participantsï?½ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Participants must have an IRIS service plan (ISP) that address all participant needs and personal goals including health and safety risks. Numerator/Denominator: Number of participant records reviewed that address all participant needs and personal goals over Number of participant records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: External Quality Review Organization (EQRO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Participant IRIS service plan (ISP) must be updated at least once every 365 days.
Numerator/Denominator: Number of participant records with an ISP that was updated in the last 365 days over Number of participant records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: External Quality Review Organization (EQRO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Participant records must have complete service authorizations that identify the type, scope, amount, description, and frequency of services. Numerator/Denominator: Number and percent of records with complete service authorizations (type, scope, amount, description, and frequency of services) over Number of participant records reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = 95%
☒ **Other** Specify: Office of Inspector General (OIG)	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and***

procedures.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Participant records must demonstrate that participants were offered a choice of waiver services and providers. Numerator/Denominator: Number and percent of participants who have a completed "IRIS Participant Education Manual: Acknowledgement (F-01947)" form over Total number of participant records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☒ **Other** Specify: External Quality Review Organization (EQRO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

To ensure waiver and program compliance by the contracted FEA and ICAs, the SMA developed performance indicators that align with CMS assurances outlined within this Appendix. Discovery and remediation information primarily comes from the Record Review process which is administered through a contract with an external quality review organization (EQRO).

Quarterly, the EQRO conducts the Record Reviews for each contracted entity. The EQRO is responsible for completing all resulting remediation activities and reporting the findings to the SMA. Additionally, the Record Review process allows the SMA to gather information about complaints, appeals and grievances, participant incident reports, and requests for the use of restrictive measures.

Additionally, discovery information is obtained when the EQRO is validating reported performance measures required by the SMA and CMS. Information is also obtained when the EQRO is assessing the quality of services and support coordination functions, assessing compliance with quality standards, and other activities, such as administration or validation of consumer surveys of quality of care.

Contractor oversight operations also provide valuable discovery information. Monthly, the SMA has meetings with individual contractors to discuss any performance and/or quality management concerns.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Quarterly, the SMA meets with each contractor to review the following:
• Remediation activities for Record Review performance indicators below the CMS required threshold;
• Review of all substantiated cases of abuse, neglect, misappropriation and exploitation cases; and
• Review of the contractor Performance Improvement Plans (PIPS) promulgated by the contractor to increase performance and address areas for improvement.

Monthly, the SMA has meetings with individual contractors to discuss any performance and/or quality management concerns. The SMA remediates those concerns accordingly.

Annually, for each contractor, the SMA conducts a “Contractor Recertification Meeting” and also reviews their Participant Satisfaction Survey results with them. Following the meeting, the SMA provides the contractor with the outcome of the Annual Recertification and if necessary, determines next steps.

These processes allow the SMA to confirm remediation of discovered problems and to identify potential areas of concern. The recertification meetings and satisfaction survey results also seek to identify if discovered and potential areas of concern, relate to systemic problems or issues within the contracted agency or the overall program. The SMA remediates these issues accordingly. All activities related to contractor performance will be documented and maintained within the SMA’s Quality Management Plan document for each contractor.

Remediation operations are continuously improved and updated so as to gain overall efficiencies within the program. Moreover, waiver amendments exist if systemic problems drastically hinder program operations.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

  Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

a) The Include, Respect, I Self-direct (IRIS) program meets the needs of people who prefer to receive their long-term care services within their home or community. IRIS program participants exercise decision-making authority over their waiver services and assume a direct role in managing their waiver services within a person-centered planning process. Because participants have increased choice about selecting their waiver services and assume a direct role in managing their self-directed, person-centered IRIS Service Plan (service plan), they also accept the risk and increased responsibility for their spending choices. Participant means the participant or their legal decision maker. If the participant has a legal decision maker who has the authority to make decisions on their behalf, the legal decision maker is required to assume and fulfill the same required self-direction roles and accompanying responsibilities on behalf of the participant. The participant exercises budget authority and employer authority in directing their waiver supports and services, excluding IRIS Consultant Agency (ICA) Services, which assists the participant with budget authority and employer authority, if elected. Specifically, the IRIS program provides the participant with the opportunity to:
1. Direct their long-term care service delivery which allows for decision making regarding which long-term care supports and services are furnished and which service providers provide them;
2. Exercise employer authority by recruiting, hiring, supervising, and directing the individuals who furnish their waiver supports and services; and
3. Exercise budget authority by making decisions about how their Medicaid-funded budget is utilized.

b) IRIS participants are able to take advantage of these opportunities by:
1. Choosing who to include in their person-centered planning process, such as family members, friends, legal representatives, qualified professionals, etc., and the extent of those individuals' participation in the person-centered planning process;
2. Deciding which ICA to utilize while in the program and having the ability to change this choice throughout their time in the program;
3. Taking the lead during the development of the service plan);
4. Receiving relevant information and support to facilitate informed decision making;
5. Determining long-term care outcomes (goals) from assessed long-term needs and preferences as well as strategies for attaining those outcomes;
6. Selecting services that best meet the participant's long-term care outcomes, preferences, strengths, abilities, and areas where the participant may need assistance;
7. Determining the amount, frequency, and duration of services and supports;
8. Selecting service providers and negotiating cost-effective rates that do not exceed the determined amount of their participant-directed budget;
9. Choosing to serve as an employer of record, which includes multiple employer-related responsibilities such as hiring and supervising individual hired workers;
10. Creating strategies to identify, assess, and manage potential risks;
11. Creating individualized back-up plans for situations that may jeopardize the participant's health and welfare.
12. Exercising decision-making authority over all aspects of waiver service delivery (excluding ICA services) and accepting the risk and increased responsibility for directly managing them in an ongoing basis; and
13. Having the ability to modify their goals, strategies, services, supports, and service providers throughout their time as a program participant.

c) The IRIS program requires full participant direction (or self-direction). The SMA contracts with organizations to provide services that are required to support the participant with self-direction and participation in the program. Specifically:
1. Information and assistance in support of participant direction: This service is provided by ICA agencies certified by the SMA. Resources, information, and services are provided to participants to assist the participant with identifying immediate and long-term care needs and outcomes, developing options to meet those identified needs and outcomes, and gaining access to needed community services, State Plan services, and waiver-funded services and supports, regardless of funding.
2. Financial management services: This administrative function is provided by an FEA contracted by the SMA. The FEA function assists the participant with exercising employer authority by acting as the participant's fiscal employer agent and budget authority by assisting with managing and directing the disbursement of the participant's waiver funds.
3. The SMA contracts with independent advocacy agencies to provide participants with a route to address concerns regarding the IRIS program or self-direction. This is further discussed in Appendix E-1-k.

d) In summary, the IRIS program not only supports the participant to achieve long-term care outcomes but also empowers the participant to expand their degree of choice and decision-making authority over their long-term care

services and supports. The IRIS program is structured to support the opportunity for the participant to freely determine all aspects of program participation including identifying needs and preferences; choosing goods, supports, and services; directing all aspects of service delivery including setting cost-effective rates and selecting providers; having the ability to hire individual providers; and monitoring quality of service delivery. These opportunities are discussed throughout Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Additional allowable living settings include:
- Home of a friend,
- Certified Residential Care Apartment Complexes (RCAC),
- Certified 1-2 Bed AFH, and
- Licensed 3-4 Bed Adult Family Homes (AFH).

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ◉ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

a) The Aging and Disability Resource Center (ADRC) is a public entity that provides individuals with information and assistance during the pre-admission and pre-enrollment options counseling process. Options counseling is a flexible, person-centered process that provides in-depth information tailored to the needs of the individual. During options counseling, individuals receive information about the various Wisconsin adult long-term care programs they are eligible for. Information provided by ADRCs help individuals make informed decisions regarding their long-term care by providing an unbiased overview of information on a variety of benefits and public programs. The overview includes information about participant direction opportunities for adult long-term care programs, including the IRIS program, to inform decision-making concerning the election of participant direction.

During this time, the individual’s long-term care functional screen and program eligibility activities are completed. The prospective participant who expresses interest in the IRIS program is provided IRIS program-specific informational documents which includes plain language scorecards that display performance on select customer service indicators of the FEA and ICAs.

b) ADRCs are the public entities responsible for furnishing the unbiased overview of long-term care options including participant direction opportunities (e.g., the benefits of participation direction, participant responsibilities, and potential risks).

c) Once a prospective participant selects the IRIS program and is referred to the program, the participant selects their ICA. The selected ICA welcomes the participant and provides the participant with a robust orientation to the program within 60 days. The orientation includes walking the participant through a participant-friendly IRIS program education document. The education document outlines information and policies, including responsibilities and liabilities with being an IRIS program participant. Topics include, at a minimum, participant rights; participant direction services and supports; service plan development; budget management; health and safety monitoring; conflicts of interest; the complaint and grievance process; and employer authority expectations, responsibilities, and tasks. The participant attests that the document was reviewed and received.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☐ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed

representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Individual Directed Goods and Services	☒	☒
Assistive Technology	☒	☒
Environmental Accessibility Adaptations (Home Modifications)	☒	☒
Adult Day Care	☐	☒
Individual Supported Employment	☒	☒
Life Skills Training and Education	☒	☒
Residential Services (Other)	☐	☒
Home Delivered Meals	☐	☒
Consultative Clinical and Therapeutic Services for Caregivers	☒	☒
Training Services for Unpaid Caregivers	☒	☒
Small Group Supported Employment	☐	☒
Respite	☒	☒
Supportive Home Care	☒	☒
Counseling, Therapeutic, and Wellness Services	☒	☒
Nursing Services	☒	☒
Prevocational Services	☐	☒
Community Transportation	☒	☒
Vehicle Modifications	☐	☒
Vocational Futures Planning and Support	☐	☒
Relocation - Community Transition Services	☒	☒
Day Habilitation	☐	☒
Specialized Medical Equipment and Supplies	☐	☒
Support Broker Services	☒	☒
Competitive Integrated Employment (CIE) Exploration	☒	☒
Residential Services (1-2 Bed AFH)	☒	☒
Housing Counseling	☐	☒

Waiver Service	Employer Authority	Budget Authority
Virtual Monitoring and Emergency Response Systems	☐	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

○ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Fiscal Employer Agent Service

◉ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

In the IRIS program, the participant is required to exercise budget authority, however the participant has the choice of exercising employer authority, where the participant is the common law employer of their worker(s), vendor(s), or agency. In order to support the IRIS participant in exercising both authorities, FMS is provided as an administrative function by a contracted, non-governmental vendor organization. The contracted vendor organization is an Fiscal Employer Agent (FEA). There is one contracted FEA in the IRIS program. Participants are provided the FEA upon enrolling into the IRIS program. Information on the FEA is provided by the Aging and Disability and Resource Center (ADRC).

The vendor contract is managed by the SMA and meets requirements set forth in 45 CFR § 92.42. Through the certification process, the SMA ensures the interested vendor organization has the capability to perform tasks in accordance with Section 3504 of the IRS code and Revenue Procedure 70-6 as well as other SMA desired tasks and responsibilities. Once contracted, the FEA contract is reviewed annually. Throughout the contracted vendor organization’s time as an FEA, the SMA provides oversight and technical assistance to ensure the FEA continues to satisfactorily uphold responsibilities and tasks outlined in the contract.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The SMA pays the FEA a per enrolled participant rate on a monthly basis.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

Processes all participant employer and employee paper. Conducts caregiver background and criminal history checks. Verifies provider qualifications. Checks Federal exclusions monthly.

Supports furnished when the participant exercises budget authority:

- ☐ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☒ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☒ **Other**

Specify:

Collects required IRIS participant Medicaid post eligibility cost share payments, when applicable.

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FEA administrative function is monitored in a variety of ways to ensure the integrity of financial transactions performed. More information about the review of waiver service expenditures, and FEA responsibility, is described in Appendix I. Oversight of the FEA includes:

a. On a weekly basis, the FEA submits expenditure data to be processed and disbursed to waiver service providers. The SMA reviews the weekly data for calculation errors.

b. On a biweekly basis, the SMA conducts random sample audits of weekly expenditure data submissions, as described in Appendix I-1.

c. On a monthly basis, the SMA reviews the performance measures expressed in this waiver, as well as other measures not expressed in the waiver, including customer service measures. This review is done by the External Quality Review Organization (EQRO) and results are communicated to the SMA quarterly.

d. On a monthly basis, the SMA meets with the FEA to review performance on the above items, discuss challenges and concerns regarding the FEA's responsibilities, and identify opportunities for technical assistance. If a corrective action plan (CAP) is in place, the SMA and FEA would discuss the FEA's progress on meeting the CAP requirements. This meeting provides for the opportunity to discuss anything related to the IRIS program and the FEA's role, including discussing participant experience from the perspective of the FEA.

e. On an annual basis, the SMA conducts a recertification visit with the FEA, reviewing and confirming their standing with the SMA, other administrative requirements, such as EQRO compliance reporting, HIPAA, etc., and provider qualifications.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

To support the IRIS participant in managing their services, information and assistance is provided as an element of the IRIS Consultant Services waiver case management service. This service is provided by an SMA certified, non-governmental, vendor organization or IRIS Consultant Agency (ICA). The ICA employs IRIS Consultants (ICs) to work individually with IRIS participants to provide services and supports appropriate to the level of participant direction the participant elects. How the IRIS Consultant Service assists participants with exercising budget authority and employer authority is described in the "IRIS Consultant Services" definition in Appendix C-1/C-3.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Individual Directed Goods and Services	☐
Assistive Technology	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Environmental Accessibility Adaptations (Home Modifications)	☐
Adult Day Care	☐
Individual Supported Employment	☐
Life Skills Training and Education	☐
Residential Services (Other)	☐
Home Delivered Meals	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐
Training Services for Unpaid Caregivers	☐
Small Group Supported Employment	☐
Respite	☐
Supportive Home Care	☐
Counseling, Therapeutic, and Wellness Services	☐
Nursing Services	☐
Prevocational Services	☐
Community Transportation	☐
IRIS Consultant Agency (ICA) Services	☒
Vehicle Modifications	☐
Vocational Futures Planning and Support	☐
Relocation - Community Transition Services	☐
Day Habilitation	☐
Specialized Medical Equipment and Supplies	☐
Support Broker Services	☒
Competitive Integrated Employment (CIE) Exploration	☐
Residential Services (1-2 Bed AFH)	☐
Housing Counseling	☐
Virtual Monitoring and Emergency Response Systems	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c)

describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- ○ **No. Arrangements have not been made for independent advocacy.**
- ◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

The SMA contracts with a private, non-profit agency (Disability Rights Wisconsin; participants ages 18-59) as well as an independent, governmental board (Board on Aging and Long Term Care, participants ages 60 and above) to act as long-term care ombudsmen. The ombudsmen are neutral, person-specific advocates that do not provide other direct services (under either the waiver or the state plan) to the participant; perform assessments; or conduct waiver monitoring, oversight or fiscal functions that have a direct impact on a participant.

As necessary, the ombudsmen will investigate participant complaints and problems about the IRIS program and self-direction, provide information to participants about their rights, and refer participants to other resources, as appropriate. The ombudsmen also represent participants at hearings and during disputes. Ombudsmen may also consult and work with the SMA to ensure the participant's concerns are fully addressed.

Information about how to contact the ombudsmen as well as the type of assistance ombudsmen provide is detailed in participant program documents. This information is also publicly provided on the SMA's website. The participant's ICA is also responsible for furnishing this information to the participant during program enrollment and as needed throughout the participant's time in the program.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

Only persons who elect to self-direct are eligible for the IRIS program. If a participant voluntarily disenrolls from the IRIS program, the participant has the option to explore alternative Wisconsin long-term care (LTC) programs.

If a participant wants to voluntarily disenroll, the participant is directed to return to the Aging and Disability Resource Center (ADRC) to go through enrollment counseling to select a different long-term care program. The ADRC communicates with the participant's current ICA regarding the participant's decision to enroll with a different ICA or in a different LTC program. Until the participant is officially enrolled in their new long-term care program or with their new ICA, their current ICA ensures the participant's health and welfare and continued IRIS waiver program supports and services.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Because the waiver targets only participants who elect to direct their services, the following are reasons for program requested disenrollments from the IRIS program:

1. Failure to utilize IRIS waiver funding (not spending funds in the budget);
2. Loss of financial eligibility, including falling into cost share arrears;
3. Loss of functional eligibility, including expiration of long-term care functional screen;
4. Mismanagement of Budget Authority responsibilities (misappropriation of funds);
5. Mismanagement of Employer Authority responsibilities;
6. Unable to reach participant for an extended period of time;
7. Health and safety cannot be assured;
8. Credible allegation of fraud;
9. Movement to an ineligible living setting; and
10. Material noncompliance with IRIS program requirements outside of reasons above.

In cases of program requested disenrollment, the participant is notified of the decision, provided a Notice of Action, and provided information on how to engage the State Fair Hearing process if the participant wishes to appeal the decision. The Aging and Disability Resource Center (ADRC) is then made aware of the program requested disenrollment and given the official disenrollment date. Up until the participant is officially disenrolled, the IRIS Consultant Agency (ICA) ensures the participant's health and welfare and continued IRIS waiver program supports and services.

In the case that the participant engages in the State Fair Hearing process to appeal the disenrollment decision, the ICA ensures continued health and welfare along with IRIS waiver program supports and services until there is a reaffirmed disenrollment date, if that is the result.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		34593
Year 2		36703
Year 3		38815
Year 4		40925
Year 5		43037

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in*

Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Agency with Choice

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☐ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

Does not vary.

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☐ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The participant’s individual budget allocation (IBA) is an estimate of the monthly costs to fulfill a participant’s needs. The estimate uses data from Wisconsin's Adult Long-Term Care Functional Screen (LTCFS). Developed by the SMA, the LTCFS provides an automated and objective way to identify the long-term care needs of elders and people with physical or intellectual/developmental disabilities and their functional eligibility for publicly funded program assistance. The LTCFS determines the degree of assistance required to address those needs, specifically, the individual's functional ability to complete both Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). The LTCFS also looks at a person's cognition, behavior(s), diagnoses, medically-oriented tasks and employment; as well as indicators for mental health issues, substance use issues and other conditions that put a person at risk of institutionalization in a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

The IBA is calculated with a regression model based upon IRIS service utilization data and LTCFS results, identifying significant predictors of costs to meet participants’ long-term care needs. The model is calibrated to predict a percentage of costs for a target percentage of participants within each target group, with adjustments for county of residence, annual cost trends, and policy initiatives. The SMA monitors performance of the IBA calculation and periodically reviews the model as a whole.

The IBA calculation is implemented within the LTCFS software for consistent application with every participant, and the result is presented to the LTCFS system user. The monthly calculated IBA is used in the SMA’s enterprise care management system to calculate a budget within which the participant develops their service plan for waiver supports, services, and goods. This cost-estimating methodology is applied consistently to each IRIS participant. The SMA shares general information about the IBA process and components, but the specific coefficients and factors used in the regression are kept confidential to maintain the integrity of the LTCFS.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Participants are informed of the budget estimate by the IRIS Consultant Agency (ICA) during orientation. Participants use this budget amount to develop their IRIS Service Plan (service plan). In addition, the participant is notified of the budget estimate each time the Long-term Care Functional Screen is administered and completed, annually and as a result of a change in condition, if the situation arises.

If the costs of the participant's long-term care supports, services, and goods exceeds the budget estimate, the participant may seek additional funding through two methods:
1. Budget Amendment Request: A participant may request an adjustment to their budget if the participant has identified a need and associated long-term care outcome that cannot be met with their current budget. The participant's IRIS Consultant Agency (ICA) assists the participant with preparation and submission of the additional funding request to the SMA for review. The SMA thoroughly reviews the request for the additional support or service for allowability, appropriateness, and cost effectiveness. If the additional funding request is approved, the budget amount is modified and the participant's service plan is updated to reflect the requested service or support. If the SMA partially approves or denies the additional funding request, the participant receives a Notice of Action and has the opportunity to request an independent review by the SMA or appeal the decision through the State Fair Hearing process.

2. One-Time Expense Request: When a participant requires a one-time support or service that cannot be met within their current budget, the participant may request an adjustment to their budget by submitting a one-time expense request to the SMA for approval. Similar to the budget amendment request process, the participant's ICA assists with preparation and submission of the additional funding request to the SMA for review. The SMA reviews the request for the additional support or service for allowability, appropriateness, and cost effectiveness. If the one-time expense request is approved, the budget is modified and the requested support or service is documented in the participant's service plan. If the SMA partially approves or denies the request, the participant receives a Notice of Action and has the opportunity to request an independent review by the SMA or appeal the decision through the State Fair Hearing process.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Fiscal Employer Agent (FEA) provides participants with a monthly budget statement listing the service authorizations within their budgeted service plans, spending within those authorizations, and indication of whether the participant is likely to exceed or is exceeding those authorizations. If questions or concerns are identified by the participant, contact information is included on the report to assist with questions.

The FEA provides the IRIS Consultant Agencies (ICA) with monthly reports to identify participants at risk of exceeding their service authorizations. ICAs are responsible for using those reports to identify participants requiring additional education and support on managing their budget and employer authority and provide them with that education and support.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR ?431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The formal State Fair Hearing process is used primarily for “adverse actions” defined as a denial, reduction, termination or limitation of previously authorized services or when a participant is determined financially or functionally ineligible for the IRIS program.

IRIS program participants receive information about opportunities to request a state fair hearing prior to program enrollment, at the time of enrollment, and while enrolled. Prior to enrollment, the Aging and Disability Resource Centers (ADRCs) and the Tribal Aging and Disability Resource Specialists who choose to perform eligibility and enrollment functions for their respective tribes, offer information about state fair hearings during the enrollment counseling process. Additionally, ADRCs and Tribal Aging and Disability Resource Specialists are available to provide details about state fair hearings to participants whenever requested. The regional income maintenance (IM) consortiums that determine financial eligibility for Medicaid and process enrollments, also sends the participant standardized eligibility forms that include information about the right to a state fair hearing.

Once the participant is enrolled, ICAs provide participants with SMA approved participant education materials which includes state fair hearing information, at program orientation and whenever the participant materials are updated by the SMA, or at a minimum, annually. Also, written notice from the SMA and its contracted entities are provided to participants whenever an adverse action is taken regarding the IRIS program. These notices can be mailed or hand-delivered and include information about state fair hearings and provide options for participants to request the continuation of their services while their appeal is being reviewed. The SMA maintains copies of all participants’ adverse actions and other related information.

The SMA also contracts for ombudsmen services which aid participants in filing a request for a state fair hearing and assist the participant at the hearings. Additionally, the SMA contracts with an external quality review organization (EQRO) to provide participants with information and support about the complaints and grievance process which includes information about the state fair hearing process. Finally, during the adjudication of “adverse action” appeals, Administrative Law Judges provide the participant with written information which includes state fair hearing information.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving

their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

When a participant's request for additional waiver funds either through a Budget Amendment (BA) or One-Time Expense (OTE) request has been denied, the participant can request an "Independent Review" from the SMA. The SMA includes the information about the availability of the Independent Review in the initial denial correspondence mailed or hand-delivered to the participant. This initial denial correspondence contains information about the state fair hearing process also available to the participant. The participant has 15 business days from the effective date of the initial denial decision to request an Independent Review from the SMA. As part of the Independent Review, the participant has the option of submitting additional information for consideration by the SMA during the Independent Review process.

After the completion of the Independent Review process, the SMA mails or hand-delivers correspondence to the participant explaining the outcome and available options for further review. If the SMA affirmed the denial of the request for additional waiver funds or the participant had not timely requested an Independent Review, the ICA mails or hand-delivers to the participant a written Notice of Action (NOA). The NOA informs and provides an explanation of the SMA's Independent Review decision and provides information of the participant's right to a state fair hearing. Throughout the entire "Independent Review" process, the participant is informed multiple times of their rights regarding a state fair hearing.

This additional dispute resolution process is separate from and does not have any impact on the state fair hearing process when the participant has a right to a state fair hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

The SMA oversees the complaints/grievance system of the IRIS program, through a contract with an external quality review organization (EQRO). The EQRO provides administration and tracking of all grievances in a confidential database. This database includes all the participants' complaints/grievances, associated timeline information, and the resulting outcomes. The SMA receives periodic reports from the EQRO, detailing the complaints/grievances and efforts to mediate a resolution. This report is reviewed by the SMA for consistency and to monitor overall trends, including specific IRIS Consultant Agency (ICA) and Fiscal Employer Agent (FEA) trends.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

a) IRIS program participants and/or representatives may file complaints/grievances regarding dissatisfaction about any aspect of the care or service provided by the IRIS program. The formal state fair hearing is used primarily for "adverse actions" defined as a denial, reduction, termination or limitation of previously authorized services or when a participant is determined financially or functionally ineligible for the IRIS program.

b) IRIS program participants and/or representatives may report complaints and grievances in several ways. Participants can contact their ICA or the FEA, SMA staff, IRIS Ombudsman, Wisconsin Department of Health Services Secretary's Office, Wisconsin State Legislator, Office of the Governor, or other external advocacy agencies. Additionally, the SMA contracts with an external quality review organization (EQRO) who provides services to assist and mediate complaints/grievances. As part of the contractual services, the EQRO provides a staff monitored email inbox and independent telephone hotline for participants and/or representatives to report complaints/grievances. The EQRO must complete its review of the complaint/grievance within 30 calendar days with the exception of participant-hired worker payments which should be resolved within 3 business days. The SMA and the EQRO reviews and analyzes trends in the data collected by the EQRO with the goal of streamlining the complaints/grievance process or eliminating reoccurring concerns/problems. All complaints/grievances not made to the EQRO and acknowledged by the SMA, are addressed and resolved expeditiously.

c) The EQRO monitors, mediates, and evaluates participants' complaints/grievances reported to them. This includes obtaining and reviewing all relevant materials (documents, records, files) from the participant and if necessary, their ICA. In doing so, the EQRO communicates directly with the participant and/or their representative, explains the rights afforded to them, communicates and provides information and options for recourse, and facilitates a collaborative environment to foster resolution of their complaint/grievance. The EQRO also keeps secured confidential records of participant's complaints/grievances and the resulting outcomes. Periodically, the EQRO provides analysis and summaries of the collected data for the SMA's internal use and overall program integrity. The IRIS Ombudsmen are also always available to assist IRIS participants with the resolution of complaints/grievances, appeals, and at state fair hearings.

This complaints/grievance process is separate from and does not have any impact on the state fair hearing process when the participant has a right to a state fair hearing.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- ◉ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ○ **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The incident types that the SMA and its contracted entities requires to be reported for review and follow-up action include the following:

• Alleged or confirmed abuse, including physical abuse, sexual abuse, emotional abuse, treatment without consent, and intentional or unreasonable confinement or restraint;
• Neglect;
• Self-Neglect;
• Exploitation;
• Financial exploitation or misappropriation;
• Fall;
• Illness, injury, or hospitalization that requires immediate emergency medical attention;
• Death of a waiver participant;
• Medication administration errors that require medical attention;
• Unapproved, emergency, or unplanned use of restrictive measures;
• Investigations by Adult Protective Services (APS), law enforcement, or when the courts are involved;
• Significant damage to property, caused by or affecting the participant, including damage to their residence due to fire, natural disaster, or other cause;
• Missing participant; and
• Any other type of accident, injury, illness that is unexplained, unusual, or around which suspicious circumstances exist and resulted in a moderate or severe illness/injury.

Participants or providers must report incidents to the designated IRIS Consultant Agency (ICA) staff immediately or within 24 hours after the incident occurred or was discovered. Incidents can be reported by phone, in writing, or through appropriate available channels accessible to the participant or provider. Additionally, immediate reportable incidents, as defined in program policy, must also be reported to the SMA by the ICA within 24 hours of the ICA becoming aware of the incident.

Also, to ensure the participant's ongoing health and safety, ICAs must report incidents and any immediate follow-up activities in the SMA's enterprise care management critical incidents reporting system within seven (7) calendar days of notification and must complete all applicable follow-up activities within 30 calendar days of the incident. The SMA uses their enterprise care management critical incident reporting system to facilitate electronic collection, tracking (status and resolution of investigations), and trending of data on critical incidents.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Utilizing the consumer-focused educational and informational resources provided to participants, ICAs provide written and verbal training to participants regarding the protections against, identification, and the reporting of abuse, neglect, and exploitation. This training occurs after enrollment and at a minimum, annually, and includes how abuse, neglect, and exploitation are reported to the appropriate authorities. The training is monitored and documented by the ICA in the participant's electronic record, both initially and annually, and is verified through the participant's signed educational acknowledgement. Additionally, as needed, participants provide their informal supports and/or families with the appropriate training and information regarding the protections against, identification, and the reporting of abuse, neglect, and exploitation.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Once they are notified of an incident, ICAs are responsible for gathering information related to the incident and ensuring the participant's immediate health and safety. Additionally, immediate reportable incidents, as defined in program policy, must be reported to the SMA by ICAs within 24 hours of the ICA becoming aware of the incident.

For each incident, ICAs must report the incident and any immediate follow-up activities in the SMA's enterprise care management critical incidents reporting system within seven (7) calendar days of notification. Utilizing their enterprise care management critical incidents reporting system, the SMA reviews all reported incidents for the appropriate follow-up and to ensure the participant's health and safety.

Additionally, ICAs must complete all applicable follow-up activities within thirty (30) calendar days of the incident and assure the participant's ongoing health and safety.

If ICAs are notified of any incidents involving alleged abuse, neglect, or exploitation, they are responsible for reporting such incidents to local law enforcement authorities and/or the local adult protective services (APS) agency. Local law enforcement authorities and APS agencies are the entities responsible for investigating allegations of abuse, neglect, and exploitation, pursuant to Wis. Stat. § 55.043 and Wis. Stat. § 46.90. As detailed in the statute, the investigative agency will provide investigation results to the victim (i.e. the participant) identified in the initial report, any agency that is listed as providing assistance (i.e. the ICA), and any other involved or covered party. As reviewed and determined by the investigative agency, records may also be requested by these parties. Additionally, pertinent information and related results regarding the investigation are actively shared between the ICAs and the local APS agencies, as detailed in the individual agreements administered between these entities.

If the participant receives services within a SMA certified or licensed setting, the certifying or licensing entity is responsible for reporting any incidents that involve alleged abuse, neglect, or exploitation to local law enforcement authorities and/or local APS agencies. The certifying or licensing entity may perform an investigation of setting compliance, if deemed appropriate by such entity.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The SMA is responsible for overseeing all incidents submitted through their enterprise care management critical incidents reporting system, which includes individually reviewing all incidents reported and ensuring that the ICAs have met the incident response requirements. Incidents are reviewed by the SMA as they are submitted which allows ICAs the flexibility to complete all applicable follow-up activities in order to meet their 30-day completion deadline.

The information collected through the enterprise care management critical incidents reporting system includes incident types, participant information, incident setting, and various stages of incident follow-up to assure the participant's health and safety. The collection of data within the system allows for a clean and efficient compilation and analysis of aggregate incident data to better address incident follow-up and identified trends. This is done through regular contacts with the ICAs, as well as a monthly remediation assurance process, where the SMA selects a sample of incidents for additional review of compliance, specifically regarding remediation activities.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Unless specifically indicated otherwise, the information provided in the SMA's Restrictive Measures Guidelines and Standards applies to all restrictive measures, including all types of restraints.

The Restrictive Measures Guidelines and Standards are available at: https://www.dhs.wisconsin.gov/publications/p02572.pdf.

Any unauthorized use of a restrictive measure or use of a restrictive measure that is not within the scope of the SMA's Restrictive Measures Guidelines and Standards is prohibited under any circumstance. All prohibited practices are outlined within the Restrictive Measures Guidelines and Standards.

Any unapproved, emergency, or unplanned use of a restrictive measure, including all types of restraints, is an incident type that must be reported to the SMA through the process defined in Appendix G-1 of this waiver. In brief, participants can self-report to their IRIS Consultant Agency (ICA), and ICA staff also assess whether any unauthorized or emergency use of restraints may be occurring during in-person meetings with the participant. The ICA must investigate and report unauthorized or emergency use of restraints to the SMA.

The Restrictive Measures Guidelines and Standards specify that if the same or similar unauthorized or emergency use occurs more than twice in a six-month period, it is no longer considered an emergency and the restrictive measures planning process for an approved restrictive measure must be initiated.

Prior to using all types of restraints with a participant, they must be formally requested, evaluated, and approved by the SMA. Review and approval of each request is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. Restrictive measures may be approved for less than but no more than one year; a renewal request, review for use and effectiveness, and approval is required prior to expiration of the previous approval. Requests must be accompanied by documentation of alternative methods attempted prior to the request for the restrictive measure, a plan for documenting and monitoring the use of the restrictive measure, the education and training plan for personnel, and the plan to reduce and eliminate the use of the restrictive measure.

Each restrictive measure on a participant's behavior support plan (BSP), including restraints, are reviewed and discussed during the participant-centered service plan development process. The participant, ICA, and provider must consent in writing to each restrictive measure annually during this planning process.

Service providers may only use restrictive measures in emergencies or as part of a treatment program. These measures should only be implemented when there is an imminent risk of harm to protect the individual or others from injury. Additionally, they must be the least restrictive option available and used for the shortest duration necessary.

All individuals involved in the administration of restrictive measures must be trained by a restrictive measures training expert and/or designated competent ICA staff annually and when there are changes to participants' needed behavior supports. Providers are required to keep all training records in the personnel files for each staff person and the records must be available to ICAs or the SMA upon request. Additionally, for identified service provider deficiencies related to the unauthorized use of seclusion, actions taken may include, but are not limited to, mandated training or re-training or the participant may have to choose a new provider.

Service providers must report the use of each approved use of restrictive measure, including seclusion, to the participant's ICA. Quarterly, each ICA reports restrictive measures participant utilization data to the SMA.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

All participants with approved restrictive measures must obtain SMA approval for the use of these measures at least annually. Quarterly, the SMA collects data on approved restrictive measures from each ICA and loads it into a data warehouse environment. The SMA extracts aggregated data from the warehouse environment for analysis, tracking, and trending to identify potential patterns and outcomes for monitoring and possible quality improvement efforts.

Additionally, when ICAs request renewal of an approved restrictive measure, the SMA reviews the data utilization summary from the prior approval period to monitor trends and verify the use and effectiveness of approved restrictive measures, including restraints. The SMA's Restrictive Measures Lead may request more information from the ICA before the SMA can approve the renewal request. All follow-up by the SMA Restrictive Measures Lead is documented.

ICAs are required to ensure the safe use of restrictive measures in accordance with the approved application. During contact with the participant, ICAs are also required to discuss and review the documented use of approved restrictive measures. ICAs must also submit all incidents related to unapproved, emergency, or unplanned use of restrictive measures to the SMA, according to the process defined in G-1 of this waiver. The SMA follows up on these instances as they are reported and ensures ongoing and documented remediation.

On an ongoing basis, the SMA is also responsible for reviewing each ICA's report of incidents of emergency or unapproved use of restrictive measures, including restraints. The SMA may determine that follow-up is necessary and review the participant's report given to the ICA. Additional follow-up may include, but is not limited to, examination of individual participant record reviews. Concerning trends or patterns are documented and promptly remediated by the SMA.

To ensure waiver and program compliance by all contracted ICAs, the SMA developed performance indicators that align with CMS assurances and these performance indicators are verified during the external quality review organization (EQRO) record review process. If the EQRO discovery indicates compliance issues, the SMA determines follow-up and remediation. Remediation may or may not include a corrective action plan, but the SMA would follow-up in its regular meetings with the ICA.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

Unless specifically indicated otherwise, the information provided in the SMA's Restrictive Measures Guidelines and Standards applies to all restrictive measures, including all types of restrictive interventions.

The Restrictive Measures Guidelines and Standards are available at: https://www.dhs.wisconsin.gov/publications/p02572.pdf.

Any unauthorized use of a restrictive measure or use of a restrictive measure that is not within the scope of the SMA's Restrictive Measures Guidelines and Standards is prohibited under any circumstance. All prohibited practices are outlined within the Restrictive Measures Guidelines and Standards.

Unauthorized or emergency use of restrictive interventions is an incident type that must be reported to the SMA through the process defined in Appendix G-1 of this waiver. In brief, participants can self-report to their IRIS Consultant Agency (ICA), and ICA staff also assess whether any unauthorized or emergency use of restrictive interventions may be occurring during in-person meetings with the participant. The ICA must investigate and report unauthorized or emergency use of a restrictive measure to the SMA.

The Restrictive Measures Guidelines and Standards specify that if the same or similar unauthorized or emergency use occurs more than twice in a six-month period, it is no longer considered an emergency and the restrictive measures planning process for an approved restrictive measure must be initiated.

Prior to using a restrictive measure with a participant, they must be formally requested, evaluated, and approved by the SMA. Review and approval of each request is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. Restrictive measures may be approved for less than but no more than one year; a renewal request, review for use and effectiveness, and approval is required prior to expiration of the previous approval. Requests must be accompanied by documentation of alternative methods attempted prior to the request for the restrictive measure, a plan for documenting and monitoring the use of the restrictive measure, the education and training plan for personnel, and the plan to reduce and eliminate the use of the restrictive measure.

Each restrictive measure on a participant's behavior support plan, including restrictive interventions, are reviewed and discussed during the participant-centered service plan development process. The participant, ICA, and provider must consent in writing to each restrictive measure annually during this planning process.

Service providers may only use restrictive measures in emergencies or as part of a treatment program. Restrictive measures include manual restraint, isolation, seclusion, and protective equipment. These measures should only be implemented when there is an imminent risk of harm to protect the individual or others from injury. Additionally, they must be the least restrictive option available and used for the shortest duration necessary.

All individuals involved in the administration of restrictive measures must be trained by a restrictive measures training expert and/or designated competent ICA staff annually and when there are changes to participants' needed behavior supports. Providers are required to keep all training records in the personnel files for each staff person and the records must be available to ICAs or the SMA upon request.

Quarterly, each ICA reports restrictive measures participant utilization data to the SMA.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

All participants with approved restrictive measures must obtain SMA approval for the use of these measures at least annually. Quarterly, the SMA collects data on approved restrictive measures from each ICA and loads it into a data warehouse environment. The SMA extracts aggregated data from the warehouse environment for analysis, tracking, and trending to identify potential patterns and outcomes for monitoring and possible quality improvement efforts.

Additionally, when an ICA requests renewal of a previously approved restrictive measure, the SMA reviews the data utilization summary from the prior approval period to monitor trends and verify the use and effectiveness of approved restrictive measures, including restrictive interventions. The SMA's Restrictive Measures Lead may request more information from the ICA before the SMA can approve the renewal request. All follow-up by the SMA Restrictive Measures Lead is documented.

ICAs are required to ensure the safe use of restrictive measures in accordance with the approved application. During contact with the participant, ICAs are also required to discuss and review the documented use of approved restrictive measures. ICAs must also submit all incidents related to unapproved, emergency, or unplanned use of restrictive measures to the SMA, according to the process defined in G-1 of this waiver. The SMA follows up on these instances as they are reported and ensures ongoing and documented remediation.

On an ongoing basis, the SMA is also responsible for reviewing each ICA's report of incidents of emergency or unapproved use of restrictive measures, including restrictive interventions. The SMA may determine that follow-up is necessary and review the participant’s report given to the ICA. Additional follow-up may include, but is not limited to, examination of individual participant record reviews. Concerning trends or patterns are documented and promptly remediated by the SMA.

To ensure waiver and program compliance by all contracted ICAs, the SMA developed performance indicators that align with CMS assurances and these performance indicators are verified during the annual external quality review organization (EQRO) record review process. If EQRO discovery indicates compliance issues, the SMA determines follow-up and remediation. Remediation may or may not include a corrective action plan, but the SMA would follow-up in its regular meetings with the ICA.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Unless specifically indicated otherwise, the information provided in the SMA's Restrictive Measures Guidelines and Standards applies to all restrictive measures, including the use of seclusion.

The SMA's Restrictive Measures Guidelines and Standards are available at: https://www.dhs.wisconsin.gov/publications/p02572.pdf.

Any unauthorized use of seclusion or use of seclusion that is not within the scope of the SMA's Restrictive Measures Guidelines and Standards is prohibited under any circumstance. All prohibited practices are outlined within the Restrictive Measures Guidelines and Standards.

Unauthorized use of seclusion is an incident type that must be reported to the SMA through the process defined in Appendix G-1 of this waiver. In brief, participants can self-report incidents to their IRIS Consultant Agency (ICA), and ICA staff also assesses whether seclusion may be occurring during in-person meetings with the participant. The ICA must investigate and report unauthorized use of seclusion to the SMA.

Prior to using seclusion with a participant, it must be formally requested, evaluated, and approved by the SMA. Each request for seclusion must include a list of support strategies, interventions, or evidence-based methods or approaches attempted prior to the request. Review and approval of each seclusion request is conducted by the SMA's Division of Medicaid Services, Restrictive Measures Review Panel. Seclusion requests may be approved for less than but no more than one year; a renewal request, review, and approval is required prior to expiration of the previous approval.

Documentation requirements related to seclusion are specified in the SMA's Restrictive Measures Guidelines and Standards. Each seclusion application must specify the monitoring and documentation plan.

All individuals involved in the administration of seclusion must be trained by a restrictive measures training expert and/or designated competent ICA staff annually and when there are changes to participants' needed behavior supports. Providers are required to keep all training records in the personnel files for each staff person and the records must be available to ICAs or the SMA upon request. Additionally, for identified service provider deficiencies related to the unauthorized use of seclusion, actions taken may include, but are not limited to, mandated training or re-training or the participant may have to choose a new provider.

Service providers must report the use of each approved use of restrictive measures, including seclusion, to the participant's ICA. Quarterly, each ICA reports restrictive measures participant utilization data to the SMA.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

All participants with approved restrictive measures must obtain SMA approval for the use of these measures at least annually. Quarterly, the SMA collects data on approved restrictive measures from each ICA and loads it into a data warehouse environment. The SMA extracts aggregated data from the warehouse environment for analysis, tracking, and trending to identify potential patterns and outcomes for monitoring and possible quality improvement efforts.

Additionally, when ICAs request renewal of an approved restrictive measure, the SMA reviews the data utilization summary from the prior approval period to monitor trends and verify the use and effectiveness of approved restrictive measures. The SMA's Restrictive Measures Lead may request more information from the ICA before the SMA can approve the renewal request. All follow-up by the SMA Restrictive Measures Lead is documented.

ICAs are required to ensure the safe use of restrictive measures in accordance with the approved application. During contact with the participant, ICAs are also required to discuss and review the documented use of approved restrictive measures, including seclusion. ICAs must also submit all incidents related to unapproved, emergency, or unplanned use of restrictive measures to the SMA, according to the process defined in Appendix G-1 of this waiver. The SMA follows up on these instances as they are reported and ensures ongoing and documented remediation.

On an ongoing basis, the SMA is also responsible for reviewing each ICA's report of unauthorized use of seclusion. The SMA may determine that further follow-up is necessary and review the participant’s incident report given to the ICA or examine individual participant records, as needed. Concerning trends or patterns are documented and promptly remediated by the SMA.

To ensure waiver and program compliance by all contracted ICAs, the SMA developed performance indicators that align with CMS assurances and these performance indicators are verified during the external quality review organization (EQRO) record review process. If the EQRO discovery indicates compliance issues, the SMA determines follow-up and remediation. Remediation may or may not include a corrective action plan, but the SMA would follow-up in its regular meetings with the ICA.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Appropriately licensed medical professionals have first-line responsibility for monitoring the participant's medication regimens as part of regular reassessment and prescription. Second-line monitoring of medication regimens is the responsibility of service providers and participants. This includes assessing medication regimens as they are prescribed and identifying any failures to comply with medication regimens, following internal medication administration protocol, and reporting any medication administration concerns or errors to the designated IRIS Consultant Agency (ICA). During the initial development and the annual review of the participant's service plan, ICAs document any medication administration needs on the service plan that were identified in the participant's long-term care functional screen. Additionally, ICAs also request from participants, any information regarding any immediate reportable or critical incidents, including medication errors, during the required monthly participant contact. The incident reporting process is intended to capture any inappropriate medication administrations, per the participant's unique needs, and initiate appropriate follow-up and remediation by the ICAs, providers, and participants.

If a participant is living in their own home or a family member's home, the participant assumes responsibility for the overall ongoing monitoring of their medication regimen.

Providers that are licensed or certified and providing services to participants have the responsibility to ensure the appropriateness of a participant's medication regimen. In accordance with the service provider's respective certifying or licensing authority, the provider has the responsibility to monitor and document appropriate medication administration regimens, including any behavior modifying medications as prescribed by a medical professional.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Participants must report any medication errors that require medical attention to their designated ICA within the applicable reporting guidelines defined in Appendix G-1 of this waiver. It is the responsibility of the designated ICA to report these incidents to the SMA for individual review and verification of appropriate follow-up as they are submitted. The reporting process requires incident information submission and individual review by the SMA. This data is collected and reviewed in aggregate to identify any harmful or problematic practices as they may arise.

In addition, providers that are licensed or certified by the SMA certifying or licensing entity have monitoring and reporting requirements related to the terms of their credentialing. Oversight of those monitoring and reporting requirements includes annual onsite reviews and investigation of any incident reported within those facilities.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

A participant who is capable of self-administering medication and lives in their own home or a family member's home, manages their medications independently, keeping them under their own control. If the participant delegates this task to a provider, the participant and/or their legal representative assumes responsibility for training any provider, monitoring the provider, and ensuring quality of medication administration, including reporting any medication administration errors that occur to their designated IRIS Consultant Agency (ICA) who in-turn reports it to the SMA for review and verification of appropriate follow-up.

If a participant receives services from a certified or licensed provider, the provider must adhere to any medication administration protocols or regulations outlined in applicable certifying or licensing criteria.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Medication administration errors that require medical attention are reported to the participant's designated ICA, which are in-turn reported to the SMA for review and verification of appropriate follow-up.

In addition, providers that are licensed or certified by an SMA credentialing entity also have reporting requirements related to the terms of their credential and must report any instances of medication administration errors to their applicable SMA credentialing authority.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record all medication errors, including medication errors for which there are no negative impacts to the participant's health.

(c) Specify the types of medication errors that providers must *report* to the state:

Providers are required to report any medication errors resulting in the need for medical attention.

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

A participant's designated ICA is required to report incidents regarding medication errors that result in the need to seek medical attention to the SMA for individual review and verification of appropriate follow-up. During plan development, ICAs also document any medication administration needs identified in the participant's functional screen.

In addition, providers that are licensed or certified by an SMA credentialing entity are monitored by that credentialing entity, which includes onsite reviews and investigation of complaints and medication error-related incidents within those facilities.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Critical Incident Report (CIR) remediation submitted for substantiated cases of abuse, neglect, exploitation & unexplained deaths. N/D: Number of participant records reviewed with CIR remediation activities related to substantiated cases of abuse, neglect, exploitation & unexplained deaths over Number of participant records with reported cases of abuse, neglect, exploitation & unexplained deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The IRIS Consulting Agency (ICA) is responsible for ensuring participant health and safety by ensuring immediate and ongoing health and safety related to the reported critical incident. Numerator/Denominator: Number of critical incidents reported in which the ICA adequately ensured the health and safety of the participant over Number of participant incidents reported.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System and Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☒ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
All SMA approved restrictive interventions are implemented as approved.

Numerator/Denominator: Number of properly implemented restrictive interventions based on SMA review over Number of approved restrictive interventions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System and Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: External Quality Review Organization (EQRO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Participants must receive annual education about their health care responsibilities which includes having a primary care provider. Numerator/Denominator: Number and percent of participants who have a completed "IRIS Participant Education Manual: Acknowledgement (F-01947)" form over Number of participant records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: External Quality Review Organization (EQRO)	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

To ensure waiver and program compliance by the contracted FEA and ICAs, the SMA developed performance indicators that align with CMS assurances outlined within this Appendix. Discovery and remediation information primarily comes from the Record Review process which is administered through a contract with an external quality review organization (EQRO).

Quarterly, the EQRO conducts the Record Reviews for each contracted entity. The EQRO is responsible for completing all resulting remediation activities and reporting the findings to the SMA. Additionally, the Record Review process allows the SMA to gather information about complaints, appeals and grievances, participant incident reports, and requests for the use of restrictive measures.

Additionally, discovery information is obtained when the EQRO is validating reported performance measures required by the SMA and CMS. Information is also obtained when the EQRO is assessing the quality of services and support coordination functions, assessing compliance with quality standards, and other activities, such as administration or validation of consumer surveys of quality of care.

Contractor oversight operations also provide valuable discovery information. Monthly, the SMA has meetings with individual contractors to discuss any performance and/or quality management concerns.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

Quarterly, the SMA meets with each contractor to review the following:
• Remediation activities for Record Review performance indicators below the CMS required threshold;
• Review of all substantiated cases of abuse, neglect, misappropriation and exploitation cases; and
• Review of the contractor Performance Improvement Plans (PIPS) promulgated by the contractor to increase performance and address areas for improvement.

Monthly, the SMA has meetings with individual contractors to discuss any performance and/or quality management concerns. The SMA remediates those concerns accordingly.

Annually, for each contractor, the SMA conducts a “Contractor Recertification Meeting” and also reviews their Participant Satisfaction Survey results with them. Following the meeting, the SMA provides the contractor with the outcome of the Annual Recertification and if necessary, determines next steps.

These processes allow the SMA to confirm remediation of discovered problems and to identify potential areas of concern. The recertification meetings and satisfaction survey results also seek to identify if discovered and potential areas of concern, relate to systemic problems or issues within the contracted agency or the overall program. The SMA remediates these issues accordingly. All activities related to contractor performance will be documented and maintained within the SMA’s Quality Management Plan document for each contractor.

Remediation operations are continuously improved and updated so as to gain overall efficiencies within the program. Moreover, waiver amendments exist if systemic problems drastically hinder program operations.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care

services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The SMA's processes for trending, prioritizing and implementing system improvements that are prompted as a result of analysis of discovery and remediation involve the steps outlined below.

1. Issues at the Individual Participant Level

IRIS is a fully self-directed program, so participants identify their day-to-day issues and seek help from various program actors. Additionally, issues are identified during regular interactions between IRIS Consultant Agents (ICA) and participants. Program actors include the ICA, Fiscal Employer Agents (FEA), external quality review organization (EQRO), IRIS Ombudsmen, and the SMA which includes their various SMA oversight teams and contracted entities. Throughout this process, when the SMA identifies single issues that require remediation, additional action, or oversight, the SMA oversight teams review those issues with ICAs or the FEA and develop plans for remediation. If quality concerns are identified, those are addressed with the ICA or FEA and may be elevated to SMA oversight teams' section managers. Individual issues may be identified through the review of participant incident or other reports submitted by ICAs, EQRO findings and other sources. These processes occur on a continuous and ongoing basis. Health and safety issues are given priority. Issues that require corrective action are identified in writing by the SMA to the contractor (ICA and/or FEA) and the SMA oversight teams track and document implementation of applicable corrective actions until issues are resolved.

2. System Issues at the Contractor Level

When systemic issues are identified within an ICA or the FEA, the SMA oversight teams work with the contractor to develop systemic plans for system improvements. These issues may be identified through the review of reports submitted by contractors, annual or monthly meetings with contractors, the findings of the EQRO, participant incident reporting, the receipt of complaints/grievances, as well as during financial auditing, and review of encounter submissions. This process occurs on a continuous and ongoing basis in addition to the regularly scheduled reviews and audits. The SMA may make related contract changes to address issues identified among multiple contractors. Performance improvement projects may also be implemented by the contractor to rectify identified issues.

3. Systemic Issues with Contractors: Prioritization

Systemic issues that impact participant health and safety, especially those involving participants with complex or high-risk needs, are prioritized. Additionally, issues related to service gaps, financial accountability, and the SMA's compliance with waiver assurances are also prioritized for remediation. Accordingly, significant issues of concern are addressed by SMA oversight teams with contractors to ensure they are addressed adequately and promptly. Systemic issues may require changes in contractor policies and procedures, such as additional staff, infrastructural changes or the implementation of performance improvement projects or corrective action plans.

a. Oversight
i. SMA Contractor Oversight Process

The SMA oversight teams for contractors are supervised by section managers who can identify trends across these contractors. The SMA oversight teams meet on a periodic basis to share information about contractor performance and best practices in relation to oversight. The SMA section managers meet regularly with other SMA section managers and discuss issues they are seeing that may affect contractors, or suggest changes to SMA policies and procedures. SMA oversight teams meet regularly with the SMA's fiscal teams and information systems staff to share information and strategically plan about issues identified in those areas. Remediation, if necessary, is conducted accordingly.

ii. SMA Review of EQRO Discovery

The SMA reviews all reports of discovery by the EQRO to identify issues that affect contractors and systems. The SMA identifies and analyzes issues that affect the overall waiver systems and recommend potential quality improvement strategies. Strategies are prioritized based on the impact of the issue on 1) health and safety; 2) compliance with waiver assurances and other Medicaid requirements; and 3) other SMA quality priorities.

b. Policy

SMA policy staff collaborate with SMA oversight teams and contractors regarding interpretation and implementation of policy, as well as to address policy-related issues. Recurring questions or issues brought to these staff are documented, discussed, and brought to management as appropriate. Issues that require an immediate response may be addressed through written policy clarifications (policy addendums or policy frequently asked questions (FAQ)) or contractor provider agreement and/or contract amendments. Annually, contractors are afforded the opportunity to suggest changes to the contractor provider agreement and/or contract which in turn may fill policy and procedural gaps.

c. Quality

i. Trending and Analysis of Performance Metrics

The SMA has identified a number of performance metrics that it tracks and trends over time. Those metrics are available to contractors for prompt discussion and to identify successes and areas that need improvement. The metrics are also used by the SMA to compare contractor performance and to identify program-wide issues. These metrics may be modified over time and include participant incident reporting, participant survey results, performance improvement project development, and financial reporting. The External Quality Review Organization also provides to the SMA, Record Review results which provide valuable quality and performance information. The ongoing Record Review process yields critical information that supports continuous quality improvement and enables timely remediation of issues identified during waiver implementation.

ii. Analysis of Waiver Performance Measures

Trends and opportunities to improve CMS-reported measures are identified annually when preparing the 372 report and the waiver renewal evidence-based report. Performance indicators yielding below-standard outcomes are identified for process improvement.

4. Methods of Implementing Quality Improvement Strategies
Quality improvement strategies can be implemented in a variety of ways including:

a. Oversight
i. Oversight processes for implementation of quality improvement strategies are substantially similar to those described above.
ii. Modification of EQRO review instructions: The periodic reviews conducted by the EQRO can be customized to address a particular issue of concern, both as a vehicle for discovery and as a way to support continuous quality improvement and enable timely remediation of issues identified during waiver implementation.
iii. Focused EQRO reviews: The SMA has the option to assign the EQRO to conduct focused reviews based on discovery of individual or systematic concerns and work with contractors on remediation strategies.

b. Policy
i. Modifications to the contractor provider agreement between the SMA and contractors: This agreement reflects the requirements and expectations of the SMA for contractors regarding the operation of the waiver. If the nature of the quality issue is one that warrants an agreement modification, it can be done by amendment or as part of the next annual contractor provider agreement cycle.

c. Quality
i. The SMA-contractor provider agreement includes provisions allowing the SMA to mandate performance improvement projects to address issues that are of program-wide concern.
ii. Specialized reporting requirements or Corrective Action Plans: The SMA can require contractors to submit materials to monitor progress related to a quality issue.

Contractors are responsible for developing annual Quality Management Plans (QMPs) to enhance performance and address potential areas for improvement. These plans must clearly define the desired outcomes, performance targets, implementation strategies, and measurable deliverables. The SMA monitors these QMPs at least quarterly to ensure alignment with waiver requirements and continuous quality improvement goals. In addition, monthly

oversight meetings are conducted with contractors to review progress and address performance concerns. Identified issues are remediated through targeted actions, supporting an ongoing cycle of quality management and compliance.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☒ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☒ **Annually**
☒ **Other** Specify: ICAs and the FEA	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The SMA is responsible for assessing the impact of any system design changes, including those related to IT infrastructure and programmatic policy structures. Changes that are precipitated by analysis of data collected through discovery activities are monitored using the various discovery methods described elsewhere in this waiver. These changes undergo the same level of scrutiny as the processes or policies they are intended to replace. The SMA staff responsible for monitoring and assessing system design changes varies with the nature of the change. Fiscal oversight staff focus on changes related to fiscal policies or practices, while Contract and Oversight Specialists monitor compliance with contract and provider agreement requirements. Enterprise care management systems staff are tasked with evaluating the viability of requested system design changes, ensuring alignment with established IT standards and facilitate the seamless support of all contractors and partners. This collaborative approach ensures that all changes align with the objectives and assurances of this waiver, fostering coordinated oversight across SMA bureaus.

A change of particular significance may be assessed through a focused review conducted by the EQRO or SMA, which includes staff from fiscal oversight, contract oversight, and enterprise care management system. These staff work collaboratively within teams, guided by leadership within the SMA, allowing them to share observations across bureaus and communicate findings to team members and SMA managers. The SMA meets regularly with the EQRO to receive updates on the outcomes of any changes. Monitoring and assessing system improvement follow standardized processes, with each indicator being reviewed every other year. The EQRO annual quality reviews routinely evaluate all indicators on a regular cycle, which is integral to both compliance monitoring and continuous quality improvement within this waiver.

When system improvements are implemented with organized performance improvement projects (PIPs), the specifications for monitoring and assessing the implemented change are developed and adopted in compliance with the standards set forth in the CMS protocol for PIPs. When a PIP is undertaken by a single contractor, the contractor develops the processes and measures for monitoring and assessing system design changes, which are approved by the SMA and annually validated by the EQRO. If the PIP is a statewide project, the processes and measures for monitoring and assessing system design changes are selected by the SMA, with the consultation of the EQRO and the contractors.

Changes to systems or processes are communicated to contractors through contract or provider agreement amendments. Contractor management and staff are alerted to upcoming changes during regular meetings. In addition, the SMA maintains a public website that provides comprehensive information about these changes and their effects on the program. This website is accessible to participants, their families, providers, advocates, and partners, and it posts any modifications to the contract or provider agreement.

The results of changes are communicated through a variety of methods, with both the communication method and frequency depending on the nature of the change. Some changes, although precipitated by discovery, are considered routine adjustments. The contract or provider agreement between the SMA and its contractors may incorporate such changes, as part of the contract or provider agreement review processes. The SMA shares results of such a change internally and with the contractors to determine if the outcomes have been achieved. When necessary, the results of more significant changes are communicated more broadly-for example, by presenting or communicating them to program participants, SMA’s partners, and other interested advocacy groups.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The Quality Improvement Strategy is evaluated annually by the SMA, in conjunction with the External Quality Review Organization (EQRO). This evaluation focuses on continuous quality improvements and operationalization of processes to measure, analyze, and improve outcomes. The SMA evaluates progress on meeting internal and CMS’ performance goals, waiver measures, and assurances, determining the course of action for unmet goals, and monitoring high-level effects of system-wide changes. In addition, the SMA continually revisits high level goals linked to the SMA’s vision, mission, and values of adult long-term care programs including the IRIS program.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

The State uses the NCI Survey as well as an internally developed statewide survey called the Participant Satisfaction Survey. The Participant Satisfaction Survey is meant to capture overall participant satisfaction with their ICA and FEA

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

a) The SMA contracts with IRIS Consultant Agencies (ICAs) and the Fiscal Employer Agent (FEA) and requires each contractor to have an annual independent financial audit performed by a third-party certified public accounting (CPA) firm. The audit must be in accordance with the Generally Accepted Auditing Standards (GAAS) and Generally Accepted Accounting Principles (GAAP).

The annual independent financial audit assesses the financial statements and internal controls of the contractor. The SMA reviews the results of the annual independent financial audits and assesses the contractors' financial reports and compliance with contract requirements on contractor finances and internal controls. Any deficiencies identified by the third-party CPA firm must be remediated by the contracted agencies, with the SMA implementing corrective action as required (including, but not limited to, updated policies and procedures, additional internal controls, increased frequency of financial reporting, or additional reporting specific to the identified finding).

The SMA does not require annual independent financial audits of other waiver service providers.

b) The SMA provides oversight of the service utilization and payment data reported to the SMA by the Fiscal Employer Agent (FEA). The FEA is the exclusive submitter of data for services in the amounts and rates approved under valid service authorizations. Service utilization and payment data is first submitted to the SMA in a payment file specifying the payments to be funded and issued, and then later at a greater level of detail as an encounter submission to the SMA's Medicaid Management Information System (MMIS). MMIS validates the data and provides a response file to the FEA, which is responsible for correcting and resubmitting data until accepted.

The FEA is responsible for verifying claims against the service authorizations specified in participant service plans prior to payment; they may pay a claim only if it is from the provider and for the service specified in the authorization, and only if the authorization has funds remaining to pay the claim. A service cannot be authorized on a participant's plan unless the participant has sufficient budget authority and identified long-term care needs and outcomes along with a strategy to meet those needs and outcomes through the waiver.

The SMA conducts biweekly random sample audits of the FEA's submitted payment files to confirm that claims submitted for payment match service authorizations and are appropriately documented. A minimum biweekly sample size and appropriate business rules are established for proportionality, to ensure that at least 20 percent of claims exceeding $2,500 are sampled, and at least one payroll and one vendor claim line are sampled for the FEA, regardless of its enrollment or claim volume. Samples are provided to the FEA through a secure file transfer, which the FEA uses to provide supporting documentation. The supporting documentation is used to verify claims against service authorizations, accuracy of the claims submitted, and accuracy of wage transactions for participant-hired workers. Invalid claims can be withheld against the FEA's monthly rate of service (MROS) payments or recovered as damages for contractual noncompliance, and ongoing deficiencies are addressed through corrective action. Other contractual performance concerns identified in the audit are referred to the SMA's quality and oversight staff for follow-up, including concerns about plan creation and service authorization by the IRIS Consultant Agencies (ICAs).

The SMA also conducts an annual high-level data review and random sample audit of the integrity of the FEA's submitted encounter data for compliance with claim submission standards, and for consistency with service authorizations and the FEA's submitted payment files. Encounter data are not used for payments, but rather for reporting and analysis. The SMA is responsible for conducting the financial audit program, either directly with SMA staff or under contract to a qualified External Quality Review Organization (EQRO).

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the state's quality improvement strategy, provide information in the following fields to detail the state's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Waiver service claims must identify a number of units of service that is consistent with the number of units on the approved service authorization. Numerator/Denominator: Number of service claims with the number of units consistent with the approved service authorization over Number of service claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System and Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%*
☒ ***Other*** *Specify:* *External Quality Review Organization (EQRO)*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
Waiver service claims must identify a date of service that is consistent with the date of service on the approved service authorization. Numerator/Denominator: Number of service claims with dates of service consistent with the approved service authorization over Number of service claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System and Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***

☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%*
☒ ***Other*** *Specify:* *External Quality Review Organization (EQRO)*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*

Performance Measure:
Waiver service claims must identify the specific provider that is consistent with the provider listed on the approved service authorization. Numerator/Denominator: Number of service claims by a specific provider consistent with the approved service authorization over Number of service claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System and Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%*
☒ ***Other*** *Specify:* *External Quality Review Organization (EQRO)*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the state to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Waiver service claims must identify a rate of service that is consistent with the rate on the approved service authorization. Numerator/Denominator: Number of service claims with rates consistent with the approved service authorization over Number of service claims reviewed.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
SMA Enterprise Care Management System and Record Reviews

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☐ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%*
☒ ***Other*** *Specify:* *External Quality Review Organization (EQRO)*	☒ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☐ ***Other*** *Specify:*	☒ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
	☐ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

To ensure waiver and program compliance by the contracted FEA and ICAs, the SMA developed performance indicators that align with CMS assurances outlined within this Appendix. Discovery and remediation information primarily comes from the Record Review process which is administered through a contract with an external quality review organization (EQRO). Quarterly, the EQRO conducts the Record Reviews for each contracted entity. The EQRO is responsible for completing all resulting remediation activities and reporting the findings to the SMA.

Additionally, the SMA requires ICAs and FEAs to have an annual independent third party audit performed by a certified public accounting firm. The audit includes sampling and testing of claims payments, as well as verification of eligibility, authorization, and provision of services. The SMA reviews the results of the independent financial audits

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

Any adverse findings resulting from the independent third party audit must be remediated by the ICA or FEA responsible for the violation. Moreover, the SMA implements corrective action with the contract agencies as required, including but not limited to updated policies and procedures, additional internal controls, increased frequency of financial reporting, and/or additional reporting specific to the identified weaknesses. The SMA also requires an annual review of the policy and procedures manual and the IRIS provider agreement of each certified ICA and the contract of the FEA provider. Internal audit controls used during claims processing are included in the annual review.

ICAs and the FEA are also trained to recognize fraudulent submission of claims and timesheets. If fraudulent activity is suspected, it is reported timely to the SMA. The SMA and ICA and/or FEA collaborate as necessary, to complete the Fraud Allegation Review and Assessment (FARA) processes and report cases of substantiated fraud to the SMA's Office of Inspector General and Department of Justice as appropriate.

Remediation operations are continuously improved and updated so as to gain overall efficiencies within the program. Moreover, waiver amendments exist if systemic problems drastically hinder program operations.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☒ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☐ ***Other*** *Specify:*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

◉ ***No***

○ ***Yes***

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The IRIS Individual Budget Allocation (IBA) is an estimate of monthly costs for an IRIS participant, calculated from a model based on historic cost data and screening results. The SMA develops target group-specific regression models to determine which attributes from the SMA's Wisconsin Adult Long-Term Care Functional Screen (LTCFS) are most predictive of a participant's costs, and the predicted cost of each of those attributes. Further adjustments, such as regional cost variances and trends over time, are applied to the IBA to maintain an equitable and cost-effective funding model. An IRIS participant's IBA is calculated within the LTCFS, which is programmed with the IBA model. The SMA updates cost trend adjustments in the IBA calculation annually and reviews the model as a whole periodically.

The monthly IBA estimate is used to determine a participant's overall annual budget in the SMA enterprise care management system (ECM), within which the participant develops a service plan for the year. If the participant believes their annual budget is insufficient to meet their needs, the participant may request a budget amendment (time limited or ongoing budget increase) or one-time expense (single purchase outside the budget) from the SMA. The SMA reviews all budget amendment (BA) and one-time expense (OTE) requests and determines if those requests are fully approved, partially approved, or denied.

Additionally, all documentation of the BA and OTE request and resulting determinations must be part of the participant's record.

The costs of IRIS Consultant Agency (ICA) services are paid by the SMA and not deducted from a participant's budget.

Provider Rates

The participant is the primary negotiator for provider rates. As part of the educational information given to participants during their orientation to the program, participants receive education on how to negotiate rates with providers. ICAs assist with rate negotiations, as requested, to ensure that the rate negotiated is usual and customary for the service in that region of the state according to SMA established rate ranges.

The SMA does not establish a mandated fee schedule for services provided by participant hired workers. The nature of the program ensures full budget authority and employer authority for participants. However, the SMA does develop rate ranges to assist participants in negotiations and for use in internal reviews of BA and OTE requests.

The SMA establishes per unit or per participant per month rate ranges for IRIS waiver services based on actual historical costs, adjusted as necessary for considerations such as geographic variation and cost trends. These rate ranges are shared with the ICAs who in turn educate participants to ensure participants have the tools, resources, and information to negotiate the most cost-effective rate with providers.

Once the provider and participant have negotiated an agreed upon rate and the participant's plan has been approved, the Fiscal Employer Agent (FEA) receives a prior authorization for each service generated by the SMA enterprise case management system.

There is only one rate set in the IRIS program: the ICA rate. This service is not paid out of the participant's budget because it is required for all participants. Participants negotiate rates for all other services.

ICA Rate Setting

The SMA establishes rates for IRIS care coordination as a uniform, capitated monthly rate of service (MROS). There is one MROS for the ICAs. The SMA develops the MROS from ICAs' reported costs, estimated workloads, and related information. MROS amounts are reviewed annually.

In its future contract with a single FEA, the services provided by the FEA will become an administrative component of IRIS, and the price for services will be established by contract.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The IRIS Fiscal Employer Agent (FEA) provides claims adjudication and processing services on behalf of the SMA. Traditional claims are submitted to the FEA from participant service providers, other than participant-hired workers. Claims are submitted with industry standard data elements required for claims adjudication, such as service type, frequency, unit, rate, and date of service.

Payroll claims are submitted to the FEA as timesheets from participant-hired workers (service providers hired by participants under their employment authority). Workers are required to specify their time worked by participant and service type. The FEA may offer electronic timekeeping but is not required to do so.

For both traditional and payroll claims, the FEA is required to adjudicate every claim against each participant's service authorizations. Only claims for authorized services are to be paid. If the FEA receives a claim partly or wholly outside a service authorization, the FEA is required to deny the unauthorized portion and inform the submitting provider or participant-hired worker of the denial and the reason for it.

The FEA submits information weekly on authorized claims to the SMA for funding through a state-held bank account, from which providers are paid through electronic funds transfer.

The SMA will be instituting claims administration improvements in its future contract with a single FEA. These improvements include, but are not limited to:
• Integration of all aspects of claims processing into a single financial management system with direct monitoring access for the SMA;
• Claim submission via X12 837 file upload, CMS 1500 or UB-04 claim form, direct entry in a web portal, or an electronic timesheet with real-time electronic visit verification (EVV) integration; and
• Real-time monitoring of claim status by providers, participant-hired workers, and the SMA.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

The Fiscal Employer Agent (FEA) is responsible to assure that payment is only made when the participant was eligible for Medicaid waiver service payment on the dates of service, as indicated in the SMA's enterprise care management system, and that the service was included in the participant's approved IRIS Service Plan (service plan) and is within the allowable budget amount.

Provider claims and participant-hired worker (PHW) payroll claims are validated by the FEA against the service authorizations the FEA receives from the SMA's enterprise care management system. Each service authorization includes the participant's ID (ensuring waiver program eligibility), provider's ID (ensuring validation of applicable provider licenses or certification), service type (ensuring allowable waiver services), service code, frequency, unit, rate, and authorization period (starting and ending dates).

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

○ ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***

○ ***Payments for some, but not all, waiver services are made through an approved MMIS.***

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◉ ***Payments for waiver services are not made through an approved MMIS.***

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Providers do not have the option of receiving payments directly from the SMA. All service claims except payment for IRIS Consultant Agency (ICA) services are submitted to the Fiscal Employer Agent (FEA).

a) The FEA makes payments to providers and participant-hired workers directly from a state-held bank account upon receipt and approval of appropriate payment files from the FEA.

b) Payments are processed through the FEA's claims adjudication system. The FEA receives a service authorization from the SMA's enterprise care management system. The FEA assures that payments to providers are in accordance with prior authorizations generated from participant's IRIS Service Plan (ISP). Services that are not part of an ISP or that exceed the approved use of the participant's individual budget are denied.

c) Claims detail is provided by the FEA through its submitted payment files and encounter data. The FEA is required to manage and adjudicate claims against service authorizations. The payment file is the source of truth for claim payments; the SMA uses its random sample audit process to validate the payment file.

d) Total costs for the draw of federal funds and claiming are based upon the information in the payment files submitted by the FEA, processed through the SMA's accounting system with allocations based upon submitted encounter data. The SMA submits quarterly CMS 64 claiming reports.

○ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☒ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The SMA contracts with a Fiscal Employer Agent (FEA) for financial management services on behalf of IRIS participants. Appendix A describes the FEA function in brief. The FEA is responsible, under contract with the SMA, for claims adjudication and processing when making payments for waiver services. There are two types of claims which are submitted for reimbursement within the IRIS waiver program: traditional provider claims, and participant-hired worker payroll claims.

The FEA functions as a limited fiscal agent for payments of all waiver services. The FEA provides claims adjudication, processing, and payment services to the FEA as described in Appendix Section I-2-b. The SMA provides program oversight to the FEA through monthly oversight meetings, monthly reports (and ad hoc per SMA request) submitted by the agency plus independent reporting by the SMA, program record review, and the annual contractor recertification site visit. The SMA contracts with an External Quality Review Organization (EQRO) to manage and work directly with the FEA to complete the Program Record Review process.

The Program Record Review consists of performance indicators derived from the performance measures identified within the 1915(c) Home and Community Based Services (HCBS) waiver, as well as programmatic requirements identified by the SMA. SMA representative conducts annual virtual site visits, during which the SMA reviews the FEA's pre-submitted documentation as requested by the SMA, and discusses FEA's current practices, procedures, policies, methodologies, and performance metrics related to the IRIS program. The SMA also reviews concerns and complaints received directly from program participants, service providers, and partner agencies as well as Ombudsmen, advocates, State Representatives (CCT), and other resources.

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

- ◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*
- ○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

County departments of human service, social services and community programs provide certain services in some counties. These services may be selected by participants in IRIS and are reimbursed by the FEAs as authorized by the participant. These services could include:

Adult Family Home
Supportive Home Care
Day Services
Prevocational Services
Supported Employment
Community Transportation

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

Answers provided in Appendix I-3-d indicate that you do not need to complete this section.

- ◉ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***

○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***

○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***

○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***

○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the***

state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as

CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- ◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*
- ○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- ◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ○ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- ◉ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Residential settings other than the personal home of the participant specified in Appendix C where the State furnishes waiver services are required to break out the participant's obligation for room and board from the cost of allowable waiver services using the following methodology prescribed by the State Medicaid Agency (SMA). The participant uses his or her own resources to pay for their room and board obligation.

The waiver participant's room and board obligation is the lesser of:
• HUD FMR rental amounts based on residential type plus the maximum Supplemental Nutrition Assistance Allocation for one person; or
• The participant's available income for room and board using procedures specified by the SMA.

Room and board obligation will be determined at time of service plan creation or renewal.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	26460.66	24616.00	51076.66	159692.26	4553.17	164245.43	113168.77
2	27478.70	25339.70	52818.40	165120.00	4696.66	169816.66	116998.26
3	28525.81	26148.33	54674.14	171193.36	4857.07	176050.43	121376.29
4	29450.65	26835.60	56286.25	176563.03	4996.10	181559.13	125272.88
5	30481.47	27609.75	58091.22	182588.66	5152.37	187741.03	129649.81

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Nursing Facility	ICF/IID
Year 1	34593	22137	12456
Year 2	36703	23362	13341
Year 3	38815	24566	14249
Year 4	40925	25748	15177
Year 5	43037	26908	16129

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

Average Length of Stay is calculated by dividing the total number of projected enrollment days for the year by the number of projected unduplicated participants served during the year.

The total number of enrollment days for the year is calculated by summing the product of each month's projected enrollment multiplied by the number of calendar days in each month.

Projected enrollment is generally based on actual enrollment as of January 2025 plus historical enrollment growth experience in the waiver of 154 participants per month, which is the growth assumed in the State budget. This amounts to annual net enrollment growth totaling 1,847 participants for an average annual net growth rate of 5.7%. Specific annual enrollment growth rates are 6.4% in CY2026 (Year 1), 6.0% in CY2027 (Year 2), 5.7% in CY2028 (Year3), 5.4% in CY2029 (Year 4), and 5.1% in CY2030 (Year 5).

The number of unduplicated participants served during the waiver year, which includes both actively enrolled and disenrolled participants, is calculated by adding the number of members expected to disenroll during the year (net of re-enrollments) to the projected participant count at the end of the year. A churn factor of roughly 1.3% per month based on the waiver's historical monthly disenrollment rate is applied to the projected monthly member count to estimate the number of members projected to disenroll each month. The sum of the monthly disenrollments is added to the projected member count at year end to compute the potential number of participants served during the year. Re-enrollments during the same year, averaging about 1.9% annually, are deducted from the potential number of participants to arrive at the annual unduplicated participant count. Including the monthly churn and annual re-enrollment factors result in the annual unduplicated participant counts being roughly 12.1% higher than the point in time year-end participant counts.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Waiver service costs and units are pulled from 7/1/2023 - 6/30/2024 certified encounter data and funding files submitted by fiscal employer agents. This is the most recent 12-month period of complete data. Alternate data sources are used for the following services:

--Costs for IRIS Consultant Agency services are based on payments made according to the monthly rate of service and trended forward using trend factors found in the State budget. These services are assumed to be utilized by all participants.

--Assistive Technology is expanded to include equipment for remote monitoring services. Utilization and cost for equipment is based on similar services provided in other states. No adjustment is needed for ongoing remote monitoring costs as these services are currently being provided and are included in Virtual Monitoring and Emergency Response Systems base data.

--Competitive Integrated Employment (CIE) Exploration is a new service. Utilization is based participant survey data. Cost is assumed to be similar to Individual Supported Employment.

--Massage therapy, nutritional counseling, and weight management counseling have been removed from Counseling, Therapeutic, and Wellness.

--Wellness services in Counseling, Therapeutic, and Wellness have been expended. Utilization is based on implementation of the service expansion in another long term care program. Services are not expected to be fully utilized until CY2027 (Year 2) due to slower uptake experienced when the service was added. Unit cost is assumed to be similar to the health classes covered in the existing waiver.

--Support Broker Services are being limited to the subservice of assistance with public benefits. Remaining subservices are no longer covered.

Base period cost and unit data is grouped by level of care (Nursing Facility and ICF-IID) and waiver service category. Total costs and units for each service are divided by total participant days in the base period to arrive at the baseline average service cost per participant per day and average units per participant per day.

To calculate projected total cost for each waiver year, the base period daily service costs per participant are trended forward and then multiplied by the projected member days for each waiver year. Cost trends are 2.9% in CY2024 (6 month trend); 3.0% in CY2025; and 3.0% in CY2026 (Year 1) - CY2030 (Year 5) based on State budget projections. The CY2023 and CY2024 trends are included to allow projections to be tracked back to the source data. IRIS Consultant Agency contract changes required policy adjustments of -0.2% in CY2024 and 0.4% in CY2025. Adjustments for new and modified services amount to 0.4% in CY2026 (Year 1) and 0.3% in CY2027 (Year 2).

Total waiver cost for both levels of care combined is divided by the projected number of unduplicated waiver participants to arrive at Factor D. The unduplicated participant count in the derivation is projected using the same method to derive Average Length of Stay as described above.

To calculate total units, average units per participant per day for each existing service from the 7/1/2023 – 6/30/2024 base period is multiplied by the projected participant days for each year and level of care. Units per participant per day for new or modified services is based on alternative data sources listed above. Other than the expanded Wellness services ramping up over the first two waiver years, average units per participant per day is held constant for all services as utilization patterns are not expected to change.

Service costs and total units for each level of care are added together by service category to combine levels of care. Combined service costs are divided by combined units to arrive at average cost per unit for each service.

The number of users for each service is calculated by multiplying the user percentage for each service by the projected unduplicated participants for each waiver year. The user percentages for existing services are based on the number of users for each service in the 7/1/2023 – 6/30/2024 base period encounter data divided by the number of unduplicated participants in the base period for each level of care. User percentages for new or modified services are based on alternative data sources listed above. Other than the expanded Wellness services

ramping up over the first two waiver years, user percentages are held constant for all services the projected waiver years as utilization patterns are not expected to change.

Average units per user for each service is calculated by dividing the projected units for each service by the number of users for each service. Derivations for total units and number of service users are described above.

Year to year changes in the waiver participant level of care proportions and Average Length of Stay (ALOS) result in the annual Factor D increase diverging from the per person cost trends.

The proportion of participants in the ICF-IID level of care is slowly increasing each year. The average waiver cost per participant for the ICF-IID level of care is roughly 285% of the average waiver cost per participant for the Nursing Facility level of care. The growing proportion of the higher cost ICF-IID level of care population increases the composite Factor D by 0.4% on average each year.

Average Length of Stay (ALOS) changes in the waiver population impact Factor D by 0.7% in CY2024 (6 month trend); -2.3% in CY2025; 0.1% in CY2026 (Year 1); 0.1% in CY2027 (Year 2); 0.4% in CY2028 (Year 3); -0.2% in CY2029 (Year 4), and 0.1% in CY2030 (Year 5). CY2024 is from actual waiver enrollment. CY2025 shows a decrease reflecting a full year without a continuous enrollment policy in place. An additional 0.3% reduction is included in CY2025 due to not having an extra leap day relative to the prior year. ALOS throughout the wavier period trends at a roughly 0.1% increase each year. CY2028 (Year 3) is a leap year resulting in an additional 0.3% increase with the extra day. The ongoing ALOS trend is reduced by 0.3% in CY2029 (Year 4) due to not having the extra leap day relative to the previous year.

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor D' is based on actual 7/1/2023 - 6/30/2024 State Medicaid plan service costs for waiver participants as well as self-directed personal care costs. The portion of Factor D' related to self-directed personal care services is from certified encounter data and funding files submitted by fiscal employer agents. All other State plan service costs in Factor D' are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. The cost of prescribed drugs furnished to Medicare / Medicaid dual eligible under the provisions of Part D are not included in the estimate. Total non-waiver cost is divided by the projected number of unduplicated waiver participants to arrive at the cost of non-waiver covered Medicaid services per waiver participant.

Separate Factor D' projections are developed for each level of care – ICF-IID and Nursing Facility – and then blended by the proportion of participants in each level of care. Base period average cost per participant per month is trended forward at average rates of 1.3% in CY2024 (6 month trend), 3.4% in CY2025, and 3.0% annually in CY2026 (Year 1) - CY2030 (Year 5) using the Consumer Price Index for Medical Care. An additional 0.5% is included in the CY2024 and CY2025 trends to reflect State plan increases in the SFY2025 State budget. CY2024 and CY2025 trends are included to allow projections to be tracked back to the source data.

Year to year changes in the waiver participant level of care proportions and Average Length of Stay (ALOS) result in the annual Factor D' increase diverging from the per person cost trends.

The proportion of participants in the ICF-IID level of care is slowly increasing each year. The average per person State plan cost for ICF-IID level of care waiver participants is roughly 79% of the average per person State plan cost for Nursing Facility level of care waiver participants. The growing proportion of the lower cost ICF-IID level of care population decreases the composite Factor D' by 0.1% on average each year.

Average Length of Stay (ALOS) changes in the waiver population impact Factor D' by 0.7% in CY2024 (6 month trend); -2.3% in CY2025; 0.1% in CY2026 (Year 1); 0.1% in CY2027 (Year 2); 0.4% in CY2028 (Year 3); -0.2% in CY2029 (Year 4), and 0.1% in CY2030 (Year 5). CY2024 is from actual waiver enrollment. CY2025 shows a decrease reflecting a full year without a continuous enrollment policy in place. An additional 0.3% reduction is included in CY2025 due to not having an extra leap day relative to the prior year. ALOS throughout the wavier period trends at a roughly 0.1% increase each year. CY2028 (Year 3) is a leap year resulting in an additional 0.3% increase with the extra day. The ongoing ALOS trend is reduced by 0.3% in CY2029 (Year 4) due to not having the extra leap day relative to the previous year.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G is based on a blend of 7/1/2023 - 6/30/2024 Medicaid institutional costs for individuals residing in ICFs-IID, State Centers, and Nursing Facilities to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS.

Separate Factor G projections are developed for each level of care – ICF-IID and Nursing Facility – and then blended by the proportion of participants in each level of care. The base period average cost per person is trended forward at average rates of 1.4% in CY2024 (6 month trend), 2.9% in CY2025, and 2.9% annually in the CY2026 (Year 1) – CY2030 (Year 5) waiver period using the Consumer Price Index for All Items. CY2024 and CY2025 trends are included to allow projections to be tracked back to the source data.

The annual average cost per person is adjusted by a factor to reflect the variation in the average length of stay (ALOS) between the institutional population versus the waiver population. The ALOS in the institutional population base data is 240.3 days. The ALOS for the wavier population is 313.5 days in CY2026 (Year 1), 313.8 days in CY2027 (Year 2), 315.0 days in CY2028 (Year 3), 314.4 days in CY2029 (Year 4), and 314.6 in CY2030 (Year 5). With the institutional population having a lower ALOS than the waiver population, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the cost of the institutional population is adjusted by the ratio of the institutional ALOS to the wavier ALOS. This has the effect of increasing Factors G and G' by roughly 31% depending on the ALOS in the waiver population for the year. Factor G is higher by $27,468 in Year 1; $29,032 in Year 2; $31,143 in Year 3; $32,428 in Year 4; and $34,250 in Year 5 than it would be without the adjustment for ALOS.

Year to year changes in the waiver participant level of care proportions and Average Length of Stay (ALOS) result in the annual Factor G increase diverging from the per person cost trends.

The proportion of participants in the ICF-IID level of care is slowly increasing each year. The average per person institutional cost for the ICF-IID and State Center population is nearly 270% higher than the average per person institutional cost for the Nursing Facility population. The growing proportion of the higher cost ICF-IID level of care population increases the composite Factor G by an average of 0.4% each year.

Average Length of Stay (ALOS) changes in the waiver population impact Factor G by 0.7% in CY2024 (6 month trend); -2.3% in CY2025; 0.1% in CY2026 (Year 1); 0.1% in CY2027 (Year 2); 0.4% in CY2028 (Year 3); -0.2% in CY2029 (Year 4), and 0.1% in CY2030 (Year 5). CY2024 is from actual waiver enrollment. CY2025 shows a decrease reflecting a full year without a continuous enrollment policy in place. An additional 0.3% reduction is included in CY2025 due to not having an extra leap day relative to the prior year. ALOS throughout the wavier period trends at a roughly 0.1% increase each year. CY2028 (Year 3) is a leap year resulting in an additional 0.3% increase with the extra day. The ongoing ALOS trend is reduced by 0.3% in CY2029 (Year 4) due to not having the extra leap day relative to the previous year.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

Factor G' is based on a blend of 7/1/2023 - 6/30/2024 Medicaid non-institutional costs for individuals residing in ICFs-IID, State Centers, and Nursing Facilities to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS.

Separate Factor G' projections are developed for each level of care – ICF-IID and Nursing Facility – and then blended by the proportion of participants in each level of care. The base period average cost per person for each level of care is trended forward at average rates of 1.1% in CY2024 (6 month trend), 3.3% in CY2025, and 3.0% annually in the CY2026 (Year 1) - CY2030 (Year 5) waiver period using the Consumer Price Index for Medical Care. An additional 0.3% is included in the CY2024 and CY2025 trends to reflect State plan increases in the SFY2025 State budget. CY2024 and CY2025 trends are included to allow projections to be tracked back to the source data.

The annual average cost per person is adjusted by a factor to reflect the variation in the average length of stay (ALOS) between the institutional population versus the waiver population. The ALOS in the institutional population base data is 240.3 days. The ALOS for the wavier population is 313.5 days in CY2026 (Year 1), 313.8 days in CY2027 (Year 2), 315.0 days in CY2028 (Year 3), 314.4 days in CY2029 (Year 4), and 314.6 in CY2030 (Year 5). With the institutional population having a lower ALOS than the waiver population, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the cost of the institutional population is adjusted by the ratio of the institutional ALOS to the wavier ALOS. This has the effect of increasing Factors G and G' by roughly 31% depending on the ALOS in the waiver population for the year. Factor G' is higher by $996 in Year 1, $1,034 in Year 2, $1,087 in Year 3, $1,114 in Year 4, and $1,156 in Year 5 than it would be without the adjustment for ALOS.

Year to year changes in the waiver participant level of care proportions and Average Length of Stay (ALOS) result in the annual Factor G' increase diverging from the per person cost trends.

The proportion of participants in the ICF-IID level of care is slowly increasing each year. The average per person institutional cost for the ICF-IID and State Center population is roughly 36% higher than the average per person institutional cost for the Nursing Facility population. The growing proportion of the higher cost ICF-IID level of care population increases the composite Factor G' by an average of 0.1% each year.

Average Length of Stay (ALOS) changes in the waiver population impact Factor G' by 0.7% in CY2024 (6 month trend); -2.3% in CY2025; 0.1% in CY2026 (Year 1); 0.1% in CY2027 (Year 2); 0.4% in CY2028 (Year 3); -0.2% in CY2029 (Year 4), and 0.1% in CY2030 (Year 5). CY2024 is from actual waiver enrollment. CY2025 shows a decrease reflecting a full year without a continuous enrollment policy in place. An additional 0.3% reduction is included in CY2025 due to not having an extra leap day relative to the prior year. ALOS throughout the wavier period trends at a roughly 0.1% increase each year. CY2028 (Year 3) is a leap year resulting in an additional 0.3% increase with the extra day. The ongoing ALOS trend is reduced by 0.3% in CY2029 (Year 4) due to not having the extra leap day relative to the previous year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Care	
Day Habilitation	
Individual Supported Employment	
Life Skills Training and Education	
Prevocational Services	
Respite	
Nursing Services	

Waiver Services	
IRIS Consultant Agency (ICA) Services	
Assistive Technology	
Community Transportation	
Competitive Integrated Employment (CIE) Exploration	
Consultative Clinical and Therapeutic Services for Caregivers	
Counseling, Therapeutic, and Wellness Services	
Environmental Accessibility Adaptations (Home Modifications)	
Home Delivered Meals	
Housing Counseling	
Individual Directed Goods and Services	
Relocation - Community Transition Services	
Residential Services (1-2 Bed AFH)	
Residential Services (Other)	
Small Group Supported Employment	
Specialized Medical Equipment and Supplies	
Support Broker Services	
Supportive Home Care	
Training Services for Unpaid Caregivers	
Vehicle Modifications	
Virtual Monitoring and Emergency Response Systems	
Vocational Futures Planning and Support	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**8135244.94**
Adult Day Care	☐	hours	585	534.04	26.04	**8135244.94**	
Day Habilitation Total:							**37134641.93**

GRAND TOTAL:	**915353688.23**
Total: Services included in capitation:	
Total: Services not included in capitation:	915353688.23
Total Estimated Unduplicated Participants:	**34593**
Factor D (Divide total by number of participants):	**26460.66**
Services included in capitation:	
Services not included in capitation:	26460.66
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Habilitation	☐	hours	3179	358.43	32.59	37134641.93	
Individual Supported Employment Total:							17997629.26
Individual Supported Employment	☐	hours	1682	250.53	42.71	17997629.26	
Life Skills Training and Education Total:							6441234.66
Life Skills Training and Education	☐	hours	963	151.26	44.22	6441234.66	
Prevocational Services Total:							3916623.13
Prevocational Services	☐	hours	591	331.19	20.01	3916623.13	
Respite Total:							40257790.73
Respite	☐	hours	3749	539.07	19.92	40257790.73	
Nursing Services Total:							91510.41
Nursing Services	☐	hours	57	37.66	42.63	91510.41	
IRIS Consultant Agency (ICA) Services Total:							90306237.25
IRIS Consultant Agency (ICA) Services	☐	months	34593	10.30	253.45	90306237.26	
Assistive Technology Total:							973078.39
Assistive Technology	☐	items	1067	3.90	233.84	973078.39	
Community Transportation Total:							26970789.84
Community Transportation - Miles	☐	miles	4329	2836.22	0.66	8103477.61	
Community Transportation - Trips	☐	trips	3179	252.66	23.49	18867312.23	
Competitive Integrated Employment (CIE) Exploration							1063104.81

GRAND TOTAL:	915353688.23
Total: Services included in capitation:	
Total: Services not included in capitation:	915353688.23
Total Estimated Unduplicated Participants:	34593
Factor D (Divide total by number of participants):	26460.66
Services included in capitation:	
Services not included in capitation:	26460.66
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Competitive Integrated Employment (CIE) Exploration	☐	hours	519	48.05	42.63	**1063104.81**	
Consultative Clinical and Therapeutic Services for Caregivers Total:							**754283.81**
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	380	14.62	135.77	**754283.81**	
Counseling, Therapeutic, and Wellness Services Total:							**8972359.70**
Counseling, Therapeutic, and Wellness Services	☐	each	4319	25.80	80.52	**8972359.70**	
Environmental Accessibility Adaptations (Home Modifications) Total:							**1950765.10**
Environmental Accessibility Adaptations (Home Modifications)	☐	projects	230	1.66	5109.39	**1950765.10**	
Home Delivered Meals Total:							**1486247.77**
Home Delivered Meals	☐	meals	1030	148.30	9.73	**1486247.77**	
Housing Counseling Total:							**10917.68**
Housing Counseling	☐	hours	12	15.41	59.04	**10917.68**	
Individual Directed Goods and Services Total:							**268577.11**
Individual Directed Goods and Services	☐	each	114	86.52	27.23	**268577.11**	
Relocation - Community Transition Services Total:							**1565.19**

GRAND TOTAL:	**915353688.23**
Total: Services included in capitation:	
Total: Services not included in capitation:	915353688.23
Total Estimated Unduplicated Participants:	**34593**
Factor D (Divide total by number of participants):	**26460.66**
Services included in capitation:	
Services not included in capitation:	26460.66
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Relocation - Community Transition Services	☐	each	2	2.22	352.52	1565.19	
Residential Services (1-2 Bed AFH) Total:							26970486.16
Residential Services (1-2 Bed AFH)	☐	days	331	288.83	282.11	26970486.16	
Residential Services (Other) Total:							42558833.24
Residential Services (Other)	☐	days	538	325.94	242.70	42558833.24	
Small Group Supported Employment Total:							1145008.19
Small Group Supported Employment	☐	hours	139	510.06	16.15	1145008.19	
Specialized Medical Equipment and Supplies Total:							1320017.18
Specialized Medical Equipment and Supplies	☐	items	1128	43.15	27.12	1320017.18	
Support Broker Services Total:							504165.55
Support Broker Services	☐	hours	264	19.70	96.94	504165.55	
Supportive Home Care Total:							592996998.38
Supportive Home Care	☐	hours	31136	1032.27	18.45	592996998.38	
Training Services for Unpaid Caregivers Total:							32369.88
Training Services for Unpaid Caregivers	☐	hours	12	24.88	108.42	32369.88	
Vehicle Modifications Total:							1412327.56
Vehicle Modifications	☐	each	132	1.31	8167.52	1412327.56	
Virtual Monitoring and							1525302.09

GRAND TOTAL:	915353688.23
Total: Services included in capitation:	
Total: Services not included in capitation:	915353688.23
Total Estimated Unduplicated Participants:	34593
Factor D (Divide total by number of participants):	26460.66
Services included in capitation:	
Services not included in capitation:	26460.66
Average Length of Stay on the Waiver:	313

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response Systems Total:							
Virtual Monitoring and Emergency Response Systems	☐	rent/mon	2665	8.10	70.66	**1525302.09**	
Vocational Futures Planning and Support Total:							**155578.27**
Vocational Futures Planning and Support	☐	each	38	5.99	683.50	**155578.27**	

GRAND TOTAL:	**915353688.23**
Total: Services included in capitation:	
Total: Services not included in capitation:	915353688.23
Total Estimated Unduplicated Participants:	**34593**
Factor D (Divide total by number of participants):	**26460.66**
Services included in capitation:	
Services not included in capitation:	26460.66
Average Length of Stay on the Waiver:	313

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**8978946.38**
Adult Day Care	☐	hours	625	534.66	26.87	**8978946.38**	
Day Habilitation Total:							**41009923.72**
Day Habilitation	☐	hours	3402	359.09	33.57	**41009923.72**	

GRAND TOTAL:	**1008550866.91**
Total: Services included in capitation:	
Total: Services not included in capitation:	1008550866.91
Total Estimated Unduplicated Participants:	**36703**
Factor D (Divide total by number of participants):	**27478.70**
Services included in capitation:	
Services not included in capitation:	27478.70
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment Total:							**19875473.82**
Individual Supported Employment	☐	hours	1800	251.01	43.99	**19875473.82**	
Life Skills Training and Education Total:							**7109572.73**
Life Skills Training and Education	☐	hours	1030	151.57	45.54	**7109572.73**	
Prevocational Services Total:							**4321867.54**
Prevocational Services	☐	hours	632	331.80	20.61	**4321867.54**	
Respite Total:							**44398727.14**
Respite	☐	hours	4006	540.11	20.52	**44398727.14**	
Nursing Services Total:							**101033.40**
Nursing Services	☐	hours	61	37.72	43.91	**101033.40**	
IRIS Consultant Agency (ICA) Services Total:							**98879203.31**
IRIS Consultant Agency (ICA) Services	☐	months	36703	10.32	261.05	**98879203.31**	
Assistive Technology Total:							**1062831.79**
Assistive Technology	☐	items	1129	3.93	239.54	**1062831.79**	
Community Transportation Total:							**29725311.14**
Community Transportation - Miles	☐	miles	4612	2844.04	0.68	**8919364.49**	
Community Transportation - Trips	☐	trips	3394	253.21	24.21	**20805946.66**	
Competitive Integrated Employment (CIE) Exploration Total:							**1165663.09**
Competitive	☐					**1165663.09**	

GRAND TOTAL:	**1008550866.91**
Total: Services included in capitation:	
Total: Services not included in capitation:	1008550866.91
Total Estimated Unduplicated Participants:	**36703**
Factor D (Divide total by number of participants):	**27478.70**
Services included in capitation:	
Services not included in capitation:	27478.70
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integrated Employment (CIE) Exploration		hours	551	48.19	43.90		
Consultative Clinical and Therapeutic Services for Caregivers Total:							**833531.77**
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	407	14.64	139.89	**833531.77**	
Counseling, Therapeutic, and Wellness Services Total:							**13296190.42**
Counseling, Therapeutic, and Wellness Services	☐	each	6434	25.04	82.53	**13296190.42**	
Environmental Accessibility Adaptations (Home Modifications) Total:							**2133949.19**
Environmental Accessibility Adaptations (Home Modifications)	☐	projects	244	1.66	5268.49	**2133949.19**	
Home Delivered Meals Total:							**1621341.21**
Home Delivered Meals	☐	meals	1090	148.45	10.02	**1621341.21**	
Housing Counseling Total:							**11230.30**
Housing Counseling	☐	hours	12	15.40	60.77	**11230.30**	
Individual Directed Goods and Services Total:							**292667.30**
Individual Directed Goods and Services	☐	each	121	86.60	27.93	**292667.30**	
Relocation - Community Transition Services Total:							**2418.25**
Relocation - Community	☐	each	3	2.22	363.10	**2418.25**	

GRAND TOTAL:	**1008550866.91**
Total: Services included in capitation:	
Total: Services not included in capitation:	1008550866.91
Total Estimated Unduplicated Participants:	**36703**
Factor D (Divide total by number of participants):	**27478.70**
Services included in capitation:	
Services not included in capitation:	27478.70
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Services							
Residential Services (1-2 Bed AFH) Total:							***29683073.99***
Residential Services (1-2 Bed AFH)	☐	*days*	*353*	*289.37*	*290.59*	***29683073.99***	
Residential Services (Other) Total:							***46933170.84***
Residential Services (Other)	☐	*days*	*575*	*326.57*	*249.94*	***46933170.84***	
Small Group Supported Employment Total:							***1265869.45***
Small Group Supported Employment	☐	*hours*	*149*	*510.87*	*16.63*	***1265869.45***	
Specialized Medical Equipment and Supplies Total:							***1447739.04***
Specialized Medical Equipment and Supplies	☐	*items*	*1200*	*43.18*	*27.94*	***1447739.04***	
Support Broker Services Total:							***555495.78***
Support Broker Services	☐	*hours*	*282*	*19.73*	*99.84*	***555495.78***	
Supportive Home Care Total:							***650421760.75***
Supportive Home Care	☐	*hours*	*33025*	*1036.57*	*19.00*	***650421760.75***	
Training Services for Unpaid Caregivers Total:							***33425.15***
Training Services for Unpaid Caregivers	☐	*hours*	*12*	*24.93*	*111.73*	***33425.15***	
Vehicle Modifications Total:							***1545594.33***
Vehicle Modifications	☐	*each*	*140*	*1.31*	*8427.45*	***1545594.33***	
Virtual Monitoring and Emergency Response Systems							***1671676.02***

GRAND TOTAL:	***1008550866.91***
Total: Services included in capitation:	
Total: Services not included in capitation:	*1008550866.91*
Total Estimated Unduplicated Participants:	***36703***
Factor D (Divide total by number of participants):	***27478.70***
Services included in capitation:	
Services not included in capitation:	*27478.70*
Average Length of Stay on the Waiver:	*314*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Virtual Monitoring and Emergency Response Systems	☐	rent/month	2819	8.11	73.12	**1671676.02**	
Vocational Futures Planning and Support Total:							**173179.08**
Vocational Futures Planning and Support	☐	each	41	6.00	703.98	**173179.08**	

GRAND TOTAL:	**1008550866.91**
Total: Services included in capitation:	
Total: Services not included in capitation:	1008550866.91
Total Estimated Unduplicated Participants:	**36703**
Factor D (Divide total by number of participants):	**27478.70**
Services included in capitation:	
Services not included in capitation:	27478.70
Average Length of Stay on the Waiver:	314

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates *(7 of 9)*

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**9895329.87**
Adult Day Care	☐	hours	665	536.61	27.73	**9895329.87**	
Day Habilitation Total:							**45284462.39**
Day Habilitation	☐	hours	3631	360.66	34.58	**45284462.39**	
Individual Supported							**21946394.19**

GRAND TOTAL:	**1107229438.48**
Total: Services included in capitation:	
Total: Services not included in capitation:	1107229438.48
Total Estimated Unduplicated Participants:	**38815**
Factor D (Divide total by number of participants):	**28525.81**
Services included in capitation:	
Services not included in capitation:	28525.81
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment Total:							
Individual Supported Employment	☐	hours	1921	252.14	45.31	**21946394.19**	
Life Skills Training and Education Total:							**7847309.71**
Life Skills Training and Education	☐	hours	1099	152.28	46.89	**7847309.71**	
Prevocational Services Total:							**4775555.81**
Prevocational Services	☐	hours	675	333.25	21.23	**4775555.81**	
Respite Total:							**48937457.80**
Respite	☐	hours	4269	542.52	21.13	**48937457.80**	
Nursing Services Total:							**111306.51**
Nursing Services	☐	hours	65	37.86	45.23	**111306.51**	
IRIS Consultant Agency (ICA) Services Total:							**108098532.92**
IRIS Consultant Agency (ICA) Services	☐	months	38815	10.33	269.60	**108098532.92**	
Assistive Technology Total:							**1162766.15**
Assistive Technology	☐	items	1191	3.98	245.30	**1162766.15**	
Community Transportation Total:							**32754323.43**
Community Transportation - Miles	☐	miles	4899	2859.23	0.70	**9805157.44**	
Community Transportation - Trips	☐	trips	3614	254.41	24.96	**22949165.99**	
Competitive Integrated Employment (CIE) Exploration Total:							**1274845.86**
Competitive Integrated Employment	☐	hours	582	48.44	45.22	**1274845.86**	

GRAND TOTAL:	**1107229438.48**
Total: Services included in capitation:	
Total: Services not included in capitation:	1107229438.48
Total Estimated Unduplicated Participants:	**38815**
Factor D (Divide total by number of participants):	**28525.81**
Services included in capitation:	
Services not included in capitation:	28525.81
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
(CIE) Exploration							
Consultative Clinical and Therapeutic Services for Caregivers Total:							**921639.29**
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	435	14.70	144.13	**921639.28**	
Counseling, Therapeutic, and Wellness Services Total:							**14610562.05**
Counseling, Therapeutic, and Wellness Services	☐	each	6824	25.18	85.03	**14610562.05**	
Environmental Accessibility Adaptations (Home Modifications) Total:							**2326802.41**
Environmental Accessibility Adaptations (Home Modifications)	☐	projects	258	1.66	5432.90	**2326802.41**	
Home Delivered Meals Total:							**1768094.64**
Home Delivered Meals	☐	meals	1150	148.98	10.32	**1768094.64**	
Housing Counseling Total:							**12555.04**
Housing Counseling	☐	hours	13	15.44	62.55	**12555.04**	
Individual Directed Goods and Services Total:							**321169.36**
Individual Directed Goods and Services	☐	each	129	86.90	28.65	**321169.36**	
Relocation - Community Transition Services Total:							**2501.99**
Relocation - Community Transition Services	☐	each	3	2.23	373.99	**2501.99**	

GRAND TOTAL:	**1107229438.48**
Total: Services included in capitation:	
Total: Services not included in capitation:	1107229438.48
Total Estimated Unduplicated Participants:	**38815**
Factor D (Divide total by number of participants):	**28525.81**
Services included in capitation:	
Services not included in capitation:	28525.81
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Services (1-2 Bed AFH) Total:							**32711006.61**
Residential Services (1-2 Bed AFH)	☐	days	376	290.65	299.32	**32711006.61**	
Residential Services (Other) Total:							**51670589.49**
Residential Services (Other)	☐	days	612	328.02	257.39	**51670589.49**	
Small Group Supported Employment Total:							**1397161.00**
Small Group Supported Employment	☐	hours	159	512.97	17.13	**1397161.00**	
Specialized Medical Equipment and Supplies Total:							**1585169.34**
Specialized Medical Equipment and Supplies	☐	items	1271	43.32	28.79	**1585169.34**	
Support Broker Services Total:							**611427.18**
Support Broker Services	☐	hours	300	19.82	102.83	**611427.18**	
Supportive Home Care Total:							**713449200.90**
Supportive Home Care	☐	hours	34913	1043.67	19.58	**713449200.90**	
Training Services for Unpaid Caregivers Total:							**37483.63**
Training Services for Unpaid Caregivers	☐	hours	13	25.04	115.15	**37483.63**	
Vehicle Modifications Total:							**1698938.47**
Vehicle Modifications	☐	each	148	1.32	8696.45	**1698938.47**	
Virtual Monitoring and Emergency Response Systems Total:							**1828849.03**
Virtual	☐					**1828849.03**	

GRAND TOTAL:	**1107229438.48**
Total: Services included in capitation:	
Total: Services not included in capitation:	1107229438.48
Total Estimated Unduplicated Participants:	**38815**
Factor D (Divide total by number of participants):	**28525.81**
Services included in capitation:	
Services not included in capitation:	28525.81
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Monitoring and Emergency Response Systems		rent/month	2972	8.13	75.69		
Vocational Futures Planning and Support Total:							**188003.40**
Vocational Futures Planning and Support	☐	each	43	6.03	725.07	**188003.40**	

GRAND TOTAL:	**1107229438.48**
Total: Services included in capitation:	
Total: Services not included in capitation:	1107229438.48
Total Estimated Unduplicated Participants:	**38815**
Factor D (Divide total by number of participants):	**28525.81**
Services included in capitation:	
Services not included in capitation:	28525.81
Average Length of Stay on the Waiver:	315

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**10824406.26**
Adult Day Care	☐	hours	706	535.71	28.62	**10824406.26**	
Day Habilitation Total:							**49580341.42**
Day Habilitation	☐	hours	3864	360.33	35.61	**49580341.42**	
Individual Supported Employment Total:							**24044236.99**

GRAND TOTAL:	**1205267813.10**
Total: Services included in capitation:	
Total: Services not included in capitation:	1205267813.10
Total Estimated Unduplicated Participants:	**40925**
Factor D (Divide total by number of participants):	**29450.65**
Services included in capitation:	
Services not included in capitation:	29450.65
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual Supported Employment	☐	hours	2045	251.93	46.67	24044236.99	
Life Skills Training and Education Total:							8583365.93
Life Skills Training and Education	☐	hours	1168	152.18	48.29	8583365.93	
Prevocational Services Total:							5228043.62
Prevocational Services	☐	hours	718	332.94	21.87	5228043.62	
Respite Total:							53516917.79
Respite	☐	hours	4535	542.07	21.77	53516917.79	
Nursing Services Total:							121548.19
Nursing Services	☐	hours	69	37.81	46.59	121548.19	
IRIS Consultant Agency (ICA) Services Total:							117082066.49
IRIS Consultant Agency (ICA) Services	☐	months	40925	10.33	276.95	117082066.49	
Assistive Technology Total:							1257659.04
Assistive Technology	☐	items	1252	4.00	251.13	1257659.04	
Community Transportation Total:							35778256.18
Community Transportation - Miles	☐	miles	5189	2859.34	0.72	10682722.99	
Community Transportation - Trips	☐	trips	3836	254.26	25.73	25095533.19	
Competitive Integrated Employment (CIE) Exploration Total:							1385389.81
Competitive Integrated Employment (CIE) Exploration	☐	hours	614	48.44	46.58	1385389.81	

GRAND TOTAL:	**1205267813.10**
Total: Services included in capitation:	
Total: Services not included in capitation:	1205267813.10
Total Estimated Unduplicated Participants:	**40925**
Factor D (Divide total by number of participants):	**29450.65**
Services included in capitation:	
Services not included in capitation:	29450.65
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Consultative Clinical and Therapeutic Services for Caregivers Total:							**1006464.69**
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	462	14.67	148.50	**1006464.69**	
Counseling, Therapeutic, and Wellness Services Total:							**15918638.88**
Counseling, Therapeutic, and Wellness Services	☐	each	7216	25.18	87.61	**15918638.88**	
Environmental Accessibility Adaptations (Home Modifications) Total:							**2529758.20**
Environmental Accessibility Adaptations (Home Modifications)	☐	projects	272	1.66	5602.76	**2529758.20**	
Home Delivered Meals Total:							**1910914.81**
Home Delivered Meals	☐	meals	1209	148.69	10.63	**1910914.81**	
Housing Counseling Total:							**13873.47**
Housing Counseling	☐	hours	14	15.39	64.39	**13873.47**	
Individual Directed Goods and Services Total:							**346467.32**
Individual Directed Goods and Services	☐	each	136	86.74	29.37	**346467.32**	
Relocation - Community Transition Services Total:							**2577.05**
Relocation - Community Transition Services	☐	each	3	2.23	385.21	**2577.05**	
Residential Services (1-2 Bed							**35813217.92**

GRAND TOTAL:	**1205267813.10**
Total: Services included in capitation:	
Total: Services not included in capitation:	1205267813.10
Total Estimated Unduplicated Participants:	**40925**
Factor D (Divide total by number of participants):	**29450.65**
Services included in capitation:	
Services not included in capitation:	29450.65
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
AFH) Total:							
Residential Services (1-2 Bed AFH)	☐	days	400	290.39	308.32	**35813217.92**	
Residential Services (Other) Total:							**56466404.22**
Residential Services (Other)	☐	days	650	327.73	265.07	**56466404.22**	
Small Group Supported Employment Total:							**1527427.14**
Small Group Supported Employment	☐	hours	169	512.36	17.64	**1527427.14**	
Specialized Medical Equipment and Supplies Total:							**1721598.68**
Specialized Medical Equipment and Supplies	☐	items	1343	43.22	29.66	**1721598.68**	
Support Broker Services Total:							**666851.72**
Support Broker Services	☐	hours	318	19.80	105.91	**666851.72**	
Supportive Home Care Total:							**775845451.55**
Supportive Home Care	☐	hours	36798	1045.31	20.17	**775845451.55**	
Training Services for Unpaid Caregivers Total:							**41587.85**
Training Services for Unpaid Caregivers	☐	hours	14	25.03	118.68	**41587.85**	
Vehicle Modifications Total:							**1859927.19**
Vehicle Modifications	☐	each	157	1.32	8974.75	**1859927.19**	
Virtual Monitoring and Emergency Response Systems Total:							**1987619.61**
Virtual Monitoring and	☐	rent/mon	3123	8.12	78.38	**1987619.61**	

GRAND TOTAL:	**1205267813.10**
Total: Services included in capitation:	
Total: Services not included in capitation:	1205267813.10
Total Estimated Unduplicated Participants:	**40925**
Factor D (Divide total by number of participants):	**29450.65**
Services included in capitation:	
Services not included in capitation:	29450.65
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Emergency Response Systems							
Vocational Futures Planning and Support Total:							**206801.09**
Vocational Futures Planning and Support	☐	each	46	6.02	746.79	**206801.09**	

GRAND TOTAL:	**1205267813.10**
Total: Services included in capitation:	
Total: Services not included in capitation:	1205267813.10
Total Estimated Unduplicated Participants:	**40925**
Factor D (Divide total by number of participants):	**29450.65**
Services included in capitation:	
Services not included in capitation:	29450.65
Average Length of Stay on the Waiver:	314

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**11830668.97**
Adult Day Care	☐	hours	747	536.14	29.54	**11830668.97**	
Day Habilitation Total:							**54313237.66**
Day Habilitation	☐	hours	4103	360.89	36.68	**54313237.66**	
Individual Supported Employment Total:							**26335238.43**
Individual Supported	☐	hours	2171	252.35	48.07	**26335238.43**	

GRAND TOTAL:	**1311831188.59**
Total: Services included in capitation:	
Total: Services not included in capitation:	1311831188.59
Total Estimated Unduplicated Participants:	**43037**
Factor D (Divide total by number of participants):	**30481.47**
Services included in capitation:	
Services not included in capitation:	30481.47
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Employment							
Life Skills Training and Education Total:							**9393278.40**
Life Skills Training and Education	☐	hours	1239	152.45	49.73	**9393278.40**	
Prevocational Services Total:							**5732135.55**
Prevocational Services	☐	hours	763	333.45	22.53	**5732135.55**	
Respite Total:							**58530724.57**
Respite	☐	hours	4808	542.98	22.42	**58530724.57**	
Nursing Services Total:							**134415.19**
Nursing Services	☐	hours	74	37.85	47.99	**134415.19**	
IRIS Consultant Agency (ICA) Services Total:							**126936985.94**
IRIS Consultant Agency (ICA) Services	☐	months	43037	10.34	285.25	**126936985.94**	
Assistive Technology Total:							**1359115.89**
Assistive Technology	☐	items	1312	4.03	257.05	**1359115.89**	
Community Transportation Total:							**39249686.08**
Community Transportation - Miles	☐	miles	5483	2866.74	0.75	**11788751.56**	
Community Transportation - Trips	☐	trips	4063	254.76	26.53	**27460934.52**	
Competitive Integrated Employment (CIE) Exploration Total:							**1505431.04**
Competitive Integrated Employment (CIE) Exploration	☐	hours	646	48.57	47.98	**1505431.04**	
Consultative Clinical and							**1103629.00**

GRAND TOTAL:	**1311831188.59**
Total: Services included in capitation:	
Total: Services not included in capitation:	1311831188.59
Total Estimated Unduplicated Participants:	**43037**
Factor D (Divide total by number of participants):	**30481.47**
Services included in capitation:	
Services not included in capitation:	30481.47
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapeutic Services for Caregivers Total:							
Consultative Clinical and Therapeutic Services for Caregivers	☐	hours	491	14.69	153.01	**1103629.00**	
Counseling, Therapeutic, and Wellness Services Total:							**17350164.81**
Counseling, Therapeutic, and Wellness Services	☐	each	7612	25.25	90.27	**17350164.81**	
Environmental Accessibility Adaptations (Home Modifications) Total:							**2743258.23**
Environmental Accessibility Adaptations (Home Modifications)	☐	projects	286	1.66	5778.20	**2743258.23**	
Home Delivered Meals Total:							**2064002.98**
Home Delivered Meals	☐	meals	1268	148.79	10.94	**2064002.98**	
Housing Counseling Total:							**15288.49**
Housing Counseling	☐	hours	15	15.38	66.27	**15288.49**	
Individual Directed Goods and Services Total:							**376432.53**
Individual Directed Goods and Services	☐	each	144	86.79	30.12	**376432.53**	
Relocation - Community Transition Services Total:							**2654.39**
Relocation - Community Transition Services	☐	each	3	2.23	396.77	**2654.39**	
Residential Services (1-2 Bed AFH) Total:							**39073067.85**

GRAND TOTAL:	**1311831188.59**
Total: Services included in capitation:	
Total: Services not included in capitation:	1311831188.59
Total Estimated Unduplicated Participants:	**43037**
Factor D (Divide total by number of participants):	**30481.47**
Services included in capitation:	
Services not included in capitation:	30481.47
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Services (1-2 Bed AFH)	☐	days	423	290.86	317.58	39073067.85	
Residential Services (Other) Total:							61648330.95
Residential Services (Other)	☐	days	688	328.26	272.97	61648330.95	
Small Group Supported Employment Total:							1668561.64
Small Group Supported Employment	☐	hours	179	513.02	18.17	1668561.64	
Specialized Medical Equipment and Supplies Total:							1870690.06
Specialized Medical Equipment and Supplies	☐	items	1416	43.23	30.56	1870690.06	
Support Broker Services Total:							728950.01
Support Broker Services	☐	hours	337	19.83	109.08	728950.01	
Supportive Home Care Total:							843417344.02
Supportive Home Care	☐	hours	38683	1049.75	20.77	843417344.02	
Training Services for Unpaid Caregivers Total:							46016.78
Training Services for Unpaid Caregivers	☐	hours	15	25.08	122.32	46016.78	
Vehicle Modifications Total:							2017376.86
Vehicle Modifications	☐	each	165	1.32	9262.52	2017376.86	
Virtual Monitoring and Emergency Response Systems Total:							2157235.61
Virtual Monitoring and Emergency Response	☐	rent/mon	3273	8.12	81.17	2157235.61	

GRAND TOTAL:	1311831188.59
Total: Services included in capitation:	
Total: Services not included in capitation:	1311831188.59
Total Estimated Unduplicated Participants:	43037
Factor D (Divide total by number of participants):	30481.47
Services included in capitation:	
Services not included in capitation:	30481.47
Average Length of Stay on the Waiver:	315

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Systems							
Vocational Futures Planning and Support Total:							***227266.66***
Vocational Futures Planning and Support	☐	*each*	*49*	*6.03*	*769.17*	***227266.66***	

GRAND TOTAL:	***1311831188.59***
Total: Services included in capitation:	
Total: Services not included in capitation:	*1311831188.59*
Total Estimated Unduplicated Participants:	***43037***
Factor D (Divide total by number of participants):	***30481.47***
Services included in capitation:	
Services not included in capitation:	*30481.47*
Average Length of Stay on the Waiver:	*315*