Application for a §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 §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 waiver's 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 an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The **State** of **Wisconsin** requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:
Self Directed Supports- Elderly and PD

C. Waiver Number:WI.0485

D. Amendment Number:WI.0485.R01.06

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

01/01/15

Approved Effective Date: 01/01/15
Approved Effective Date of Waiver being Amended: 01/01/11

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:
When Wisconsin's Self-Directed Supports Waivers (IRIS program) were initially designed, the number of individuals estimated to participate in the program was very small, approximately 600. Currently, there are nearly 10,000 participants enrolled in the program and the average growth is around two percent per month. In evaluating the IRIS Program, several areas for potential improvement to service delivery and overall participant experience were identified. The Department of Health Services is proposing to make the following changes to the administration of the IRIS Program during the remaining waiver approval period.

IRIS Self-Directed IT System – The outcome of this initiative is to purchase, operate, and maintain a centralized web-based IT system housing all the relevant data for participants, guardians and providers, contracted agencies and the Department. This will allow these user groups (with user based security roles) access to real time data to improve the ability of participants to self-direct their long term care supports. In order to move to a model described below with a Third Party Administrator (TPA – Claims Processor), multiple Fiscal/Employer Agents, and multiple IRIS Consultant Agencies, a centralized IT system that is owned by the Department of Health Services is crucial to the Department's ability to maximize efficiency, cost-effectiveness and program integrity oversight. The Department of Health Services and all participants, employees, providers, and contracted agencies will use the same centralized IT system to operate and/or participate in the IRIS program. The contract has been awarded through the State's Request for Proposal process. This system will allow the Department to sunset two systems currently used and the platform of this system may be utilized by other Waiver programs. The Department is also pursuing an Implementation Advanced Planning Document with CMS for this system. Further detail outlining the functionality and capacity of this system is located in Appendix A.

Multiple IRIS Consultant Agencies (ICA) – Recognizing the importance of choice of service provider, the Department of Health Services is transitioning towards contracting with multiple IRIS Consultant Agencies to provide participants with an opportunity to select the ICA that will best meet their consultant service needs. The Department of Health Services will certify ICAs through a predefined set of certification criteria. The certification process includes mechanisms to allow ICAs to become certified through successful demonstration of the core requirements of ICA functions. This certification process allows the Department greater flexibility in analyzing the quality of service being delivered from each ICA through the standardization of consistent metrics established within the certification criteria. This also allows the Department diverse options in the remediation of identified deficiencies up to an including decertifying a contractor that is not meeting the requirements of certification.

The Department will enter into contracts with the ICAs that satisfactorily meet the certification criteria. The Department will start

certifying ICA applicants in calendar year 2014 and will concurrently continue to promote the certification process throughout the state to help ensure maximum choice of ICA provider in all IRIS counties. The ICA will be reimbursed a monthly rate of service for each participant that utilizes their agency for ICA services. The detail of the transitioning to multiple ICAs is outlined in Appendix A of this proposed amendment.

Multiple Fiscal / Employer Agents (F/EA) – Recognizing the importance of choice of service provider, the Department of Health Services is transitioning towards contracting with multiple IRIS Fiscal / Employer Agencies to provide participants with an opportunity to select the F/EA that will best meet their Fiscal / Employer agent service needs. The Department of Health Services will certify F/EAs through a predefined set of certification criteria. The certification process includes mechanisms to allow F/EAs to become certified through successful demonstration of the core requirements of F/EA functions. This certification process allows the Department greater flexibility in analyzing the quality of service being delivered from each F/EA through the standardization of consistent metrics established within the certification criteria. This also allows the Department diverse options in the remediation of identified deficiencies up to an including decertifying a contractor that is not meeting the requirements of certification.

The Department will enter into contracts with the F/EAs that satisfactorily meet the certification criteria. The Department will start certifying F/EA applicants in calendar year 2014 and will concurrently continue to promote the certification process throughout the state to help ensure maximum choice of F/EA provider in all IRIS counties. The F/EA will be reimbursed a monthly rate of service for each participant that utilizes their agency for F/EA services. The detail of the transitioning to multiple F/EAs is outlined in Appendix A of this proposed amendment.

Third Party Administrator Initiative (TPA)– The outcome of this proposed amendment is to contract with a traditional claims processing and adjudication agency rather than an accounts payable agency. The TPA will be selected through a contract amendment to one of four existing contracts the Department holds with TPAs providing claim services to other programs within the Department. The Third Party Administrator will be responsible for paying provider claims submitted by providers with employees providing service not directly employed by the participant. The TPA will also be responsible for adjudicating claims submitted by the F/EA for participant hired workers directly employed by the participant. Regardless of the type of claim (provider or F/EA) the TPA will adjudicate the claim using industry standard best practice data required for claims adjudication, which includes but not limited to participant ID, provider ID, service type, service code, unit, rate, and date of service. The TPA will receive the claims and adjudicate that claim based on the participant's approved Individualized Service and Support Plan (ISSP) and corresponding prior authorization received by the TPA from the IRIS centralized IT system.

Changes to Service Definitions – The outcome of this initiative and corresponding amendment is to more clearly define the current service definitions and enhance use of code modifiers for services. In reviewing the current service definitions, it was determined that several of the services could benefit from refining the language describing the service. This initiative will also benefit the TPA in claims adjudication and encounter reporting helping to ensure that the service code definition defined in the waiver align with the claim files received from providers, including various modifiers not currently being utilized. This will also help ensure that claims are being submitted under the most appropriate code.

IRIS Policy Initiative – The outcome of this initiative is to produce a consistent, accessible, transparent, comprehensive and uncomplicated standard operating procedure for use by all groups involved with the IRIS program. The IRIS Section is working towards compiling current IRIS policy as it exists in different formats and converting the various polices and documentation into a single standard program wide manual. Through this initiative, the IRIS program will be able to identify any areas within the program that have evolved with program maturation and address those areas. This initiative will also identify areas that may be currently unaddressed or need development based on the changing landscape of the IRIS program.

Another critical element of the policy initiative is the IRIS Service Code Definition Manual. This is a comprehensive list of the services defined in Appendix C of this waiver in an accessible, easy to understand and easy to navigate manual. This will allow the Department to operationalize the service definition in the waiver but will not reduce or expand the definition of the service defined in Appendix C. If a change is required to the service definition, the Department will use the waiver amendment protocol to request this change.

This initiative will provide participants/guardians the opportunity to utilize this manual during negotiation of rates with their providers to help ensure participants have all of the resources available while developing their long term care service plan. For example, a participant may be able to negotiate a more cost effect weekly rate with their provider verses a daily or hourly rate.

A critical area of this initiative is the Work Instructions which will clearly define the roles and responsibilities of all groups involved in the IRIS program including, the participant, contracted agencies and the Department. The Work Instructions will also include systematic instructions for all aspects of the IRIS program including, areas such as enrollment, plan amendments, flexible spending and home or vehicle modifications. This manual is critical to the future of IRIS as offer choice of ICA and F/EA providers and implement the centralized IT system. This clearer definition of roles and responsibilities will also provide greater transparency for IRIS Consultants when working with participants/guardians in developing a safe and healthy plan for their long term care service needs.

Addition of Services – The state is adding the IRIS Consultant service and the IRIS F/EA service to the waiver service benefit (Reference Appendix C for detailed definitions of these services). The services provided by the ICA and F/EA are required as part of the overall model of the IRIS Program and are essential to participants to help ensure successful navigation of a self directed program such as IRIS. The model of the IRIS program includes mandatory areas of health and safety assurance oversight and a diverse level of involvement from IRIS Consultants depending on the level of the participant's familiarity with the IRIS program and the complexities of their disabilities. The

program also requires that those participants that choose to hire their own employees have a Fiscal Employer Agent provide payroll and relevant tax withholding and garnishment services.

The ICA and F/EA will be reimbursed a monthly rate of service for each participant that utilizes their agency for ICA or F/EA services. This monthly rate of service was developed by the Department based on historical costs and enrollment in the IRIS program. The Department will track and monitor the number of participants being served by each individual ICA or F/EA on a monthly basis and will provide each ICA and F/EA with reimbursement based on monthly enrollment. This monthly rate of service will be applied to all participants in the program and listed on their plan but will not reduce their individual budget as the model of the IRIS program requires the ICA and F/EA services be included. Reference Appendix A for information on how the Department will certify and contract with multiple ICA and F/EA providers.

Population and Cost Neutrality Projections – As a result of the IRIS program's continual increase in population, the Department recognizes the need for updated population and cost neutrality projections. An error in the unit of measure for Supportive Home Care in Years 4 and 5 of Appendix J-2.d.ii has been corrected. Units and unit costs had inadvertently reflected 15 minute increments rather than hours. This correction results in a nominal change to the Component Cost and Total Cost for the service due to rounding.

PM's have been adjusted (see Appendix H).

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

Component of the Approved Waiver	Subsection(s)
☐ **Waiver Application**	
☑ **Appendix A – Waiver Administration and Operation**	All
☑ **Appendix B – Participant Access and Eligibility**	All
☑ **Appendix C – Participant Services**	All
☑ **Appendix D – Participant Centered Service Planning and Delivery**	All
☑ **Appendix E – Participant Direction of Services**	All
☑ **Appendix F – Participant Rights**	All
☑ **Appendix G – Participant Safeguards**	All
☑ **Appendix H**	All
☑ **Appendix I – Financial Accountability**	All
☑ **Appendix J – Cost-Neutrality Demonstration**	All

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

- ☐ **Modify target group(s)**
- ☐ **Modify Medicaid eligibility**
- ☑ **Add/delete services**
- ☑ **Revise service specifications**
- ☑ **Revise provider qualifications**
- ☐ **Increase/decrease number of participants**
- ☑ **Revise cost neutrality demonstration**
- ☐ **Add participant-direction of services**
- ☑ **Other**

Specify:
Addition of Multiple IRIS Consultant Agencies, Third Party Administrator, Multiple Fiscal/Employer Agents, & Centralized IT System.
NOTE: The state will send a summary of changes via email to reference the specific locations of changes.

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 §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*):
Self Directed Supports- Elderly and PD

C. Type of Request: amendment

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**

Waiver Number:WI.0485.R01.06
Draft ID: WI.05.01.06

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

E. Proposed Effective Date of Waiver being Amended: 01/01/11
Approved Effective Date of Waiver being Amended: 01/01/11

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 in42 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 §1915(a)(1)(a) of the Act and described in Appendix I**

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

☐ **A program operated under §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 §1915(i) of the Act.**

☑ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §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 Waiver is intended to provide persons with a nursing home level of care a fee-for-service alternative to enrolling in Family Care, which operates under a s. 1915 (b)(c) waiver and is the state's managed care long term care program. This waiver will provide eligible consumers the choice of a fully self-directed Medicaid Home and Community-Based Services Waiver.

The Department has laid out a framework for a self-directed support(SDS) waiver program as an alternative to managed care in Wisconsin. The framework that the Department will build on includes the following basic assumptions regarding the IRIS waiver.

IRIS implementation is synchronized with Family Care expansion. As Family Care begins in a county, IRIS will also be available in that county. When people are given the opportunity to enroll in long-term supports, the ADRC offers unbiased option counseling related to IRIS and Family Care.

Participants in the IRIS Waiver are given an individual long-term support budget that is generated using a highly data driven process developed using regression modeling and analysis conducted by the SMA's actuarial firm. A standardized method has been developed, with budgets generally increasing in acuity, which is applied to each and every member's Long-Term Care Functional Screen. This budget is used as the basis for planning for waiver services to meet individual outcomes, assessed needs, and health and safety needs. The participant receives assistance from the IRIS Consultant and is able to use the long-term support budget flexibly, in coordination with Medicaid State Plan Services and informal supports.

The IRIS participant, and any person or persons providing assistance with self-direction, will receive information and individualized assistance from an IRIS Consultant. The amount of support from the IRIS Consultant varies based upon the participant's needs, but in all instances assures that the person's needs are assessed, outcomes developed, and services both formal and informal are coordinated to address assessed needs, including health and safety. The ongoing level of support from the IRIS Consultant may range from a minimal level to assure that all federal waiver requirements are met related to assessment, service planning, and implementation in order to assure appropriate community supports to an ongoing level of support, assistance and coordination consistent with support and service coordination services (care management).

Each person who chooses to participate in IRIS (The enrollment counseling portion – information provided to the individual in order that they may make an informed choice of program is provided at the local Aging and Disability Resource Center (ADRC)) meets with an IRIS Consultant to receive orientation information about SDS, the waiver services available, the services covered by the MA card and the requirements for content of the individual support and service plan. Once the person has developed their individual support and service plan with support from the IRIS Consultant as needed, the IRIS Consultant reviews the individual support and service plan to ensure that it is consistent with the waiver-allowable services and addresses assessed needs including health and safety. The IRIS Consultant conveys this information to the participant's chosen IRIS Consultant Agency to ensure that all waiver requirements are met and to convey the information from the approved plan to the Fiscal/Employer Agent (F/EA), Third Party Administrator (TPA), via the IRIS centralized IT System (ISITS), as well as the IRIS participant.

The IRIS participant will solicit and hire workers, train workers as necessary, and make arrangements to purchase needed services and supports from vendors with support from the IRIS Consultant as needed. The participant will review and approve timesheets and other documentation and submit them to the Fiscal/Employer
Agent for payment.

The participant's chosen Fiscal/Employer Agent supports the IRIS participant to complete employer functions, maintains the State Medicaid Agency Provider agreements for participant-employed workers, and that tax on other required verifications are in place for each provider. The Third Party Administrator (TPA) serves as the claims administrator for supports and services authorized in the IRIS individual support and service plans, adjudicates all claims for payment, issues payments for services and enters the services and supports

in the Encounter data system.

The Department has an IRIS Advisory Committee that meets bi-monthly. This is an active advisory group with ad-hoc subcommittees related to Outreach and Education, Self-Directed Personal Care, Data and Individual Budgets, Quality Assurance, Supports and Services and Employment that meet as needed to address issues and projects related to these subjects.

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 §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 §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 §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:
The IRIS waiver is intended to provide an alternative to the managed care waiver programs under Family Care and Medicaid State Plan Services available to beneficiaries. People are given the choice to enroll in Family Care or IRIS as they transition from the current waivers, are taken off the waitlist, or in instances where wait list have been eliminated, upon eligibility determination. Participants in IRIS continue to have access to the Medicaid card services (fee for service) to obtain needed medical or health related services such as Personal Care; Physical, Occupational, Speech Therapies;

Mental Health treatment Services; and Durable Medical Equipment they need as these services are not included within this waiver.

As of September 30, 2013, this waiver will be operational in the following counties in Wisconsin:
Ashland
Barron
Bayfield
Buffalo
Burnett
Calumet
Chippewa
Clark
Columbia
Crawford
Dodge
Douglas
Dunn
Eau Claire
Fond du Lac
Green
Green Lake
Iron
Jackson
Jefferson
Juneau
Kenosha
La Crosse
Lafayette
Langlade
Lincoln
Manitowoc
Marathon
Marquette
Milwaukee
Monroe
Outagamie
Ozaukee
Pepin
Pierce
Polk
Portage
Price
Racine
Richland
Rusk
St. Croix
Sauk
Sawyer
Sheboygan
Trempealeau
Vernon
Walworth
Washburn
Washington
Waukesha
Waupaca
Waushara
Winnebago
Wood

Wisconsin needs legislative approval to expand Family Care and IRIS to additional counties. Under 2013 Wisconsin Act 20, the Department was required to submit a report to the Legislature to develop a comprehensive projection of the expected future change in the need for publicly funded community-based long-term care. The report is due in December 2014. The Department anticipates being able to provide a timeline for additional expansion when the Legislature has had an opportunity to review that information.

Remaining Counties:
Adams
Brown
Dane
Door
Florence
Forest
Kewaunee
Marinette
Menominee
Oconto
Oneida
Rock
Shawano
Taylor
Vilas

☐ **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 §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 §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §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. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, 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 §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:
The Department has an IRIS Advisory Committee that meets bi-monthly. The Committee provides input and makes recommendations to the Department related to IRIS Program operations and policies. Members of this advisory group include IRIS participants, family members of IRIS participants, and representatives from a wide variety of providers and advocacy groups representing the needs and interests of all three target groups served by the IRIS program.

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: Rodriguez-Williams

First Name: Camille

Title: Director -Bureau of Long Term Support

Agency: Department of Health Services

Address: 1 West Wilson Street

Address 2: P O Box 7851

City: Madison

State: **Wisconsin**

Zip: 53707-7851

Phone: (608) 266-9366 **Ext:** ☐ **TTY**

Fax: (608) 261-6752

E-mail: Camille.Rodriguez@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 the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature: Camille Rodriguez

State Medicaid Director or Designee

Submission Date: Apr 25, 2014

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

Last Name: Rodriguez

First Name: Camille

Title: Bureau Director

Agency: Department of Health Services - Bureau of Long Term Supports

Address: 1 W. Wilson St., Rm 418

Address 2:

City: Madison

State: **Wisconsin**

Zip: 53707

Phone: (608) 266-9366 **Ext:** **TTY**

Fax: (608) 261-6752

E-mail: camille.rodriguez@dhs.wisconsin.gov

Attachments

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

See Optional Attachment B for Transition plan.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan
Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.
Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.
To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

DHS utilizes contracted services of multiple agencies to support the participants in IRIS. the Aging and Disability Resource Centers (ADRC), IRIS Consultant Agencies (ICAs), Fiscal/Employer Agents (F/EAs), and a Third Party Administrator (TPA).

Aging and Disability Resource Centers
Aging and Disability Resource Centers are public or non-profit entities that 1) provide Information and Assistance; 2) provide pre-admission counseling; 3) conduct level of care evaluation activities using the State's automated long-term care functional screen; 4) coordinate other program eligibility activities on behalf of the SMA, and 5) carry out prevention activities. These functions include coordination with the Income Maintenance Consortia to assist participants with the Medicaid financial eligibility processes as needed; administer the Long Term Care Functional Screen (LTCFS) to determine functional eligibility and level of care, and convey the individual budget amount to people considering IRIS for SDS. There is an ADRC that serves every county in Wisconsin.

IRIS Consultant Agencies
The IRIS Consultant Agency (ICA) Services (Reference Appendix C – IRIS Consultant Services for service definition) are required services within the IRIS Program. ICAs will be certified through a predefined set of service delivery and financial solvency criteria (Reference Attached ICA Certification Criteria). These criteria emphasize the core functional requirements ICA's must possess to deliver high quality consulting services to IRIS Participants. These criteria require ICA to demonstrate their business philosophy, goals and model align with the core principles of self direction and the values of the IRIS Program. These criteria also requires the ICA to demonstrate the ICA has a comprehensive understanding of the consultant service responsibilities as well as well as the business infrastructure, IT infrastructure, qualified personnel, and financial solvency to provide IRIS consulting services with the highest quality and program integrity. The certification process includes mechanisms to allow ICAs to become certified through successful demonstration of the core requirements of ICA functions while allowing the Department to impose Certification Criteria Improvement Plans (CCIP). CCIPs are only applied to those areas that are not core to the ICA services and waiver assurances. CCIPs can be imposed by the Department to ensure that

any non-core functional areas of the ICA service that do not meet the Department's requirements are brought up to standard in a timely manner regulated by the Department.

As part of successful completion of the certification criteria, ICAs will be required to provide all ADRCs in the IRIS region they intend to serve with Department-approved and predefined information about their agency. This information will include general information such as physical office locations and hours, as well as years of experience in case management or consulting. It will also include any specific licensing or certification the agency or members of their staff hold such as registered nurses on staff, specially trained or experienced staff in areas such as dementia or autism, or staff experience with certain target groups served through the IRIS program. This information will also include data compiled from the results of customer satisfaction surveys completed by other IRIS participants for whom the ICA provides consulting services.. This data will rate the ICA in different core areas of services, such as customer service, responsiveness, program knowledge, issue resolution, and accuracy of information provided. The Department-approved information developed by each ICA will be consistent in form and format and will be given to potential IRIS participants after they have completed enrollment counseling at the ADRC. This information serves to ensure that participants have the tools, resources, and information to make the most informed decision regarding their choice of ICA. If a participant has no preference regarding the selection of their ICA, an ICA will be auto-assigned to the participant at the ADRC based on ICA availability in that region and capacity of the ICA (if applicable). When a participant selects an ICA, the ADRC will route the referral information accordingly.

ICAs are required to: 1) conduct annual level of care redetermination/evaluation activities using the State's automated long-term care functional screen; 2) develop individual support and service plans; 3) perform prior authorization of waiver services; 4) assure that approved plans and any modifications remain within a person's Individual budget; 5) recruit and train IRIS Consultants; 6) develop and implement QA/QI plans related to all of these functions; and 7) assist the participant in ensuring that employee/provider new-hire paperwork is completed correctly and submitted to the Fiscal/Employer Agent. These agencies assure that there are adequate, well-trained IRIS Consultants to facilitate participant self-direction within the Medicaid regulations. The extent of IRIS Consultant services may range from very limited, minimal assistance to ongoing support in plan development and implementation based upon the needs of the individual IRIS participant. The IRIS Consultants are also responsible to provide ongoing contacts to monitor implementation of the plan, to assure participant health and safety, to ensure that services are provided according to the approved plan and to review monthly expenditure reports to assure appropriate use of the authorized budget.

The participant will function as the common law employer, soliciting and hiring workers, training workers as necessary and making arrangements to purchase needed services and supports from vendors. The participant will review and approve timesheets and other documentation and submit them to their chosen Fiscal/Employer Agent for payment and record-keeping. The F/EA will assure that participant-employed caregivers meet appropriate requirements, report payroll claims to the TPA, provide required data to DHS, and provide monthly payroll expenditure reports to the participant's chosen ICA and the participant.

The ICA will be reimbursed a monthly rate of service for each participant that utilizes their agency for ICA services. This monthly rate of service was developed by the Department based on historical costs and enrollment in the IRIS program. The Department will track and monitor the number of participants being served by each individual ICA on a monthly basis and will provide the ICA with their reimbursement based on monthly enrollment. Because these services are required as a part the IRIS program model, these monthly rates will not be charged against the participant's budget.

IRIS Fiscal / Employer Agencies
The IRIS Fiscal / Employer Agent (F/EA) Services (Reference Appendix C – IRIS Fiscal / Employer Agent Services for service definition) are required services for those participants who choose to employ participant-hired workers to provide services within their approved Individual Support and Service Plan (ISSP). F/EAs will be certified through a predefined set of service delivery and financial solvency criteria (Reference Attached F/EA Certification Criteria). These criteria emphasize the core functional requirements F/EAs must possess to deliver high-quality fiscal services to IRIS Participants. These criteria require F/EAs to demonstrate that their business philosophy, goals, and model align with the core principles of self-direction and the values of the IRIS Program. These criteria also require the F/EA to demonstrate that the F/EA has a comprehensive understanding of the financial service responsibilities required to be a Fiscal / Employer Agent for IRIS participants. The F/EA must also demonstrate evidence of the required business infrastructure, IT infrastructure, qualified personnel requirements, and financial solvency to provide IRIS F/EA services with the highest quality and program integrity. Similar to the ICA certification process, this process includes mechanisms to allow F/EAs to become certified through successful demonstration of the core requirements of F/EA functions while allowing the Department to impose Certification Criteria Improvement Plans (CCIP). CCIPs are only applied to those areas that are not core F/EA services or related to the waiver assurances. CCIPs can be imposed by the Department - to ensure that any non-core functional areas of the F/EA service that do not meet the Department's requirements are brought up to standard in a timely manner regulated by the Department. As part of successful completion of the certification criteria, F/EAs will be required to provide all ICAs in the IRIS region they intend to serve with Department-approved and predefined information about their agency. This information will include general information such as physical office locations and hours, as well as years of experience as a fiscal / employer agent. It will also include any specific technological capacities the F/EA utilizes such as electronic time sheet submittal, mobile phone applications, direct deposit, debit card deposits, or electronic confirmation of timesheet receipt and/or payment deposit. This information will also include data compiled from customer satisfaction surveys completed by other IRIS participants for whom the F/EA provides services. This data will rate the F/EA in different core areas of services, such as customer service, responsiveness, payment accuracy, and issue resolution. This information will be consistent in form and format and will be provided to potential IRIS participants during their orientation meeting with their chosen ICA. This ensures that IRIS participants have the tools, resources, and information to make the most informed decision regarding their choice of F/EA. If a participant has no preference on selecting their F/EA, an F/EA will be auto-assigned to the participant based on F/EA availability in that region and capacity (if applicable). When the participant chooses an F/EA, the IRIS Consultant processes the referral accordingly.

The Fiscal/Employer Agents will: 1) assist the participant with employer functions including obtaining and Federal Employer Identification Number (FEIN) and processing payroll payments for participant-hired workers while ensuring that accurate tax and withholdings are applied; 2) enter information into the centralized IT system so that reports generated by the system reflect the status of the participants' service utilization and budget available to participants and ICAs; 3) maintain all required records related to these functions; 4) maintain Medicaid Provider agreements for participant-hired workers; 5) complete the criminal and caregiver background checks for participant-hired workers ; and 6) develop and implement local QA/QI plans related to these functions.

The F/EA will be reimbursed a monthly rate of service for each participant that utilizes their agency for F/EA services. This monthly rate of service was developed by the Department based on historical costs and enrollment in the IRIS program. The Department will track and monitor the number of participants being served by each individual F/EA on a monthly basis and will provide each F/EA with their reimbursement based on monthly enrollment. Because these services are required as a part the IRIS program model, these monthly rates will not be charged against the participant's budget.

ICAs and F/EAs
The Department will provide interested ICAs and F/EAs the certification criteria and application process in a variety of ways. Some of which included uploading the certification criteria to the DHS external website, utilizing the state's procurement system VendorNet to electronically notify contractors currently providing these services of the availability of applying for certification. The Department will also use the networking voice of the IRIS Advisory Committee and the Wisconsin Long Term Care Council to broadcast the accessibility of the ICA and F/EA criteria and application process. The Department will also hold regional listening / informational sessions around the state specific to the ICA and F/EA certification process in order to help ensure there is sufficient interest in applying for certification ultimately ensuring choice of qualified providers in all IRIS counties. Both the ICA and the F/EA draft certification criteria have been released for public comment through the IRIS Advisory Committee and the Department has received numerous inquiries from interested parties. In regions where a sufficient number of applications have not been received or sufficient interest has not been expressed, the Department will reach out to potential companies who may be interested and would likely be able to meet the certification criteria. The Department will meet individually with these companies to answer any questions they may have or to mitigate any misconceptions about the IRIS program or certification process.

In order to maintain the highest level of program integrity, no providers of any other long term care services will be allowed to provide any other waiver services, such as Supportive Home Care or Personal Care, and ICA or F/EA services to the same IRIS participant. For example, a participant who receives IRIS Consultant services from ICA X, the participant may not also receive Supportive Home Care Services from ICA X.

The transition to multiple ICAs and F/EAs is not contingent upon the centralized IT system implementation. As with many other Medicaid provider certifications, the record retention and case management capacity is part of the certification process. If providers have the IT capacity and functionality to carry out the ICA or F/EA requirements, the Department would certify those agencies assuming they comply with all other requirements of the criteria. Alternatively, if an ICA or F/EA would like to proceed with the certification process with the exception of full certification compliance until the centralized IT system is operational the Department would allow this option. Services could not be rendered and reimbursements would not be issued until the ICA or F/EA met full compliance with certification.

The state will release both the criteria for the IRIS Consultant Agency certification and Fiscal / Employer Agent certification in July 2014. Both certification criteria will be released on the Department's public-facing website for ease of access. A centralized email address will be available to all inquiring providers to address questions and concerns related to the certification process. Listening sessions will be scheduled regionally in August/September 2014. These sessions will address potential providers' questions regarding the pre-qualification process, the actual provider services requirements, and the required financial solvency projections. Stakeholders may also attend these listening sessions to have their questions answered and concerns heard. In any region where the state feels that there is a lack of interest in becoming an ICA or F/EA, the state will provide additional outreach to potential providers to answer any questions through targeted discussions. These follow-up targeted discussions will be ongoing in any underrepresented region.

As part of the certification criteria, there is a set of pre-qualification criteria that the potential provider must meet in order to demonstrate the viability of the provider in advance of completing the entire certification process. For providers who meet the criteria of the pre-qualification process, documentation will be submitted demonstrating evidence of the provider's ability to complete all requirements outlined in the certification criteria. These responses will be scored using a certification tool to ensure uniform scoring criteria and assessment.

All providers submitting a response to the certification criteria will receive a status of approved, conditionally approved, or denied. A conditional approval is certification with deficiencies identified within the application that do not prevent the applicant from providing core ICA or F/EA services with a high degree of quality. As part of the state's commitment to ensure that providers are ready to begin accepting referrals, the state will prescribe Conditional Certification Improvement Plans (CCIPS) to remedy all deficiencies found during the certification process in advance of receiving referrals.

All new IRIS Consultant Agencies and Fiscal/Employer Agents will receive in-depth training on each SharePoint site assigned to the agency to be used including Critical Incident Reporting, Program Integrity, Notice of Action, Grievances, Behavior/Restrictive Measures, Record Review, Budget Amendment/One-Time Expense, etc. These training sessions will include an intensive review of the IRIS Policy Manual Work Instructions, SharePoint Instruction Manual, Participant Education Sheets, and other required forms. For subject matter outside the use of the agency-specific SharePoint sites, including participant-centered plan development and allowable service providers,

the Department will provide training on these subjects in a variety of ways including but not limited to web-based training, webinars, face-to-face training, and literature. The Department is developing a tool to provide ICAs and participants with regionalized rate ranges for the various waiver services. All agencies will have access to the DHS Website that will include real-time versions of the IRIS Policy Manual including Work Instructions.

The IRIS section has hired an administrative assistant as well as a contract specialist. The administrative assistant will help with the overall administrative requirements and coordination of the IRIS Section. The contract specialist is responsible for overseeing the receipt of contract deliverables for all IRIS Consultant Agencies and Fiscal/Employer Agents. A request for six additional positions to facilitate the oversight of multiple ICAs and F/EAs has been made to the Administration. In addition, the state will have control of all data through the use of the centralized IT system and state-owned SharePoint sites unique to each provider which will improve the state's ability to provide oversight of multiple agencies through technological means.

Currently, the majority of Quality Assurance activities take place through SharePoint sites dedicated to the following subjects: Critical Incident Reporting, Program Integrity, Notice of Action, Grievances, Behavior/Restrictive Measures, Record Review, Budget Amendment/One-Time Expense, etc. Each IRIS Consultant Agency and/or Fiscal/Employer Agent will have a replication of each site to ensure consistency in process yet managing the integrity of participant information. Each SharePoint site was designed with the intention of being used in an environment with multiple providers and to serve as the foundation for the module in the centralized IT system. Eventually, all SharePoint sites will be incorporated into the centralized IT system through continue enhancements of the system.

The state's IRIS Quality Assurance Team completes record reviews on a quarterly basis with results and remediation activities, to include the state's validation of the remediation activities being stored in a Record Review SharePoint site. These activities will continue as they do presently with the exception that each new IRIS Consultant Agency will have its own unique Record Review SharePoint site.

The billing process for all IRIS Consultant Agency providers and all Fiscal/Employer Agent providers will be carried out by the Third Party Administrator. The providers will submit their claims to the Third Party Administrator and the Third Party Administrator will adjudicate the claims in the same manner as they adjudicate claims for all other provider types.

Third Party Administration (Claims Processing)
The Department will also use a Third Party Administrator (TPA) for claims adjudication and processing. The TPA has been selected through a contract amendment to one of four existing contracts with TPAs providing claim services to other programs within the Department of Health Services. There are two types of claims which are submitted for reimbursement within the IRIS waiver program, traditional provider claims, and participant-hired payroll claims.

Traditional Provider claims are submitted from provider agencies that provide services to participants in which the participant is not the employer. Examples of these services include Adult Family Home Services, Adult Day Care Services, and Supportive Home Care Services provided through a Supportive Home Care Agency. These types of claims will be submitted directly to the TPA using industry standard best practice data required for claims adjudication, including but not limited to participant ID, provider ID, service type, service code, unit, rate, and date of service. The TPA will receive the claim from the provider and adjudicate that claim based on the participant's approved Individualized Service and Support Plan (ISSP) and corresponding prior authorization received by the TPA from the IRIS centralized IT system. Through the adjudication process the TPA will determine if the claim is authorized. If the claim is authorized, the TPA will submit the claim to the Department for funding. The state will then fund a zero balance state-held bank account. The provider will then receive reimbursement for the claim through electronic funds transfer. If the claim exceeds the authorization on the ISSP, the amount that exceeds the authorization will be pended until the TPA has been able to resolve the authorization issue, or if the claim was submitted inaccurately or not authorized, the claim will be denied. In either case, the provider will be notified of the pended or denied claim. If the TPA receives a claim that is not on the participant's ISSP, the claim will be denied and the provider will be notified of the denied claim.

Participant-hired worker payroll claims will be submitted to the TPA by the participant's F/EA. Prior to claim submittal to the TPA the F/EA will receive the participant-hired worker timesheet and enter the timesheet into the payroll timesheet system. The payroll timesheet system will perform a validation against the participant's ISSP and notify the F/EA of any errors, unauthorized services, or services exceeding the authorization amount for the participant-hired worker. After completion of the timesheet validation process, the F/EA will conduct their payroll processing procedures to reimburse the participant-hired worker for services provided. The F/EA will also submit a line item claim to the TPA that includes the industry standard best practice data required for claims adjudication, including but not limited to participant ID, provider ID, service type, service code, unit, rate, and date of service. The TPA will receive this claim from the F/EA and perform the same adjudication of this claim as required for those claims submitted by traditional providers described above.
The Department will receive encounter data from the TPA for the claims submitted and reimbursed through the TPA for the IRIS program. The utilization of a TPA will allow the Department to receive more accurate and timely service utilization data. This timely and accurate data will allow the Department to more efficiently and economically analyze service utilization trends by specific service group, target group, and geographical location, as well as other unique elements detected through receiving encounter data in a consistent and standardized method. This will also allow the Department to update the budgeted service utilization of the participant's ISSP in a more precise and timely manner.

Centralized IT System
The Department has procured via the state's Request for Proposal process a third party contractor to host, configure, and maintain the IRIS program's centralized IT system. The system is web-based and will allow for multiple user groups with varying degrees of security access, which can be assigned down to the data element. The user groups who will be able to access the system include participants, guardians, participant-hired workers, providers, ICAs, F/EAs, ADRCs, the TPA, and the State. One advantage of a web-based system is there is no

special hardware needed by the various user groups. The only external requirement is a minimum operating system such as Windows or Mac and commonly-used browser technology , such as Internet Explorer, Chrome, or FireFox.
Although the software selected will be very intuitive and user-friendly, the selected IT contractor is required to supply the initial training to a core group of users from each user group. The IT contractor is also required to provide training modules for the different areas of functionality within the system. After the core training has been completed, the contracted agencies will be required to train new or additional staff on use of the system. Specific to the participants and guardians of the IRIS program, the IT contractor will utilize the ICAs to provide direct one-on-one training to all participants and their guardians who choose to use the system. For those participants who choose not to take advantage of the technology available, their individual IRIS Consultant will be able to use the system on their behalf and provide them with paper copies of all necessary information that they would have access to via the centralized IT system.
The system is fully HIPAA compliant, complies with W3C's Web Content Accessibility Guidelines (WCAG) 2.0, complies with Section 508, and meets the Plain Writing Act of 2010.

The centralized IT system will house a variety of functions critical to the administration of the IRIS program. The functional areas have been segregated into twelve categories. These categories include:
1.) Intake – initial information entered upon referral
2.) Assessments – including but not limited to the initial assessment of support and service needs
3.) People Record – contacts, communication preference, circle of support
4.) Plan Setup – outcomes, supports, services, ISSP, authorizations
5.) Employee Setup – employee paperwork
6.) Provider Setup - provider information and services
7.) Plan Amendments, Budget Amendments, and One Time Expense
8.) Financial Commitments – cost share / spend down
9.) Case Notes – required documentation consistent with industry best practices to record events of ICA and/or F/EA service delivery and participant involvement in the IRIS program.
10.) Secure Communications
11.) Participant Status Changes – non-allowable settings, disenrollments, program change
12.) Enterprise Functions – reporting, dashboards, security, environments, training

The Department's transition plan anticipates fully sun-setting of the current operating systems by the end of calendar year 2014. The Department is actively engaged with the current IT contractor in developing the twelve functional areas described above. The implementation and transition plan uses an iterative approach to develop, test, migrate sample data, retest, and finalize each functional area. As the requirements gathering and definitions are completed for one functional area, the testing and data migration and finalization are taking place for those areas already defined and developed. This iterative approach maximizes efficiency while minimizing the risk of a universal system failure to which alternate system transition plans are more susceptible. As part of the transition and back up planning for this system conversion, the Department will not fully abandon the current systems until the Department is completely assured of total functionality. This will mean that for a short period of time (30-60 days), the Department will operate the old and new systems concurrently. Included in this planning, is the disaster recovery plan required of the IT contractor. The Department requires an alternate hot site to back up the new system. This is essentially a mirror of the live system backed up in another geographic location in almost real time. If there would be a systemic failure, the Department would be able to switch over to the "hot site system" in less than 48 hours.

In February 2013, the Department started a data migration and clean up initiative in anticipation of migrating the data from the two existing systems into the new centralized IT system. This proactive effort has placed the Department in a well-suited position to start data migration and testing of functional areas as soon as they have been configured for the IRIS program.

The preceding description is a general overview of the functionality the Department will implement in the first release of the new system. There will be ongoing and additional functionality added to the centralized IT system throughout calendar year 2015-2016, such as enhanced interfaces with the functional and financial eligibility systems, improved access to provider information, qualified participant-hired workers, and employment for participants through a participant portal.
The transition to multiple ICAs and F/EAs is not contingent upon this system implementation. As with many other Medicaid provider certifications, the record retention and case management capacity is part of the certification process. If providers have the IT capacity and functionality to carry out the requirements of the ICA or F/EA, the Department would certify those agencies assuming they comply with all other requirements of the certification criteria. Alternatively, if an ICA or F/EA would like to proceed with the certification process with the exception of full certification compliance until the centralized IT system is operational, the Department would allow this option. Services could not be rendered and reimbursements would not be issued until the ICA or F/EA met full compliance with certification. The Department also provides an additional benefit to IRIS participants through a contract for Ombudsmen services for IRIS participants. The Ombudsmen Program does not supplant any rights the participant has under the Medicaid Waiver. The Ombudsmen Program provides the following upon participant request: 1) investigate complaints; 2) resolve and mediate issues; 3) provide information and education on consumer rights; 4) assist in negotiating individual support and service plans; 5) assist with denials of services or changes in services with which the participant disagrees; and 6) works with enforcement and regulatory agencies.

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:

(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.
Division of Long Term Care
(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:
The Department of Health Services (DHS) utilizes a Division structure under the authority of the Department Secretary in order to carry out the Department's mission and to assure compliance with federal and state regulations as these relate to the operation of programs within the Department.

The Department of Health Services is the Wisconsin Medicaid Agency. The Governor appoints the Department Secretary. The DHS Secretary has designated the status of State Medicaid Director to the Administrator of the Division of Health Care Access and Accountability. That person is responsible for the overall policy direction of the Medicaid programs and securing the financial well-being of all Medicaid programs and is accountable to the Department Secretary. This includes coordinating decision-making on all policies that affect State plan services.

The Secretary has delegated the oversight and management of all Medicaid long-term care programs, including IRIS, to the Administrator of the Division of Long Term Care who is responsible for assuring the well-being and financial accountability of the Medicaid Waiver programs to the Department Secretary. There are mechanisms in place for ongoing coordination of policy and procedure between the two Divisions and with the Secretary's Office. These include regular status meetings with the Secretary for each Division Administrator; Executive staff meetings that include all Division Administrators and the Secretary; and meetings between the Division of Health Care Access and Accountability and the Division of Long Term Care.

Ultimately, the Secretary's authority assures coordination over all Medicaid programs.

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.:*
   DHS utilizes contracted services of four types of agencies to support the participants in IRIS including the Aging and Disability Resource Centers and the Third Party Administrator.

   Aging and Disability Resource Centers are public entities that 1) provide Information and Assistance; 2) provide pre-admission counseling; 3) conduct level of care evaluation activities using the State's automated long-term care functional screen; 4) coordinate other program eligibility activities on behalf of the SMA, and 5) carry out prevention activities. These functions include coordination with the Economic Support Unit to assist participants with the Medicaid financial eligibility processes as needed; administer the Long Term Care Functional Screen (LTCFS) to determine functional eligibility and level of care, and convey the individual budget allocation amount to people considering IRIS for SDS.

   The Department will also use a Third Party Administrator (TPA) for claims adjudication and processing. The TPA has been selected through a contract amendment to one of four existing contracts with TPAs providing claim services to other programs within the Department of Health Services. The Department will receive encounter data from the TPA for the claims submitted and reimbursed through the TPA for the IRIS program.

   The Department also provides an additional benefit to IRIS participants through a contract for Ombudsmen services for IRIS participants. The Ombudsmen Program does not supplant any rights the participant has under the Medicaid Waiver. The Ombudsmen Program provides the following upon participant request: 1) investigate complaints; 2) resolve and mediate issues; 3) provide information and education on consumer rights; 4) assist in negotiating individual support and service plans; 5) assist with denials of services or changes in services with which the participant disagrees; and 6) works with enforcement and regulatory agencies.

   ( ) **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:
   The SMA contracts with a Third Party Administrator (TPA) to provide claims adjudication for the IRIS program. The oversight of the TPA is performed primarily by the IRIS Section of the Bureau of Long Term Support (BLTS) within the Department of Health

Services Division of Long-Term Care. The BLTS assesses the performance of this contractor in conducting the contractor's operational and administrative functions according to the contract with the Department. The contract standards for the TPA are summarized below. These performance standards will be updated during the next contract period for Calendar Year2015 and will include measureable performance outcomes.

TPA Agency Standards:

Claims Processing
Fraud and Abuse Oversight
General Accounts Payable, Receivable, and Cash Receipting Functions
Eligibility and Enrollment Maintenance
Service Authorization Management
Provider Management
Grievance and Appeal Management
Eligibility and Enrollment Maintenance
Data Maintenance and Data Integrity
Reporting
Claims Processing
General Accounts Payable, Receivable, and Cash Receipting Functions
Eligibility and Enrollment Maintenance
Service Authorization Management

The SMA also contracts with the Aging and Disability Resource Centers (ADRCs) to operate as the single entry point for enrollment in Wisconsin's long term care and other publicly funded programs for adults who have long-term care needs. The Office of Resource Center Development within the Department of Health Services Division of Long-Term Care is responsible for the oversight for the contracts with local ADRCs and conducts its assessment of operational and administrative functions with the contracts with the Department. Although the ADRCs play a key role in the process to refer potential enrollees to the IRIS program and process disenrollments, these contracts are not managed as part of IRIS self-directed supports Waiver program.

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 SMA maintains direct administrative oversight of the waiver consistent with 42 CFR 431.10(3). DHS maintains sole authority to provide administrative direction and issue policies, rules, and regulations. Contract agencies including the Third Party Administrator (TPA) and Aging and Disability Resource Centers (ADRCs) do not have the authority to change or disapprove any administrative decision of the SMA authority or otherwise substitute their judgment for that of the SMA with respect to the application of policies, rules, and regulations. This requirement is defined through the DHS contract with these agencies. The performance of the contracted agencies is evaluated through multiple oversight functions by the SMA as described below. The DHS assures that contracted agencies adhere to policies and procedures through participant record reviews, analysis of aggregated data, and through other oversight functions. Where oversight of contracted agencies overlaps between Department agencies, there are centralized processes to ensure consistency is applied across programs.

Any quality issues identified concerning the TPA with regard to the policies and procedures established by the SMA are managed by the DHS/DLTC/BLTS IRIS staff to ensure compliance. These issues are tracked in a SharePoint site including how the issue was resolved. Further, any changes are communicated in policy directives, policy manual revisions and notifications to contractors. If any performance or compliance issue identified does not improve, then a corrective action plan (CAP) is developed with measurable outcomes, including timelines. The DHS IRIS staff monitors the agency's response to the CAP to ensure improvement. DHS retains the right to take a fiscal disallowance or to terminate a contract for performance issues.

The TPA is required to have an annual independent financial audit conducted by a Certified Public Accounting Firm as part of its contract with the Department. The results of the audit are reviewed by the Bureau of Financial Management (BFM) and BLTS within the Department; any findings must be corrected and recommendation implemented as determined by the DHS contract administrator. If the Department identifies quality concerns, then it would require the contractor to meet provisions of a corrective action plan.

DHS centralized processes include:
- Maintenance and oversight of the Long-Term Care Functional Screen (LTC FS) related to level of care (LOC) determinations for adults in the Frail Elder/Physically Disabled, and Developmental Disabilities populations.
- Management of unbiased options and enrollment counseling by ADRCs that refer potential enrollees to the Family Care or IRIS waiver programs.
- Financial oversight of adult waiver programs, including IRIS by the DHS Bureau of Financial Management (BFM). This bureau is responsible for ensuring contracted agencies such as the Third Party Claims Administrator (TPA) correctly enter claims data into the Encounter system to assure accurate and timely reporting of service utilization and costs. A Data Integrity Audit will be implemented as part of the contractual oversight of the TPA contract.

IRIS Advisory Committee and its sub-committees including the quality sub-committee is an external public entity that provides some limited oversight as an advisory group providing recommendations for improvement to the Department. The committee reviews IRIS waiver program policies and procedures, implementation of program operations and infrastructure, and reports produced by contractor agencies. The IRIS Advisory Committee meets bimonthly. Subcommittees also meet as needed based upon specific projects. Agendas and meeting summaries are maintained.

The following is a summary of the frequency of various functions and management meetings noted in this area. Weekly DLTC Managers Meeting includes the DLTC Administrator and Deputy Administrator, the Director of the Office of Family Care Expansion(OFCE), the Director of the Bureau of Aging and Disability Resources (BADR), the Director of the Bureau of Long-Term Support (BLTS) and the Director of the Bureau of Financial Management (BFM); as well as relevant lead staff attend these meetings. Staff within OFCE, BADR, and BLTS (including the Long-Term Care Functional Screen team) meet regularly to address quality issues and program coordination.

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.*

Function	Medicaid Agency	Contracted Entity
Participant waiver enrollment	☑	☐
Waiver enrollment managed against approved limits	☑	☐
Waiver expenditures managed against approved levels	☑	☐
Level of care 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 required reports that were submitted by each ICA to the SMA per contract requirements. Numerator/Denominator: Number of each ICA's reports submitted per contract requirements over the number of required reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports to SMA from IRIS Consultant Agencies per certification criteria.

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:

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

Performance Measure:
Number and percent of required F/EA reports from each F/EA that were submitted by each F/EA to the SMA per contract requirements. Numerator/Denominator: Number of each F/EA's reports submitted per contract requirements over the number of required reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Reports provided from the F/EAs per Certification Criteria.

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:

Number and percent of new enrollees who had a level of care determination completed by the ADRC that indicates an eligible level of care prior to waiver enrollment. Numerator/Denominator: Number of new enrollees during designated time period who had an eligible LOC determined prior to start date over number of new enrollees during the designated time period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Long-Term Care Functional Screen data and Enrollment data

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:
Number and percent of annual eligibility redeterminations that were conducted by the ICAs or ADRCs within 365 days of the participant's last LOC determination. Numerator/Denominator: Number of participants whose most recent screen is older than 365 days on the last day of the designated period over the number of participants on the final day of the designated period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Long-Term Care Functional Screen and Enrollment data

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:
Number and percent of initial service plans that were developed and approved in accordance with Waiver timelines (within 62 days of referral date). Numerator/Denominator: Number of service plans developed and approved within 62 days over the total number of service plans developed within the designated time period.

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

IRIS Centralized IT System - The source data is currently originating from the centralized IT system which holds the participants' current and historic plans.

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: ICAs	☐ **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: ICAs	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participants who received services within the approved individual budget allocation, as verfied in a retrospective review. Numerator/Denominator: Number of participants reviewed who received services within the approved individual budget allocation over number of plans 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:	☐ **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 screeners from each of the ICAs who are qualifed and certified to conduct level of care screenings using the Long-Term Care Functional Screen. Numerator/Denominator: Number of certified screeners from each of the ICAs over total number of IRIS screeners.

Data Source (Select one):
Other
If 'Other' is selected, specify:
ICAs' screener reports submitted to SMA

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: ICAs	☐ **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 IRIS screeners from each ICA who pass the Inter-Rater Reliability test. Numerator/Denominator: Number of IRIS screeners from each ICA who pass the IRRT over the total number of IRIS screeners from each ICA who take the IRRT.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Inter-rater reliability test results

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: Biennially

Performance Measure:
Number and percent of recent service plans (annual or updated plan) that were approved prior to implementation of services. Numerator/Denominator: Number of most recent service plans approved over of the number of service plans reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Service plan and claims data will be taken from the centralized IT 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:

Performance Measure:
Number and percent of new participant-hired workers for which each F/EA ensured that the provider had a signed Medicaid Provider agreement prior to furnishing services.
Numerator/Denominator: Number of new participant-hired workers on each F/EA's provider registry that have signed Medicaid provider agreements over the number of new participant-hired workers on each F/EA's registry.

Data Source (Select one):
Other
If 'Other' is selected, specify:
F/EAs reports

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: F/EAs	☐ **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: F/EAs	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of new providers for which the TPA ensured that the provider had a signed Medicaid Provider agreement prior to furnishing services. Numerator/Denominator: Number of new providers on the TPA provider registry that have signed Medicaid provider agreements over the number of new providers on the TPA registry.

Data Source (Select one):
Other
If 'Other' is selected, specify:
TPA Reports

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: TPA	☐ **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: TPA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of required TPA reports that were submitted to the SMA per contract requirements. Numerator/Denominator: Number of TPA reports submitted per contract requirements over the number of required TPA reports.

Data Source (Select one):
Other
If 'Other' is selected, specify:
TPA Reports

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**

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 performance measures in this section related to administrative authority will ensure that the IRIS Consultant Agencies, Fiscal/Employer Agents, and ADRCs implement program operations as indicated in their contract with DHS. Performance measures within other appendices in this application will also be used to ensure administrative oversight in the implementation of program operations, policies and process as indicated in the waiver program and Department requirements, but are not duplicated in this section. Additional discovery methods related to administrative oversight include issues that arise in the implementation of program operations that are identified by contracted agencies (ICAs, F/EAs) or through discovery methods employed by other sections within the Department related to its oversight of related program operations such as LOC determination and referral process by ADRCs, and Encounter data reporting.

The F/EAs submit monthly reports to the SMA which are used for monitoring the performance of the contracted agency in meeting contract expectations and waiver requirements. Some of these reports provide data for performance measures while others provide information for monitoring contract expectations. If concerns are noted through this discovery process, the SMA follows up on the concern with the appropriate F/EA and ensures that remediation occurs. If the nature of the concern/issue reflects a systems issue, then a corrective action plan is established. Additionally, the F/EAs conduct internal QA following each payroll period (bi-monthly) using a sample of transactions to ensure it is accurately performing steps in the payroll process - the F/EAs provide the SMA with a report on the results of this QA activity and action steps to correct any errors.

The state will evaluate the information provided in the ICA/F/EA financial projections documentation through the Bureau of Fiscal Management audit area. This is the same area within the Division of Long Term Care that evaluates the financial solvency of the MCO's in Family Care and will help ensure consistent application of financial solvency for MCO's and ICAs and F/EAs.

There is a minimum threshold that providers certified as IRIS Consultant Agencies or Fiscal/Employer Agents that requires all providers are require to have both the service delivery and financial capacity to serve a minimum of 25% of the IRIS Region's participants by the end of year one of their business projection plan and throughout the following years of their business projection plan.

The IRIS section has hired an administrative assistant as well as a contract specialist. The administrative assistant will help with the overall administrative requirements and coordination of the IRIS Section. The contract specialist is responsible for overseeing the receipt of contract deliverables for all IRIS Consultant Agencies and Fiscal/Employer Agents. A request for six additional positions to facilitate the oversight of multiple ICAs and F/EAs has been made to the Administration. In addition, the state will have control of all data through the use of the centralized IT system and state-owned SharePoint sites unique to each provider which will improve the state's ability to provide oversight of multiple agencies through technological means.

Data Sources and Performance Measures
For all performance measure utilizing service plan data, The source data is originating from the centralized IT system which holds the participants' current and historic plans. The data needs for each performance measure were considered during the development of the centralized IT system. As a result, the appropriate data elements were identified in advance and built into the centralized data system along with the necessary reporting functionality. The state controls the source data and the reports are produced from that source data. There are business rules and workflows built into the centralized IT system that ensure that valid and accurate information is captured.

Record Reviews are completed by the DHS Quality Management Team. From the DHS office, the DHS Quality Reviewers examine the participants' electronic records in contrast with a tool consisting of pre-determined indicators based on CMS

performance measures and elements of best practice. This information is collected on a quarterly basis and the results are communicated to the IRIS Consultant Agencies using each ICA's assigned Record Review SharePoint site. The Department informs each ICA of the negative findings, the reason for the negative findings, and the required remediation activities. Each ICA is required to complete the required activities and record their findings in the participant's record within the Record Review SharePoint site. The Department then validates each report of the remediated negative finding by going back into the participant's record and ensuring that the participant's ICA contains adequate documentation of the completed remediation activities. The DHS Reviewer documents the approval or need for additional activity in the SharePoint record. The record review is not closed in SharePoint until the remediation activity is completed according to the standards outlined in the criteria for the initial review. The Department provides each ICA with their own Record Review SharePoint site to ensure that participant information is not shared with other ICAs.

The information collected via these Record Review SharePoint sites will be collected by the centralized IT system in future phases of system development.

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. In addition, provide information on the methods used by the State to document these items.

DHS works with its contracted agencies to correct any issues discovered through administrative oversight activities. Single forum meetings with all ICAs and/or F/EAs will take place for global programmatic changes. Individual meetings will take place with each ICA and F/EA to address provider-specific issues and performance. The contracted agencies are responsible for correcting any individual issues discovered. The Department may also require immediate remedial action and impose corrective action plans to address these issues. The DLTC IRIS QM team collects information to document that the appropriate actions have occurred.

Individual issues related to LOC determinations that are conducted by ADRCs prior to enrollment are addressed in collaboration with the Long Term Care Functional Screen (LTCFS) Section in BLTS. Quality oversight of LOC determinations are a centralized function within the Department. Individual issues related to timeliness of initial screens are addressed by the LTCFS Section. Annual LOC redeterminations and change in condition screens are conducted by the IRIS Consultant Agencies.. Any individual issue related to these types of screens will be addressed by the participant's chosen IRIS Consultant Agency and ultimately DHS, if resolution cannot be accomplished at the contracted agency level.

Each year the Department renegotiates its contracts with these agencies. This provides an opportunity to add specifications to the contract. Additionally, DHS is able to require contract changes at any time within the existing contract structure.

The IRIS section has hired an administrative assistant as well as a contract specialist. The administrative assistant will help with the overall administrative requirements and coordination of the IRIS Section. The contract specialist is responsible for overseeing the receipt of contract deliverables for all IRIS Consultant Agencies and Fiscal/Employer Agents. A request for six additional positions to facilitate the oversight of multiple ICAs and F/EAs has been made to the Administration. In addition, the state will have control of all data through the use of the centralized IT system and state-owned SharePoint sites unique to each provider which will improve the state's ability to provide oversight of multiple agencies through technological means.

Currently, the majority of Quality Assurance activities take place through SharePoint sites dedicated to the following subjects: Critical Incident Reporting, Program Integrity, Notice of Action, Grievances, Behavior/Restrictive Measures, Record Review, Budget Amendment/One-Time Expense, etc. Each IRIS Consultant Agency and/or Fiscal/Employer Agent will have a replication of each site to ensure consistency in process yet managing the integrity of participant information. Each SharePoint site was designed with the intention of being used in an environment with multiple providers and to serve as the foundation for the module in the centralized IT system. Eventually, all SharePoint sites will be incorporated into the centralized IT system through continue enhancements of the system.

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 F/EAs	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	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 SubGroup	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**			☐
	☐	**Intellectual Disability**			☐
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:

When people with disabilities reach age 65 years they will be transferred to the Elderly target group.

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	2548
Year 2	5146
Year 3	7397
Year 4	7118
Year 5	7688

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	

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:

The role of the ADRC in managing waiver capacity is to manage the waitlist for enrollment during the initial three-year period of long-term care reform within a service area. The State of Wisconsin is moving away from local county agencies operating waivers to implement LTC Managed Care and Self-Directed Supports Waivers.

As new counties are added to the reform effort all waiver participants in the legacy waivers (Community Integration and Community Options Waivers), as well as children aging-out of the Children's Long-Term Support Waivers are offered the choice of long-term program and make the transition to the program of his or her choice without delay. Wisconsin then serves people on waiting lists in those areas on a first-come, first-serve basis until the wait lists are eliminated. After the waitlist is eliminated, typically three years after transition, entitlement begins. At this point, people who meet eligibility requirements receive options counseling and are immediately enrolled in the program of his or her choice and there will no longer an ADRC role 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 are eligible for Medicaid home and community-based services under s. 1915 (c) waiver will receive options and enrollment counseling through the Aging and Disability Resource Center. When a person is found to be functionally (meeting level of care) and financially eligible for a waiver program, the applicant receives counseling to make an informed choice between

community care and institutional care. If the individual chooses to receive services in the community, he/she is asked to make a second choice among the managed care programs available in his/her area or the IRIS waiver. Should the individual choose IRIS, the ADRC will provide the individual with information to inform their choice among available IRIS Consultant Agencies. Based on the individual's choice, he or she would be referred by the ADRC to the participant's chosen IRIS Consultant Agency for enrollment in IRIS.

IRIS participants will be enrolled on a first-come, first-served basis until the number of unduplicated recipients specified in the waiver application is reached. Wisconsin has sufficient budget appropriations from the Legislature to cover the costs of services for the number of unduplicated recipients specified. Please refer to Appendix B-3 e. Allocation of Waiver Capacity above for details about rollout of statewide expansion for IRIS.

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)*:
   - (•) **§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] **Low income families with children as provided in §1931 of the Act**
- [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:

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §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 §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §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:

All other mandatory and optional groups under the state plan are included.

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 spenddown 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:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

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 State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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 *(select one):*

Spousal impoverishment rules under §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 §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 (SSI 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 §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 4)

b. Regular Post-Eligibility Treatment of Income: SSI State.

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:

The basic needs allowance, indexed annually by the percentage increase in the state's SSI-E payment; plus an allowance for employed individuals equal to the first 65 dollars of earned income and ½ of remaining earned income; plus special exempt income which includes 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.

- **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 §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 4)

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

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 4)

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §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 §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, indexed annually by the percentage increase in the state's SSI-E payment; plus an allowance for employed individuals equal to the first 65 dollars of earned income and ½ of remaining earned income; plus special exempt income which includes 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.
- **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:

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-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:

Initial Evaluations are performed by the local Aging and Disability Resource Centers. These initial Level of Care (LOC) evaluations are conducted prior to any potential enrollee choosing a long-term care program.

Annual and change in condition re-evaluations of level of care will be performed by the IRIS Consultant Agencies. All IRIS Consultant Agencies are required to have enough certified screeners that meet DHS' criteria on staff to meet the annual and change of condition screening needs of their participants.

Other
Specify:

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:

Anyone who performs the Long Term Care Functional Screen, the web-based application/tool that determines a participant's level of care for eligibility determination (initial evaluations and re-evaluations), must meet the same certification and education/experience standards. The "screener" must be either a registered nurse or certified social worker in Wisconsin or have a four year Bachelor's degree in a related field, and have at a minimum one year of experience working with at least one of the long-term care target groups and/or specialized knowledge of the long term care target populations.

Screeners must pass an on-line certification course through the Wisconsin School of Nursing Continuing Education web portal. No screener is granted access to the screen application until he or she has passed the online test that evaluates the understanding of content (knowledge) and the application of instructions (skills). Electronic records of these tests are created and maintained by the DHS.

The records of screener qualifications employed by an ADRC are maintained by that ADRC. The Office of Resource Center Development (ORCD) conducts its own process to monitor and ensure that ADRC's employ screeners who meet qualifications and certification standards. ADRC screeners conduct initial evaluations for Level of Care prior to a person enrolling in any long-term care program and therefore this monitoring is outside the scope of the IRIS SDS Waiver.

The IRIS Consultant Agencies (ICAs) ensures that the screeners it employs to conduct re-evaluations of Level of Care (annual and change-in-condition) meet qualifications and certifications which are maintained in their employee records. The ICAs has a tracking mechanism in place that documents qualifications and certification standards. The ICAs will provide a report to the SMA on an annual basis related to its screener qualifications. This report will be used as the data source for the performance measure under Administrative Authority related to screener qualifications.

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 levels of care criteria are the same as the criteria for Medicaid reimbursement of nursing facility care in Wisconsin. The specific level of care for this waiver is nursing home level of care. The long-term care functional screen applies these criteria when determining level of care for this waiver.

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 levels of care criteria are the same as the criteria for Medicaid reimbursement of care in nursing home level of care in Wisconsin. The specific level of care allowed is nursing home level of care. The level of care tool used is the Wisconsin Long -term Care Functional Screen. It can be administered by trained screeners other than registered nurses. The functional screen was developed with the registered nurses in the State Medicaid Agency who evaluate Physician Plans of Care to determine Medicaid eligibility for nursing home admission. It has been evaluated by the State Medicaid Agency and determined to be valid, reliable, and to result in comparable level of care.

On a biennial basis the Department conducts inter-rater reliability testing (IRRT) of all certified LTC FS screeners in Wisconsin. The test results are maintained by the Department. If a screener does not pass the IRRT, the screener's employer receives notification with details about how to proceed to help the screener get into compliance. If the screener is unable to meet improvement expectations, they would be de-certified.

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 enrollees is gathered by ADRC screeners during a face-to-face meeting with the participant using the State's automated long-term care functional screen. When this information is entered into the functional screen tool, it applies the level of care criteria to issue a result for the individual. Information for annual reevaluations of level of care is gathered during a face-to-face meeting with staff at the ADRC using the same tool.

Annual and change in condition re-evaluations are a requirement of the IRIS Consultant Agencies.

A review of "ineligible" LOC determinations, which ensures that individuals are not inappropriately designated as ineligible is addressed through the following processes:

•Screeners are instructed to call the Clinical Help Desk if a screen returns an unexpected result. The SMA Clinical Help Desk staff reviews the screen, element by element, with the screener, until both parties are satisfied that the screen was completed accurately.

•Monthly queries are run on the database associated with the screen. This report pulls all screens completed during the preceding month. All of the screens (100%) that returned "ineligible" results are identified. The SMA Clinical staff then review the internal consistency and apparent completeness of each one of those screens. Patterns of ineligible submissions are noted and explored. This includes whether there are patterns specific to a screener or screen agency. All questionable screens are investigated and the SMA has the authority to order a screen to be repeated or revised as necessary to assure accuracy.

•On an ongoing basis, every screen that is challenged, appealed or results in a complaint, is reviewed by the DHS Clinical Team for completeness and accuracy. The Clinical experts complete individual remediation to assure a proper result for individuals and track this information for trends to ensure continuous improvement of the process.

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:

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):*

As part of the referral packet, the ADRC will provide a copy of the LTC Functional Screen for each participant to the participant's chosen ICA which will include the date of the screen. A new screen is required within 12 months of that date. The participant's chosen ICA is then responsible for completing the re-evaluation of level of care on an annual basis as well as when the participant experiences a change in condition.

The SMA uses the automated long-term care functional screen database in conjunction with the Medicaid eligibility system (CARES) to ensure timely reevaluations of level of care. The level of care annual result is sent automatically to the CARES system. The Economic Support worker who recertifies Medicaid eligibility annually cannot complete this process unless there is a current (within the last 12 months) screen completed with a LOC result.

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 central office 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:
Number and percent of new enrollees who had a level of care determination indicating an eligible level of care prior to receipt of services. Numerator/Denominator: Number of new enrollees during designated time period who do not have a completed LTCFS on record over number of new enrollees during the designated time period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Long-Term Care Functional Screen data and Enrollment data

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 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.

Performance Measure:
Number and percent of waiver participants who received an annual redetermination of eligibility within 365 days of their of their last LOC evaluation. Numerator/Denominator: Number of participants whose most recent screen is older than 365 days on the last day of the designated period over the number of participants on the final day of the designated period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Long-Term Care Functional Screen data and Enrollment data

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:

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.

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 Long Term Care Functional Screen (LTC FS) is a web-based application/tool that is used statewide to determine an individual's level of care (LOC) and eligibility for multiple adult waiver programs, including IRIS. The quality and administrative oversight of the LTC FS is centralized within the Division of Long Term Care through a cross-unit team with Department staff members who are jointly responsible for ensuring that the quality standards for the LTC FS are consistently applied across programs, agencies, and screeners statewide. These standards include ensuring that screeners meet all required qualifications before being granted access to the web-based LTC FS for the purpose of conducting the functional eligibility and level of care determination, implementing inter-rater reliability testing (IRRT) to ensure screeners are applying the LTC FS criteria appropriately, and conducting quality review of screens at both the agency and individual screener levels.

Other discovery activities the cross unit team performs through the use of LTC FS data include: monitoring timeliness of LTC FS, routine analysis of submitted screens and ad hoc studies, reviewing screens in which individuals were determined ineligible to ensure accuracy (checking for false negatives prior to enrollment in a specificied program), conducting desk review of the LTC FS at the agency level for ADRCs, Managed Care Organizations (MCOs) and IRIS Consultant Agencies.

Desk reviews of IRIS participants found to be ineligible for IRIS services take place on a monthly basis. Desk reviews are

conducted on a quarterly basis using a random sample of 25 people who had a screen calculated by the ICA during any month within the quarter. These reviews are performed viewing the on-line screen and look at screen scoring for comprehensiveness and consistency. The data and results from these activities are documented by this cross-unit team; this information is then shared internally and within DHS for information sharing and decision-making about remediation efforts across programs. Additionally, other performance measures related to LOC determinations are included under the Appendix A and not duplicated in this section.

LTC FS Screener qualifications/certification is maintained in employee files at the agencies in which they are employed. The SMA maintains a central list of qualified screeners (who passed certification and IRRT). Screeners only gain access to this system after completing all required training and after the agency verifies the screener's qualifications. As noted in the performance measure under Administrative Authority, an annual screener qualification/certification report is submitted to the SMA annually.

Performance Measures related to sub-assurance C can be found under Administrative Authority. There are four measures that evaluate the processes and instruments used in determining level of care. In addition, the SMA determined that it would not measure the number of false negatives/false positives as this quality assurance activity is conducted through a centralized SMA (DHS)process for LTC FS and is not exclusive of the IRIS program; it encompasses ALL adult LTC FS screens performed throughout the state for all programs and for screens conducted by an ADRC prior to a person's enrollment.

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. In addition, provide information on the methods used by the State to document these items.
Quality issues or inaccuracies associated with individual LOC determinations are addressed through the correction of the LTC FS through edits or a rescreen as appropriate. These screens are updated by either an ADRC or ICA screener as necessary.

Individual issues related to the screener qualifications and certification are addressed by the statewide inter-rater reliability testing (IRRT) developed by the Division of Long-Term Care. This IRRT is conducted on a biennial basis at the agency level. If an individual screener does not pass the initial IRRT, quality staff at the agency level will work with the screener to develop a corrective action plan and individualized remediation.

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 Aging and Disability Resource Center (ADRC) has a conversation with the consumer about their personal situation and service needs. The ADRC may then offer a functional screen to each individual who may have a need for long-term care services. The functional screen automatically determines Level of Care and Functional eligibility for publicly funded LTC. The functional screen process must include a face-to-face interview with the recipient and/or his/her legal representative. If the person is determined to be eligible for an available long term care program, the ADRC would provide options counseling. During the options counseling process implemented, people are informed about their right to choose between institutional and home and community-based services and their options under the Family Care and IRIS waivers, including alternatives to the waiver programs (i.e. local community resources or use of Medicaid-fee-for-service). The ADRC documents that these choices were offered during options counseling and this documentation is maintained within the ADRC system. After the individual makes a decision, the ADRC staff assists the person with enrollment in his or her preferred program. Copies of the signed referral form are provided to the enrollee and retained by the ADRC, which then facilitates the enrollment process.

Once a participant enrolls in IRIS, he or she is again informed about: 1.) the choice between institutional care and home/community based services 2.) the choice of waiver services, and 3.) the choice of providers during the initial plan development process. The choice of provider excludes agency providers that do not obtain and maintain the licensures and/or certificates required to operate as a provider (e.g. 3-4 Adult Family Home) or have become federally debarred from providing Medicaid services. For participant-hired workers, choice of provider excludes those who do not meet the qualifications to be employed in the United States, or those who do not pass the criminal background check. Participant-hired workers that do not pass the criminal background check may have the option to be employed through a provider agency.

The participant will verify they were informed by signing the document which will be maintained in the participant's record and will be verified during the SMA's Record Review.

An individual may disenroll at any time, return to the ADRC for enrollment counseling and seek admission into Family Care or Medicaid fee for service.

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.

The Aging and Disability Resource Centers, which is responsible for conducting level of care assessment evaluations and for facilitating the eligibility determination and enrollment processes maintains documentation of the option counseling provided to potential enrollees about their choices and the IRIS Referral form that indicates a person chooses the IRIS program.

The IRIS Consultant Agencies maintain copies of the signed documentation that indicate choices were discussed for each participant in the electronic record.

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 are required to have enrollment and other materials related to Family Care - managed long term care and IRIS - the SDS waiver, including an SMA-developed brochure and the participant handbook, available in the prevalent foreign languages spoken in Wisconsin – Hmong, Russian and Spanish, and are required to obtain interpreters or telephonic interpretation services when needed by an applicant.

All agencies under contract with DHS, are required to provide written information to participants in the prevalent foreign languages spoken in Wisconsin - Hmong, Russian and Spanish, and are required to obtain interpreters or telephonic interpretation services when needed by members to participate fully in care planning and to benefit fully from the receipt of services.

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	Daily Living Skills Training		
Statutory Service	IRIS Consultant Services		
Statutory Service	Live-in Caregiver (42 CFR §441.303(f)(8))		
Statutory Service	Prevocational Services		
Statutory Service	Respite		
Statutory Service	Supported Employment		
Extended State Plan Service	Nursing Services		
Supports for Participant Direction	Fiscal / Employer Agent Services		
Other Service	1-2 Bed Adult Family Home		
Other Service	3-4 Bed Adult Family Home		
Other Service	Adaptive Aids		
Other Service	CBRF		
Other Service	Communication Aids Vendors/Interpreter Services		
Other Service	Consumer Education and Training		
Other Service	Counseling and Therapeutic Services		
Other Service	Customized Goods and Services		
Other Service	Day Services		
Other Service	Home Delivered Meals		
Other Service	Home Modification		
Other Service	Housing Counseling		
Other Service	Personal Emergency Response System		
Other Service	Relocation - Housing Start Up and Related Utility Costs		
Other Service	Residential Care Apartment Complex		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Specialized Transportation 2		
Other Service	Specialized Transportation		
Other Service	Support Broker		
Other Service	Supportive Home Care		
Other Service	Vocational Futures Planning		

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: **Sub-Category 1:**

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

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

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

Service Definition *(Scope):*
Adult day care services are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision and/or protection. Services may include personal care and supervision, light meals, medical care, transportation to and from the day care site. Transportation between the individual's place of residence and the adult day health center may be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. Meals provided as part of adult day care may not constitute a "full nutritional regimen" (3 meals per day). Adult Day Care cannot be provided within a substitute care setting. Adult day care services that are provided as a part of the residential facility program cannot also be paid separately as Adult Day Care as this would represent billing twice for the same service and violates the Medicaid rule that requires providers accept one single payment as payment in full. Funding for Adult Day Care is separate from the substitute care rate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult Day Care is available up to 8 hours per day.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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):*
Persons providing these services shall comply with all relevant provisions of Section 1.05 of Chapter IV of the Medicaid Waivers Manual. Adult Day Care must be provided in a state certified facility. Providers of services are governed by the certification standards for Adult Day Care issued by the Department of Health Services, Division of Quality Assurance. Certification Standards for Adult Day Care for six or fewer people are found in OQA 2611. Certification Standards for Adult Day Care for more than six people are found in OQA 947. These standards may be obtained by contacting the Division of Quality Assurance.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

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):
Daily Living Skills Training

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Daily living skills training services provide education and skill development or training to improve the participant's ability to independently perform routine daily activities and effectively utilize community resources. Services are instructional, focused on skill development and are not intended to provide substitute task performance. Daily living skills training may include education and skill development related to:

- Personal hygiene
- Food preparation
- Home upkeep/maintenance
- Money management
- Accessing and using community resources
- Community mobility
- Parenting

- Computer Use
- Driving evaluation and lessons

When a participant selects an agency for the provision of daily living skills training services, the agency must document that the provided services relate to the above areas. The IRIS Participant works with the agency to ensure that his or her individual needs are met and the IRIS Consultant verifies the need for continued assistance on an annual basis, at minimum. Daily living

skills training is intended to be a short-term service designed to allow a participant to acquire additional skills in order to meet their long term care related outcomes. The Department will require bi-annual reports included in the participant's record of the progress the participant is making in obtaining the daily living skill and outcome identified on their ISSP. This will help ensure the training provided to the participant is effective in acquiring the skill identified.

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

No more than 8 hours of Daily living skills training may be provided per each day.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

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	Daily living skills trainer
Agency	Daily living skills training agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Daily Living Skills Training

Provider Category:

Individual

Provider Type:

Daily living skills trainer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Individuals providing assistance must meet the standards set forth in Appendix T of the Medicaid Waivers Manual. The participant should ensure that only competent and qualified providers of daily living skills training services that have the appropriate expertise, training and background are paid with IRIS funds. Generally, a best practice is to require providers to have a minimum of two years of experience working with the target population. Providers should ensure that staff is adequately trained and that the ratio of staff to participants is appropriate. All staff must also pass a criminal background check.

1. Providers of daily living skills training must have a minimum of two years experience working with the target population. However, a consumer may employ qualified providers who are less experienced. In that event, the participant must ensure that the provider receives comprehensive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the care plan.

2. Providers shall ensure Daily Living Skills Training staff are knowledgeable in the adaptation and use of specialized equipment and in the modification of participant environments and that these staff complete regular training/continuing education coursework to maintain/update their level of expertise.

3. Providers shall assure that the ratio of staff to participants is adequate to meet the specific needs of the participant(s) receiving services. Providers directly employed by participants must meet the qualifications to be employed in the United States, and pass the criminal background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

Frequency of Verification:

Criminal Background checks are completed prior to rendering services and every four years thereafter.

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Daily Living Skills Training

Provider Category:

Agency

Provider Type:

Daily living skills training agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers of Daily Living Skills training must meet the standards set forth in Chapter IV of the Medicaid Waivers Manual.

Other Standard *(specify):*

1. Providers of daily living skills training must have a minimum of two years of experience working with the target population. However, a consumer may employ qualified people who have less experience. In that event, the participant must ensure that the provider receives comprehensive participant-specific training to enable them to competently work with the participant to meet the objectives outlined in the care plan.

2. Providers shall ensure Daily Living Skills Training staff are knowledgeable in the adaptation and use of specialized equipment and in the modification of participant environments and that these staff complete regular training/continuing education coursework to maintain/update their level of expertise.

3. Providers shall assure that the ratio of staff to participants is adequate to meet the specific needs of the participant(s) receiving services.

When a participant selects an agency for the provision of services, the agency must maintain this documentation and the IRIS participant works with the agency to ensure that his or her individual needs are met. This is verified by the IRIS Consultant Agency as part of monitoring and /or plan review.

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

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:

Case Management

Alternate Service Title (if any):

IRIS Consultant Services

HCBS Taxonomy:

Category 1: 01 Case Management

Sub-Category 1: 01010 case management

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition *(Scope):*
IRIS Consultant Services are services/functions that assist the participant and/or legal representative in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. The IRIS Consultant assists the participant and/or legal representative in developing person-centered outcomes and Individual Support and Service Plans (ISSPs); and facilitates the processing of all ISSPs and plan updates. Practical skills training is offered to enable participants to independently direct and manage their waiver services and participant-hired workers. Examples of skills training include providing information on recruiting and hiring and managing participant-hired workers, and providing information on effective communication and problem-solving. IRIS Consultant Services include providing the tools, resources and information to participants to ensure that participants can make the most informed choice about their Long Term Care outcomes, supports and services as well as understand the responsibilities involved with directing their services. The IRIS Consultant is not responsible to directly coordinate services; or hire, manage, schedule, train, or terminate participant-hired workers.

Through this service, the IRIS Consultant will provide the participant with the following tools, resources, and information:
• person-centered planning and how it is applied;
• the range and scope of individual choices and options;
• the process for changing the Individual Support and Service Plan and individual budget;
• the grievance process;
• risks and responsibilities of self-direction;
• freedom of choice of providers;
• individual rights;
• the reassessment and review schedules; and,
• other subjects pertinent to the participant and/or family in managing and directing services.

Assistance may be provided to the participant with:
• defining goals, needs and preferences,
• identifying and accessing services, supports and resources;
• practical skills training (e.g., how to hire, manage, and terminate workers, problem solving, conflict resolution;
• developing of an emergency backup plan;
• recognizing and reporting critical events;
• providing assistance in filing grievances and complaints when necessary; and, other areas related to managing services and supports.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Providers of IRIS Consultant Services cannot provide other WI Long Term Care waiver services to the same participant.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

Provider Category	Provider Type Title
Agency	IRIS Consultant Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: IRIS Consultant Services

Provider Category:
Agency
Provider Type:
IRIS Consultant Agency
Provider Qualifications

License *(specify):*
N/A
Certificate *(specify):*
IRIS Consultant Agencies are certified using DHS' IRIS Consultant Agency Certification Criteria and Process; Specific requirements of IRIS Consultants are listed in the "Other Standard" section below.
Other Standard *(specify):*
IRIS Consultant Agencies shall ensure that all individuals providing consultant services meet the criteria specified in this section:

1. IRIS Consultants shall:

a. Be at least 18 years of age;
b. Possess a minimum of a Bachelor's degree in social work, psychology, human services, counseling, nursing, special education or a closely related field;
c. Have one year of supervised experience working with seniors and/or people living with disabilities;
d. Complete all required IRIS orientation and training courses; and
e. Pass a nationwide caregiver criminal history screening pursuant to the Department's policy.

OR

2. IRIS Consultants shall:

a. Be at least 18 years of age;
b. Have a minimum of four (4) years of direct experience related to the delivery of social services to seniors and/or people living with disabilities;
c. Complete all required IRIS orientation and training courses; and
d. Pass a nationwide caregiver criminal history screening pursuant to the Department's policy.

OR

3. Current IRIS Consultants in good standing who do not meet the above criteria may petition the Department of Health Services to receive an exemption. These consultants must also pass a nationwide caregiver criminal history screening pursuant to the Department's policy and complete all required IRIS orientation and training courses.

NOTE: Current IRIS Consultants in good standing who do not meet the above criteria may petition the Department of Health Services to receive an exemption. These consultants must also pass a nationwide caregiver and criminal history screening pursuant to the Department's policy and complete all required IRIS orientation and training courses as outlined in Appendix F of the IRIS Consultant Agency Certification Criteria.

The IRIS Consultant Agencies will ensure that hired consultants have the following attributes that will aid in their success as a consultant: be well-organized, have good written and oral communication skills, have knowledge of community resources, have effective critical thinking abilities, have effective negotiation skills, have sufficient knowledge of technology to be able to use and teach others to use ISITS, and the ability to provide excellent customer service.

The IRIS Consultant Agencies will ensure all employees providing consultant services attend all state-required orientation and trainings and demonstrate knowledge of and competence with the IRIS policies and procedures, philosophy, including self-direction, financial management processes and responsibilities, behavior management,

risk and needs assessments, person-centered planning and service plan development, and adhere to all other training requirements as specified by the state. Training requirements are further clarified in Appendix F of the IRIS Consultant Agency Certification Criteria.

Verification of Provider Qualifications

Entity Responsible for Verification:

The SMA is responsible for the annual certification of each IRIS Consultant Agency. Each IRIS Consultant Agency is responsible for the verification of the qualifications of the individual IRIS Consultants.

Frequency of Verification:

IRIS Consultant Agencies are subject to recertification by the SMA annually. IRIS Consultants are subject to criminal background checks and caregiver registry checks completed prior to providing services and reviewed every 4 years.

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:

Live-in Caregiver (42 CFR §441.303(f)(8))

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Live-In Caregiver (42 CFR §441.303(f)(8)) is the payment of the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who lives in the participant's household. The intent of the service is to meet the needs of participants who require assistance with daily living activities in order to ensure adequate functioning in their home and permit safe access to the community. The Live-In Caregiver service is not available in a situation where the participant lives in the provider's home (the lease or deed is in the name of the provider.

Legally responsible persons (spouses), relatives, and guardians are not allowable providers of live-in caregiver's services, and their room and board costs may not be funded by IRIS. Excludes situations where the participant lives in the provider's home (the lease or deed is in the name of the provider).

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

Excludes services available through the Medicaid State Plan. Excludes payment when a participant lives in a caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. Excludes training provided to a participant intended to improve the participant's ability to independently perform routine daily living tasks, which may be provided as daily living skills training. This service may not duplicate any service that is provided under another waiver service definition. This service excludes legally responsible persons, relatives or legal guardian from receiving "Live-In

Caregiver" payments. It also excludes payment for "Live-In Caregiver" payments when the home is owned or leased by the provider of Medicaid services.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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 Worker

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Live-in Caregiver (42 CFR §441.303(f)(8))

Provider Category:
Individual

Provider Type:
Individual Worker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Live in caregivers may provide services only after they have been sufficiently trained and provided an orientation by their employer. The must also meet all other employment eligibility requirements including successfully passing a caregiver and criminal background check at employment and every four years thereafter.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

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:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Prevocational services involve the provision of learning and work experiences where a participant can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time as determined by the participant and his/her IRIS Consultant in the ongoing participant-centered planning process and only until integrated community employment can be obtained. Services are expected to specifically involve strategies that enhance a participant's employability in integrated, community settings. Competitive employment and/or supported employment are considered successful outcomes of prevocational services.

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

Support of employment outcomes is a part of the participant-centered planning process, which includes the individual, his or her guardian if any, and the IRIS Consultant and emphasizes informed consumer choice. This process includes identification of the participant's personal Long Term Care outcomes and identification of services and items, including prevocational services and other employment-related services that advance achievement of the participant's outcomes. The participant and his or her IRIS Consultant will identify alternatives that are effective in supporting his or her outcomes and from those select the most cost-effective alternative.

Participants who receive prevocational services during some days or parts of days may also receive supported employment, educational, or day services at other times.

Participants participating in prevocational service may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment situation.

Participation in prevocational services is not a required pre-requisite for supported employment services provided under the waiver. Prevocational services may be provided in a variety of community locations including but not limited to work centers operated by community rehabilitation programs (CRPs).
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Prevocational services furnished under the waiver are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17). Prevocational services may be provided to supplement, but may not duplicate services provided under supported employment or vocational futures planning and support services provided under the waiver. IRIS is the funding source of last resort for employment services. If the participant has an open case with WI DVR, those funds must be used before any IRIS funds can be utilized

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.

If the transportation to the prevocational service is provided by the prevocational services provider, the cost of this

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

Personal care provided to a participant during the receipt of prevocational services may be included in the reimbursement paid to the prevocational services provider, or may be covered and reimbursed under the waiver service supportive home care or state plan personal care, but not both. All providers of supportive home care or personal care shall meet the appropriate provider qualifications.

Only activities or assistive technology that contribute to the participant's work experience, work skills, or work-related knowledge can be included in prevocational services.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

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 or Facility-Based Workshop

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:
Supported Employment Agency or Facility-Based Workshop
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of vocational services must meet the applicable standards and process requirements set by the Wisconsin Department of Workforce Development, Division of Vocational Rehabilitation (WI DVR). Information on the provider requirements for WI DVR can be found at: https://dwd.wisconsin.gov/dvr/service_providers/agreement_for_services.pdf

All providers of supportive home care or personal care shall meet the appropriate provider qualifications.

All providers of transportation shall ensure that the provider qualifications for specialized transportation are met.

Prevocational providers must meet the standards and requirements of this service as set forth in the Medicaid Waivers Manual:

1. A Vocational Service Plan is required to address the following:

a. Establishes each participant’s rate of pay and any anticipated wages;

b. Focuses on and describes general habilitative objectives and clearly indicates the specific pre-vocational

activities that the participant will engage in;

c. Provides the rationale as to why the participant is not expected to join the general work force, or participate in supported employment within a year; and

d. Addresses what the participant needs to do to participate in supported employment.

2. Services must be reviewed semi-annually to determine if progress is being made toward achieving goals and if pre-vocational services remain the most appropriate for the participant.

3. There shall be a direct service staff person or persons who shall possess skills and knowledge that typically would be acquired through:

a. A course of study that would lead to a bachelor's degree in one of the human services; or

b. A minimum of 2 years of academic, technical or vocational training consistent with the type of work to be supervised; or

c. A minimum of 2 years experience in a work situation related to the type of work supervised.

d. Additional staff or consultants who are knowledgeable and skilled in adapting or modifying equipment and environments, and the application of special equipment for persons with physical disabilities shall be available, as needed.

4. Pre-vocational Services shall include remunerative work including supervision and instruction in work tasks and observance of safety principles in a realistic work atmosphere. A realistic work atmosphere is most effectively provided within a community job site setting, whenever possible.

5. The organization of work shall embody awareness of safe practices and of the importance of time and motion economy in relation to the needs of individuals being served.

6. Information concerning health and special work considerations of participants should be taken into account and shall be clearly communicated in writing to supervisory personnel.

7. Vocational counseling shall be available.

8. The agency offering pre-vocational Services, shall maintain provisions either within its parent organization or through cooperative agreements with the Division of Vocational Rehabilitation or other job placing agencies, for the placement of any individuals served into regular competitive industry. Individuals shall be informed of the availability of placement services in regular competitive industry.

9. The agency offering pre-vocational services shall maintain payroll sub-minimum wage certificates and other records for each participant employed in compliance with the Fair Labor Standards Act.

10. The agency offering pre-vocational services shall provide the participant with effective and accessible grievance and complaint procedures.

11. Pre-vocational Services shall be provided as recommended in the individual service plan.

12. Appointed staff supervising the pre-vocational services shall send a written report to the Care Manager/ Support and Service Coordinator at least every six months. The report shall contain a statement on progress toward the goals and objectives of the participant service plan and the recommendations for changes.

13. If the participant receiving pre-vocational services displays challenging needs, a positive written behavior support plan must be developed and implemented to assist the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

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:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Respite care services are those services provided to a waiver eligible participant on a short-term basis, to relieve the participant's primary caregiver(s) from care demands. Respite care services may be provided in a residential setting, the home of the participant, or in another community setting.

1. Residential Respite

Residential respite may be provided in the following allowable settings:

a. Adult Family Home certified for one or two persons – Wisconsin Administrative code 82
b. Adult Family Home licensed for three or four persons – Wisconsin Administrative code 88
c. Licensed Community Based Residential Facility – Wisconsin Administrative code 83
d. Certified Residential Care Apartment Complex – Wisconsin Administrative code 89

Residential respite may involve overnight stays or partial day stays by the participant. Costs for room and board in these settings may be included in the charge to the waiver program. The actual length of the respite stay must be specified in the participant record.

2. Home Based Respite

When respite care service is provided in the home of the participant it is defined as Home-Based Respite. Home-based respite care services may be provided in partial day or overnight increments. Costs for room and board in these settings may not be included in the charge to the waiver program. The actual length of the respite stay must be specified in the participant record. The standards for respite provided within an individual's home are determined primarily by the participant and/or their legal decision-maker. However, the respite provider would still be subject to a background check the same as other providers.

3. Other Setting Respite

Other Setting Respite services may be provided in a home or in another location (but not in an institution) in the community. Services may involve overnight or partial day stays by the participant. The actual length of the respite stay must be specified in the participant record. The standards for other setting respite are determined primarily by the participant and/or their legal decision-maker. However, the respite provider would still be subject to a background check.

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

The receipt of respite 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 care, unless there is clear documentation that the hours of service were delivered at distinct times from respite services.

Excludes the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence or a residential care complex.

A special modifier of "TV" is provided to allow participants to creatively receive respite care at special, typically lower cost, rates. Each situation can creatively define what is a "special or holiday/weekend" rate, with the point being that the hourly rate or the flat fee will be more cost effective than traditional respite care. The service authorization in the participant's ISSP should indicate the hours that services will be provided.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	CBRF or RCAC
Agency	Adult Family Home 3 to 4 Bed
Individual	Adult Family Home - 1 to 2 Bed, Individual Respite Provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:
CBRF or RCAC
Provider Qualifications
License *(specify):*
CBRF - Licensed according to Administrative Rule DHS 83
Certificate *(specify):*
RCAC - Administrative Rule DHS 89
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
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:
Adult Family Home 3 to 4 Bed
Provider Qualifications
License *(specify):*

3-4 Bed Home - Administrative Rule HFS 88

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

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:

Adult Family Home - 1 to 2 Bed, Individual Respite Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

1-2 bed home - Administrative Rule DHS 83

Other Standard *(specify):*

Individual Respite provider - Appendix T of the Medicaid Waivers Manual

The standards for respite provided within an individual's home are determined primarily by the participant and/or their legal decision-maker. However, the respite provider would still be subject to a background check.

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual provider

Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

Agency provider

Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

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):

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Supported employment services is the provision of support to participants who, because of their disabilities, need intensive on-going support to obtain and maintain competitive or customized employment in an integrated work setting. Supported employment may also include support to maintain self-employment, including home-based self-employment. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits management, transportation and career advancement services, and tools/equipment needed to work effectively. Other workplace support services including services not specifically related to job skill training may also be provided based on the needs of the specific participant served.

Supported employment services may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker or other personnel and these individuals meet the qualifications established below for individual providers of service. Employers may be reimbursed for supported employment services provided by co-workers. This is referred to as a "paid co-worker supporter." Paid co-worker supports on the job have proven to be less intrusive than a typical job coaching situation as well as providing a more inclusive and integration environment for the participant.

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

Self-Directed Personal care provided to a participant by their employee during the receipt of supported employment services may be included in the reimbursement paid to the supported employment provider, or may be covered and reimbursed under the waiver service personal care, but not both. All providers of personal care shall meet the personal care provider qualifications.

With regard to self-employment and microenterprises, supported employment services may include: (a) aiding the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Waiver funds may not be used to defray expenses associated with starting up or operating a self-employment business. Supported employment does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business. IRIS is the funding source of last resort for employment services. If the participant has an open case with WI DVR, those funds must be used before any IRIS funds can be utilized.

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.

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

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

☐ **Provider managed**

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	On-the-job support person
Agency	Supported Employment Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Individual
Provider Type:
On-the-job support person
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of vocational services must meet the applicable standards and process requirements set by the Wisconsin Department of Workforce Development, Division of Vocational Rehabilitation (WI DVR). Information on the provider requirements for WI DVR can be found at: https://dwd.wisconsin.gov/dvr/service_providers/agreement_for_services.pdf.

As best practice, providers should meet National APSE's Supported Employment Competencies relevant to particular aspect(s) of supported employment being provided.

For self-employment provider must have knowledge of the unique needs/preferences of the participant and knowledge of self-employment best practices.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency
Provider Type:
Supported Employment Agency
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Providers of vocational services must meet the applicable standards and process requirements set by the Wisconsin Department of Workforce Development, Division of Vocational Rehabilitation (WI DVR). Information on the provider requirements for WI DVR can be found at: https://dwd.wisconsin.gov/dvr/service_providers/agreement_for_services.pdf.

As best practice, providers should meet National APSE's Supported Employment Competencies relevant to particular aspect(s) of supported employment being provided.

For self-employment provider must have knowledge of the unique needs/preferences of the participant and knowledge of self-employment best practices.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

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:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Nursing services are those medically necessary, skilled nursing services that may only be provided safely and effectively by a nurse practitioner, a registered nurse, or a licensed practical nurse working under the supervision of a registered nurse. The nursing services provided must be within the scope of the Wisconsin Nurse Practice Act and are not otherwise available to the participant under the Medicaid state plan or Medicare.
Nursing services are typically a Medicaid ForwardHeath Card coverable service or Medicare service and are not typically included in IRIS plans; however, when nursing services are needed beyond the Medicaid ForwardHealth allowable services, IRIS funds may be used to pay for nursing services.

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes services available through the Medicaid State Plan. The Statewide IRIS Self-Directed Personal Care Oversight Agency provides for the review of the need for nursing services to assure that it exceeds the State Plan benefit. This serves as the prior authorization for this service. DHS reviews all authorizations on a quarterly basis.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

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	Registered Nurse/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):*
Agency-directed and individual Registered Nurses/Licensed Practical Nurses must comply with licensing, accreditation and practice standards under Wisconsin Administrative Code DHS 441.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
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:
Registered Nurse/LPN

Provider Qualifications

License *(specify):*
Agency-directed and individual Registered Nurses/Licensed Practical Nurses must comply with licensing, accreditation and practice standards under Wisconsin Administrative Code DHS 441.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

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:
Financial Management Services

Alternate Service Title (if any):
Fiscal / Employer Agent Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directi
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Fiscal/Employer Agent Services are services/functions that assist the participant and/or legal representative in:
(a) managing and directing the disbursement of funds contained in the participant-directed budget related to the payment of participant-hired workers;
(b) facilitating the employment of participant-hired workers by the family or participant, by performing as the participant's agent such employer responsibilities as processing payroll; withholding Federal,state, and local tax; withholding garnishments

as necessary; and making tax payments to appropriate tax authorities; and,
(c) performing fiscal accounting and making expenditure reports to the participant or family, and state authorities.

Specific tasks completed by the Fiscal/Employer Agent include:

Employer Authority
• Assist the participant to verify worker citizenship status
• Receive and process timesheets of participant-hired workers
• Process payroll, withholding, filing and payment of applicable Federal, state and local employment-related taxes and insurance

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
• Provide participant with periodic reports of expenditures and the status of the participant-directed budget

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Providers of Consulting Services cannot provide other WI Long Term Care waiver services to the same participant. Does not include representative payee services.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

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	Fiscal / Employer Agent

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Fiscal / Employer Agent Services

Provider Category:
Agency
Provider Type:
Fiscal / Employer Agent
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
IRIS Fiscal / Employer Agents must be certified through successful completion of the Department-approved certification criteria.
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

The SMA is responsible for the annual certification of each Fiscal / Employer Agent.

Frequency of Verification:

IRIS Fiscal / Employer Agents are subject to recertification by the SMA 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:

1-2 Bed Adult Family Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

An adult family home is a community residence where one or two adults live and in which care, treatment, support or service above the level of room and board is provided. The residence is the Adult Family Home operator(s) primary residence. Adult family home also includes “community care home.” A community care home is a residence where one or two adults reside and in which care, treatment, support or service above the level of room and board is provided. In the community care home the operator owns, rents, or leases the residence and employs staff who provides the care, treatment, support or service. The community care home is not the provider’s primary residence. Only the costs directly associated with participant care, support and supervision in the adult family home may be billed under this service. No costs associated with room and board of the residents may be billed to the waiver program.

The adult family home and also the services of the home are identified for each individual participant by the participant and the adult family home operator. Services typically include supportive home care, personal care and supervision, which are provided by the home and included in their rate. Services may also include transportation and recreational/social activities, which may be purchased from separate providers, in which case the adult family home is responsible to provide access to and coordination with those services. Adult family home services also coordinate with other services received by the participant, including health care, work or vocational services. Each provider is expected to have an agreement with the IRIS participant that specifies the nature and scope of the adult family home services to be provided. Additional requirements are described in the 1-2 bed adult family home certification standards. Each 1-2 bed adult family home operator must maintain current certification in order to provide services as a 1-2 bed adult family home.

All providers of adult family home services must communicate with designated IRIS program representatives and other providers within confidentiality laws about any critical incidents that occur in the home. In addition, the home must report to the county adult protective services unit regarding any incidents or situations or conditions that have endangered the health or safety of the participant living in the home.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• IRIS funds may not be used to pay for the cost of room and board.
• Supportive Home Care is not available to persons living in this residence unless it is SHC provided outside the home that assists the participant to access the community.
• The same services provided that are described in the participant provider agreement may not (also) be provided by another service provider.
• Care and supervision costs cannot be supplemented by the participant or others.

Participants living in an adult family home are ineligible to have their budget increased. However, in the case where the participant lives in an adult family home but made plans to move to his/her own home, a temporary increase in budget for up to 90 days may be made to allow the participant to prepare for and accomplish the move. A budget increase is also permissible when the services of the adult family home are needed as part of a backup plan or when the adult family home services are to be used as respite services.

Additional funding for temporary residential care services is available when:

* Residential care is needed as part of the back-up plan when primary services/supports are not available.
* Residential care is needed temporarily for recuperative purposes.
* The person is living in residential care when coming onto the SDS waiver, but wants to move to his or her own apartment/home. Residential care could be approved for up to three months while the person develops necessary services and transitions to the community.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Adult Family Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 1-2 Bed Adult Family Home

Provider Category:
Individual
Provider Type:
Adult Family Home
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Adult family homes standards are decribed in the Medicaid Waiver Standards for Adult Family Homes under section 202.01 which can be found at: http://www.dhs.wisconsin.gov/bdds/waivermanual/afh202memo200513.pdf
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Individual provider
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

Agency provider

Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
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:
3-4 Bed Adult Family Home

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
An adult family home is a residence where three or four adults who are not related to the licensee live, in which care, treatment; support or service above the level of room and board is provided. The residence is the primary residence of the Adult Family Home operator(s). Adult family home also includes "community care home." A community care home is a residence where three or four adults who are not related to the licensee live and in which care, treatment, support or service above the level of room and board is provided. In the community care home, the operator owns, rents, or leases the residence and employs staff who provides the care, treatment, support or service. The community care home is not the provider's primary residence. Only the costs directly associated with participant care, support and supervision in the adult family home may be billed under this service. No costs associated with room and board of the residents may be billed to the waiver program.

The adult family home and also the services of the home are identified for each individual participant by the participant and the adult family home operator. Services typically include supportive home care, personal care and supervision, which are provided by the home and included in their rate. Services may also include transportation and recreational/social activities, which may be purchased from separate providers, in which case the adult family home is responsible to provide access to and coordination with those services. Adult family home services also coordinate with other services received by the participant, including health care, work or vocational services. Each provider is expected to have an agreement with the IRIS participant that specifies the nature and scope of the adult family home services to be provided. The operator must maintain current license in order to operate as a 3-4 bed adult family home.

All providers of adult family home services must communicate with designated IRIS program staff and other providers within confidentiality laws about any critical incidents that occur in the home. In addition, the home must report to the county adult protective services unit regarding any incidents or situations or conditions that have endangered the health or safety of the participant living in the home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

• IRIS funds may not be used to pay for the cost of room and board.
• Supportive Home Care is not available to persons living in this residence unless it is SHC provided outside the home that assists the participant to access the community.
• The same services provided that are described in the participant provider agreement may not (also) be provided by another service provider.
• Care and supervision costs cannot be supplemented by the participant or others.

Participants living in an adult family home are ineligible to have their budget increased. However, in the case where the participant lives in an adult family home but may plans to move to his/her own home, a temporary increase in budget for up to 90 days may be made to allow the participant to prepare for and accomplish the move. A budget increase is also permissible when the services of the adult family home are needed as part of a backup plan or when the adult family home services are to be used as respite services.

Additional funding for temporary residential care services is available when:

* Residential care is needed as part of the back-up plan when primary services/supports are not available.
* Residential care is needed temporarily for recuperative purposes.
* The person is living in residential care when coming onto the SDS waiver, but wants to move to his or her own apartment/home. Residential care could be approved for up to three months while the person develops necessary services and transitions to the community.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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 Family Home

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: 3-4 Bed Adult Family Home

Provider Category:
Agency
Provider Type:
Adult Family Home
Provider Qualifications
License *(specify):*
The Wisconsin Department of Health Services Division of Quality Assurance licenses and oversees 3-4 bed adult family homes. The rules and requirements for licensure can be found at:
http://www.dhs.wisconsin.gov/rl_DSL/AdultFamilyHomes/AFHregs.htm

Chapter 88 of Wisconsin Administrative Code.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
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:

Adaptive Aids

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Adaptive aids are controls or appliances that enable persons to increase their abilities to perform activities of daily living or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services and material benefits that enable individuals to access, participate and function in their community. These include the purchase of vehicle modifications (such as van lifts, hand controls, equipment modifications etc.) that allow the vehicle to be used by the participant to access the community, or those costs associated with the maintenance or repair of these items. Some examples include:

• Patient lifts
• Control switches
• Eating and cooking utensils
• Grabbers
• Toilet risers
• Shower chairs
• Grab bars
• Scald preventing showerhead
• Talking alarm clocks
• Accessible computer keyboard
• Lift chair
• Van lift
• Vehicle hand controls
• Wheelchair
• Cane
• Walker
• Wheelchair tray
• Adult tricycle
• Specialized furniture/mattress

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

• If IRIS funds are used to pay for installation of the grab bars then they are considered home modifications and are not billed as adaptive aids.
• Durable Medical Equipment (DME) that can be obtained through Wisconsin's approved Medicaid State Plan is excluded. IRIS funds may be used to pay for aids that meet a documented need that are not allowable under Medicaid state plan or that are denied by Medicaid.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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	Adaptive Aids Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Aids

Provider Category:
Agency
Provider Type:
Adaptive Aids Vendor
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DHS Administrative Code 105.40
https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/40
Other Standard *(specify):*
Qualifications and requirements for Adaptive Aids vendors include that they are a Medicaid certified provider. Adaptive aids must meet all applicable laws, regulations and standards for the manufacture and design for safety and utility. Best practice suggests that to ensure participant safety, the installation or repair of adaptive aids should be completed by professional installers who can provide documentation of their training and experience.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
Frequency of Verification:
At the time of purchase

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:
CBRF

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Community-based residential facilities (CBRF) are larger congregate care settings where 5 or more unrelated adults who are not related to the operator or administrator reside and receive care, treatment, support, supervision and training that is provided as needed for support in one or more aspects of living such as: health care, personal care, supervision, behavior and social supports, daily living skills training and transportation when transportation is part of providing the services and that may include several hours per week of nursing care per resident.

Beginning January 1, 2014, CBRF may no longer be added to an existing participant's plan as a residential setting. Individuals enrolling in IRIS after January 1, 2014, may not be living in a CBRF. Participants who are living in a CBRF as of January 1, 2014 will have one calendar year to evaluate their options and choose to either switch to another long term care program to continue residing in the CBRF, or work with their IRIS Consultant to make arrangements to move an allowable setting. The Department will make written notification of the transition plan to the IRIS participants residing in CBRF's during the first thirty days after January 1, 2014. Both ADRC staff and the participant's chosen IRIS Consultant Agency will be available to assist the participant in obtaining information to make their choice. For participants wishing to remain in the CBRF, ADRC staff will provide enrollment counseling so that the participants can make an informed decision among long term care programs. For participants wishing to remain in the IRIS program, the IRIS Consultant Agency will provide the participant with the information, tools, and resources necessary to assist the participant in making an informed decision and successful relocation to an allowable living situation. The Department and the IRIS Consultant Agency will each assign a responsible party to ensure that the transition plan is executed timely and efficiently so that participants are afforded maximum time to make an informed decision and seamlessly transfer to their new living situation or long term care program.
Residential respite in a CBRF may appear on a participant's Individual Support and Service plan as a short-term arrangement consistent with criteria under the Respite service definition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Additional funding for temporary residential care services is available when:
* Residential care is needed as part of the back-up plan when primary services/supports are not available.
* Residential care is needed temporarily for recuperative purposes.
* The person is living in residential care when coming onto the SDS waiver, but wants to move to his or her own apartment/home. Residential care could be approved for up to three months while the person develops necessary services and transitions to the community.

Waiver funds are not used to pay for the cost of room and board. Supportive Home Care is not available to recipients of residential services. This service may not duplicate any other service that is provided under another waiver service definition.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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	CBRF

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: CBRF

Provider Category:
Individual
Provider Type:
CBRF
Provider Qualifications

License *(specify):*
HFS 83 Wisconsin Administrative Code
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
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:
Communication Aids Vendors/Interpreter Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Communication aids are devices or services needed to assist with hearing, speech, communication or vision impairments in order to access and deliver services. These services assist the individual to communicate with service providers, family, friends and the general public. Results of improved communication may include a decrease in the reliance on paid staff, an increase in personal safety, an enhanced independence, and an improved social and emotional well-being. Communication aids include: communication devices, speech amplifiers, aids and assistive devices, and cognitive retraining aids and include costs related to the repair of these aids. Communication aids also include electronic technology such as tablets or mobile devices and related software that assist with communication. Applications for mobile devices or other technology also are covered under this service.

Interpreter services are provided to people who have hearing impairments and need sign language translation in order to communicate with people in their community, employees, and others. Interpreters provide sign language services for participants with hearing impairments. IRIS funds may only be used in situations where it is the responsibility of another party to provide this service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes Durable Medical Equipment (DME) that can be obtained through Wisconsin's approved MA State Plan.

Interpreter services may not be paid when provided by a spouse, relative or guardian. Interpreter services required by a participant to interact with their IRIS Consultant are part of the IRIS Consultant service benefit. IRIS funds cannot be used to provide interpreter services that are the responsibility of another entity (school, court, hospital, etc.).

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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 Interpreters
Agency	Communication Aids vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication Aids Vendors/Interpreter Services

Provider Category:
Individual
Provider Type:
Individual Interpreters
Provider Qualifications
License *(specify):*

Certificate *(specify):*
A qualified interpreter for the deaf is a person who has been certified by the National Registry of Interpreters for the Deaf or one that has successfully participated in the DHS Office for the Deaf and Hard of Hearing program, "Wisconsin Interpreting and Transliterating Assessment (WITA)."
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.
Frequency of Verification:
At the time of purchase

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Communication Aids Vendors/Interpreter Services

Provider Category:
Agency
Provider Type:
Communication Aids vendor
Provider Qualifications
License *(specify):*

Certificate *(specify):*
As best practice, vendors of communications aids should meet the requirements in Wisconsin Medicaid Waiver Manual - CHAPTER IV – ALLOWABLE SERVICES AND
PROVIDER REQUIREMENTS SPC 112.47.

Items considered DME must meet Wisconsin Administrative Code 105.40
https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/40
Other Standard *(specify):*
1. The providers of systems or devices purchased as communication aids shall ensure that such items meet all the applicable standards of manufacture, safety, design and installation (Underwriter's Laboratory, Federal Communication Commission, etc.) and should be obtained from authorized and qualified dealers.

2. A qualified interpreter for the deaf is a person who has been certified by the National Registry of Interpreters for the Deaf or one that has successfully participated in the DHS Office for the Deaf and Hard of Hearing program, "Wisconsin Interpreting and Transliterating Assessment (WITA)."

3. Allowable foreign language interpreter services are those provided by a person recognized by the waiver program agency as proficient in the translation of the applicable language and who has been instructed by the agency as to the privacy and confidentiality of the participant-related communication.

Items purchased must meet a reasonable buyer expectation of quality and performance.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
Frequency of Verification:
At the time of purchase

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:
Consumer Education and Training

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Participant education and training is intended to provide educational services to help the participant develop self-advocacy skills, exercise civil rights and acquire the skills necessary to exercise control and responsibility over their other supportive services. Covered services may include enrollment fees, books and other educational materials and transportation related to participation in training courses, conferences and other similar events that address the objectives of this service category.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes payment for hotel and meal expenses while participants or their legal representatives attend allowable training/education events. Fees and lodging for attendants supporting the participant while at educational services are excluded. (These may be paid under the service supportive home care as supportive home care worker expenses.)

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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	Education and training agency
Individual	Personal assistant, teacher

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Education and Training

Provider Category:
Agency
Provider Type:
Education and training agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Certification from the Department of Public Instruction if the person is a teacher.
Other Standard *(specify):*

The participant should ensure that competent and qualified providers of participant education and training services have the necessary required credentials.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Consumer Education and Training

Provider Category:
Individual

Provider Type:
Personal assistant, teacher

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The participant should ensure that competent and qualified providers of participant education and training services have the necessary required credentials.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

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 and Therapeutic Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Counseling and therapeutic services includes the provision of professional treatment-oriented services to participant's identified needs for physical, medical, personal, social, behavioral, cognitive, developmental, emotional, or substance abuse treatment. The goal of treatment is to maintain or improve participant health, welfare or functioning in the community. Counseling and therapeutic resources may include assistance in adjusting to aging and disability including understanding capabilities and limitations. Counseling and therapeutic resources may also include assistance with interpersonal relationships. If the service occurs in a camp setting, certain codes should be used as noted below.

Counseling and therapeutic resources may also include recreational therapy, music therapy, art therapy, nutritional counseling, medical and legal counseling, grief counseling, weight counseling (except when the participant is on Medicare), and health club memberships for the participant. The therapy or treatment service may be provided in a natural setting or in a service provider's office - includes therapies or treatments provided by state licensed or certified medical professionals or practitioners of the healing arts, which are not available under the Medicaid State Plan. Costs associated with memberships, parking, passes and fees that are directly related to the Long Term Care outcome of the participant and to the counseling or therapy received are included in this service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes inpatient services. Excludes services provided by a physician. Excludes services available through the Medicaid State Plan or that are covered by other insurance including Medicare. Costs for attendants to assist participants while attending the counseling and therapeutic services are excluded. (These costs should be included with in supportive home care services as direct expenses.)

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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 counselors
Agency	Counseling agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:
Individual
Provider Type:
Individual counselors
Provider Qualifications
License *(specify):*
Individuals providing counseling and therapeutic services must be appropriately licensed or certified in the State of Wisconsin per Wisconsin Administrative Code DHS 61.35 found at https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/61/II/35.
Certificate *(specify):*
Only competent and qualified providers may provide services to participants. Alternative therapies and treatments must be provided by licensed professionals who maintain current state licensure or certification in their field of practice.

Other Standard *(specify):*
If services are provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification, the services need to be carefully considered in order that the treatment is not averse to the health and safety of the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Counseling and Therapeutic Services

Provider Category:
Agency

Provider Type:
Counseling agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*
Agencies or individuals providing counseling and therapeutic services must be appropriately licensed or certified in the State of Wisconsin per Wisconsin Administrative Code DHS 61.35 found at https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/61/II/35.

Other Standard *(specify):*
Only competent and qualified providers may provide services to participants. Alternative therapies and treatments must be provided by licensed professionals who maintain current state licensure or certification in their field of practice.

If services are provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification, the services need to be carefully considered in order that the treatment is not averse to the health and safety of the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

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:
Customized Goods and Services

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Customized Goods and Services refers to a service, support or good that addresses a participant's assessed long-term support need, enhances the participant's opportunities to achieve long-term support outcomes related to living arrangement, relationship, community inclusion, work and functional or medical status with respect to a long-term support need. Each service, support or good selected must address a long-term support need and must meet all of the following four criteria and at least one of the criteria as stated in the second list of criteria:
 The item or service is designed to meet an assessed long-term support need related specifically to the participant's functional, vocational, medical or social needs and also advances the desired outcomes in his/her Individual Support and Service Plan;
 The service, support or good is documented on the Individual Support and Service Plan;
 The service, support or good is not prohibited by Federal and State statutes and regulations, or guidance including the State's Procurement Code;
 The service, support or good is not available through another source (natural, community-based, Medicaid funded)
• The service, support or good is not experimental(as defined in DHS 107.035). http://docs.legis.wisconsin.gov/code/admin_code/dhs/101/107/135

Each service, support or good selected must meet at least one of the following criteria:
 The service, support or good will maintain or increase the participant's safety in the home or community environment;
 The service, support or good will decrease or prevent increased dependence on other Medicaid-funded services to meet a long-term support need;
 The service, support or good will maintain or increase the participant's functioning related to the disability; or
 The service, support or good will address a long-term support need and will maintain or increase the participant's access to or presence in the community.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Items, goods or services that are not for the primary benefit of the participant are prohibited.

Items, goods or services that are unrelated to the person's assessed long-term support needs and outcomes related to those needs are prohibited.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Family, friend, neighbor, supportive home care worker
Agency	Home Health Care Agency, Supportive Home Care Agency, Aging Network Agency, Education and Training Agency, Other Merchants or Contractors.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Customized Goods and Services

Provider Category:
Individual
Provider Type:
Family, friend, neighbor, supportive home care worker
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Supportive Home Care agency - DHS 105.17 Wisconsin Administrative Code
Other Standard *(specify):*
Typical vendors in the community, according to the goods, services and supports needed. Only competent and qualified providers of goods and services that have the appropriate expertise, training and background may be paid with IRIS funds.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.
Frequency of Verification:
Annually or at the time of purchase

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Customized 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):*
Supportive Home Care agency - DHS 105.17 Wisconsin Administrative Code
Other Standard *(specify):*
Typical vendors in the community, according to the goods, services and supports needed. Only competent and qualified providers of goods and services that have the appropriate expertise, training and background may be paid with IRIS funds.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
Frequency of Verification:
Annually or at the time of purchase

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:

Day Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Day services programs provide regularly scheduled, individualized skill development activities to participants. Services are typically provided in a non-residential setting. Day services include services primarily intended for adults with disabilities. Program goals may include developing/enhancing participant skills for social interaction, communication, or community integration. Day services must have a training component providing service above the level of basic supervision. Services are typically provided four or more hours per day, up to five days per week outside the home of the participant. Services may occur in a single physical environment or multiple environments or in the community at large.

Community- based services take place in the community (and not in a facility) where interaction with people without disabilities could occur. Facility- based services take place in a facility, such as a day program, a prevocational center, or a senior center.

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

Services are typically provided four or more hours per day, up to five days per week outside the home of the participant. Services may occur in a single physical environment or multiple environments or in the community at large.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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	Day Service program operated by agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Day Services

Provider Category:
Agency
Provider Type:
Day Service program operated by agency
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Only competent and qualified providers of Day Services that have the appropriate expertise, training and background may be paid with IRIS funds per Wisconsin Administrative Code 61. Providers certified by the Rehabilitation Accreditation Commission for Activity Services may use this certification as evidence of qualification.
Other Standard *(specify):*
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
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:
Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	Sub-Category 2:
Category 3:	Sub-Category 3:
Category 4:	Sub-Category 4:

Service Definition *(Scope):*
Home-delivered meal services include the provision of meals to participants who are at risk of institutionalization due to inadequate nutrition. Home-delivered meals provider costs may include the purchase and planning of food, supplies, equipment and labor, as well as the transportation costs associated with the delivery of one or two meals per day to the participant's home. Participants provided with home delivered meals may be unable to plan, prepare or obtain nutritional meals without assistance or may be unable to manage a special diet recommended by their physician. Generally these meals

are provided in the participant's home.
Home-delivered meals are intended for those IRIS participants who live in a house or apartment and who do not have paid or natural supports available to assist with meal preparation. Home-delivered meals can be provided when access to meals outside of the home is unrealistic or difficult to accomplish.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Home-delivered meals may not constitute a "full nutritional regimen" (3 meals per day). Excludes payment for meals at federally subsidized nutrition sites.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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	Aging network agencies, hospitals or nursing homes, restaurants

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 agencies, hospitals or nursing homes, restaurants
Provider Qualifications
License *(specify):*
Home-delivered meal providers must be licensed food service providers or Older American's Act program providers. Licensed providers include restaurants, nursing facilities, hospitals, public schools, etc. Older American's Act programs and licensed providers must comply with Wisconsin Statutes 254 and Administrative Code DHS 196. Hospitals that provide home delivered meals must comply with Administrative Code DHS 124. Nursing facilities that provide these meals must comply with Administrative Code DHS 132.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
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:

Home Modification

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Home modifications are services designed to assess the need for, arrange for and provide modifications and/or improvements to a participant's residence that address a need identified to improve health, safety, accessibility, or provide for the maximization of independent functioning. Home modifications may include the materials and services needed to complete the installation of specific equipment, the modification of the physical structure, or the reconfiguration of essential systems within the home. Home modifications are generally permanent fixtures/changes to a physical structure.

Home modifications include the cost of the permit to authorize the changes, the materials and services needed to complete the installation of specific equipment, the modification of the physical structure, or the reconfiguration of essential systems within the home. Home modifications are generally permanent fixtures/changes to a physical structure owned by the participant). Only the most economical approach to achieve the outcome will be considered.

Home modifications are considered to be a one-time expense. Home modifications are generally not available in a rental unit as the IRIS program is not responsible to modify a rental unit. Items that are considered to be portable (portable ramp) are defined as adaptive aids. Home modifications may include adaptations including, but not limited to:

- Ramps (fixed), ramp extensions and platforms
- Porch/stair lifts
- Doors/doorways, door handles/door opening devices
- Adaptive door bells, locks/security items or devices
- Plumbing, electrical modifications related to adaptations
- Medically necessary heating, cooling or ventilation systems
- Shower, sink, tub and toilet modifications
- Faucets/water controls
- Accessible cabinetry, counter tops or work surfaces
- Grab bars (See exception below), handrails, accessible closets
- Smoke/fire alarms and fire safety adaptations
- Adaptive lighting/light switches
- Flooring and/or floor covering to address health and safety
- Wall protection

Modifications not specifically described above may be approved if the item or service meets the definition and the standards for allowable home modifications. DHS or the IRIS Consultant Agency will determine if the modification is waiver allowable and notify the participant of the decision.

Home modifications must be necessary to address disability related long term care needs that increase self-reliance and independence, or to ensure safe, accessible means of ingress/egress to a participant's living quarters, or to otherwise provide safe access to rooms, facilities or equipment within the participant's living quarters, or adjacent buildings that are part of the residence. Only those modifications determined to be the most cost effective approach to meeting the participant's long term

care related outcomes may be funded.

A qualified assessor who is independent of all contactors must complete an accessibility assessment. The cost of this assessment is funded by the IRIS Program and is not considered to be a cost to the participant's budget. Three viable provider estimates must be obtained and submitted with each request for a home modification. In all cases, the provider with the most reasonable costs and the assurance of the appropriate level of quality will be selected.

Home modifications made prior to a person leaving an institutional setting cannot be paid for until the person leaves the institution and is enrolled in the IRIS Program with a plan start date.

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

• Modifications which increase the square footage or that enhance the general livability and value of a privately owned residence are excluded.
• Modifications not recommended in the accessibility assessment are excluded.
• Modifications that are not the most cost effective approach to meeting the participant's long term care related outcomes are excluded.
• Modifications proposed to modify a rental unit are generally excluded.

Home modifications must demonstrate how the modification addresses disability related long term care needs that increase self-reliance and independence, or to ensure safe, accessible means of ingress/egress to a participant's living quarters, or to otherwise provide safe access to rooms, facilities or equipment within the participant's living quarters, or adjacent buildings that are part of the residence. Modifications which increase the square footage or that enhance the general livability and value of a privately owned residence are excluded.

Home modifications made prior to a person leaving an institutional setting cannot be paid for until the person leaves the institution and is enrolled in the IRIS Waiver with a plan start date. Quotations from at least three providers must be obtained and submitted with the request for the home modification for modifications with costs exceeding an amount set annually by the Department. In all cases, the provider with the most reasonable costs and the assurance of the appropriate level of quality will be selected.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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	Carpenter, electrician, plumber, contractor, engineer

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Individual
Provider Type:
Carpenter, electrician, plumber, contractor, engineer
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Home modifications should be done according to ADA standards. If the project will not meet ADA requirements, additional review and approval is required.

The provider and designers of any home modifications must meet all of the applicable state and local requirements for professional licensure for building contractors, plumbers, electricians, engineers or any other building trades.

All modifications must be made in accordance with any applicable local and state housing or building codes and are subject to any inspection required by the municipality responsible for administration of the codes.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA

Frequency of Verification:
At the time of purchase

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:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Housing counseling is the provision of comprehensive guidance on housing opportunities that are available to meet the participant's needs and preferences. Qualified counselors provide guidance on how a participant may gain access to available public and private resources available in order to obtain or retain safe, decent, accessible, and affordable housing and remain in the community avoid institutionalization.
Housing Counseling includes planning, guidance and assistance in accessing resources related to:

1. Home ownership, both pre and post purchase.
2. Home financing and refinancing.
3. Home maintenance, repair and improvements including abating environmental hazards.
4. Rental counseling, not including any cash assistance.
5. Accessibility and architectural services and consultation.
6. Weatherization evaluation and assistance in accessing these services.
7. Lead based paint abatement evaluation.
8. Low income energy assistance evaluation.
9. Access to transitional or permanent housing.
10. Accessibility inventory design.

11. Health and safety evaluations of physical property.
12. Debt/credit counseling.
13. Homelessness and eviction prevention counseling.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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):*
Agencies providing Housing Counseling must have expertise in housing issues relevant to the participant and may not be a provider of residential support services to the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers will be validated and maintained by the Third Party Administrator.
Frequency of Verification:
At the time of purchase

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:

Personal Emergency Response System

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A Personal Emergency Response System (PERS) is a service that provides immediate assistance in the event of a physical, emotional, or environmental emergency through a community-based electronic communications device. This service can provide a direct link to health professionals or other service professionals, enabling the user to secure an immediate response by the activation of an electronic communications unit in the participant's home. Allowable items under this service may also include a cellular telephone and cellular service as an alternative to a land-based telephone PERS system. Note that free cell phone services should be used whenever possible. Several programs offer free wireless Personal Emergency Response service and are supported, in part, by the Federal Government. If a landline is required for the operation of the PERS system, the basic cost of the landline can be funded only when there is not another landline already available.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Installation and/or monthly cost of landline service if there is currently existing landline service is excluded.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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	PERS Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response System

Provider Category:
Agency
Provider Type:
PERS Vendor
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The PERS provider should assure that these devices, where applicable, meet Federal Communication Commission performance standards.

The installation of PERS systems should be done by qualified installers representing the health agency managing the personal emergency response system. In the event these installers are not available, the agency should seek experienced technicians to complete necessary line adaptations.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers will be validated and maintained by the Third Party Administrator.

Frequency of Verification:
At time of purchase

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 - Housing Start Up and Related Utility Costs

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*
Relocation-related services may be funded by IRIS as a last payment resource when no other sources are available. This service includes the provision of services and essential items needed to establish a community living arrangement for persons who are relocating from an institution, a residential setting or who are moving out of a home controlled by another individual to establish an independent living arrangement. Costs may include the initial fees to establish utility service or the purchase of basic and essential items and services needed to establish a community living arrangement. Only basic and essential items and services will be funded.

Relocation-related housing start-up services includes person-specific services, supports or goods that may be arranged, scheduled, contracted or purchased, and that will be put in place in preparation for the participant's relocation to a safe, accessible community living arrangement. There is no institutional length of stay requirement that must be met in order to access this service. When this service is provided to an individual transitioning from a residential institution to a community-based setting, the service is not billed until the date the individual leaves the institution and enters the IRIS Program.

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

Excludes purchase of food, the payment of rent, or the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service, etc.); and excludes the use of waiver funds to purchase service agreements or extended warranties for appliances or any other home furnishings.

Housing startup costs will require prior approval for purchases exceeding an identified budget amount or that exceed the participant's budget.

Payments for utility or telephone connection charges may only be made to providers registered with the Wisconsin Public Service Commission.

When this service is provided to an individual transitioning from an institution to a community-based setting, the service is not billed until the date the individual leaves the institution and enters the waiver.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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	Moving companies, public utilities, real estate agencies, vendors of home furnishings

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Relocation - Housing Start Up and Related Utility Costs

Provider Category:
Agency
Provider Type:
Moving companies, public utilities, real estate agencies, vendors of home furnishings
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Security deposits for lease agreements may only be made to owners or providers of safe, quality housing who comply with all local housing and building codes.
Furnishing and equipment purchased must be in good and safe working condition.
Payments for utility or telephone connection charges may only be made to providers registered with the WI Public Service Commission.
Providers of service to prepare the housing arrangement for occupation and assist the participant with the moving of personal belongings must meet the same standards as applied to Home Care workers.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
Frequency of Verification:
At the time of purchase

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 Care Apartment Complex

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Residential care apartment complex (RCAC) means a place where five or more adults reside and which consists of independent apartments, each having an individual lockable entrance and exit. Each unit must have a kitchen, including a stove or microwave oven, an individual bathroom, and sleeping and living areas. Persons who reside in the RCAC can also receive the following services: supportive services (e.g., laundry, house cleaning), personal assistance (e.g., personal care), nursing services (e.g., wound care, medication management), and assistance in the event of an emergency (e.g., PERS and response).

RCAC services can be provided by an RCAC, either directly or under contract, to meet the needs identified in a tenant's service agreement, to meet unscheduled care needs or to provide emergency services 24 hours a day (DHS 89.13 (2)).

An RCAC does not include a nursing home or a community based residential facility, but may be physically part of a structure that is a nursing home or community based residential facility (DHS 89.13 (1)). To be a Medicaid waiver allowable setting, the facility or a distinct part of the facility must consist entirely of certified RCAC units or a combination of certified RCAC units and conventional independent apartments.

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

• The RCAC may provide not more than 28 hours per week of supportive, personal and nursing services to persons living at the RCAC. RCACs that are registered with but are not certified by DQA are not allowed. A Certified RCAC may not admit a person who has been found incompetent or who has an activated power of attorney for health care or a person who has been found by a physician or psychologist to be incapable of recognizing danger, summoning assistance or making care decisions. Supportive home care, personal emergency response system, and nursing care are services expected to be provided by the RCAC and are therefore not (also) available elsewhere. Care and supervision costs cannot be supplemented by the participant or others.

Waiver funds are not used to pay for the cost of room and board. Supportive Home Care is not available to recipients of residential services. This service may not duplicate any other service that is provided under another waiver service definition.

RCAC Administrative code HFS 89 requires that an RCAC maintain a home-like environment defines as follows: all residential care apartment complexes must provide each tenant with an independent apartment in a setting that is home-like and residential in character; make available personal, supportive and nursing services that are appropriate to the needs, abilities and preferences of individual tenants; and operate in a manner that protects tenants rights, respects tenant privacy, enhances tenant self-direction, self-reliance and supports tenant autonomy in decision-making including the right to accept risk.

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

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

☐ **Provider managed**

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Residential Care Apartment Complex

Provider Category:
Agency
Provider Type:
Residential Care Apartment Complex
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The Wisconsin Department of Health Services Division of Quality Assurance certifies Residential Carte Apartment Complexes. The rules and requirements for certification can be found at: http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/89.pdf.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
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:**

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

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

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

Service Definition *(Scope):*
Specialized medical and therapeutic supplies are those items necessary to maintain the participant's health, manage a medical or physical condition, improve functioning or enhance independence. Items or devices provided may be in excess of the quantity of medical equipment or supplies covered under the Medicaid state plan when coverage of the additional items or devices has been denied. Items or devices provided must be of direct medical or remedial benefit to the participant.

Allowable items, devices, or supplies may include incontinence supplies, wound dressings, intravenous or life support equipment, orthotics, nutritional supplements, vitamins, over the counter medications and skin conditioning lotions/lubricants. Additional allowable items may include books and other therapy aids that are designed to augment a professional therapy or treatment plan. Room air conditioners, air purifiers, humidifiers and water treatment systems may be allowable when recommended or prescribed by the participant's physician.

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

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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	Purchase of services - other merchants
Agency	Authorized DME 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:
Individual

Provider Type:
Purchase of services - other merchants

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

All items and supplies shall meet applicable standards of manufacture, design, installation, safety and treatment efficacy. Authorized providers of these supplies include authorized Durable Medical Equipment providers and other valid Medicaid vendors. Items purchased must meet a reasonable buyer expectation of quality and performance.Items purchased must meet a reasonable buyer expectation of quality and performance. Items considered DME must meet Wisconsin Administrative Code 105.40.
https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/40

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

Frequency of Verification:
At the time of purchase

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:
Authorized DME Vendor

Provider Qualifications

License *(specify):*
HFS 105.40 Wisconsin Administrative Code

Certificate *(specify):*

Other Standard *(specify):*
Authorized providers of these supplies include authorized Durable Medical Equipment (DME) providers and other valid Medicaid vendors.
Items considered DME must meet Wisconsin Administrative Code 105.40
https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/40
Items purchased must meet a reasonable buyer expectation of quality and performance.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

Frequency of Verification:
At the time of purchase

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 Transportation 2

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
Same as Specialized Transportation
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Same as other Specialized Transportation

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Transportation 2

Provider Category:
Individual
Provider Type:
Same as other Specialized Transportation
Provider Qualifications
License *(specify):*
Same as Specialized Transportation
Certificate *(specify):*
Same as Specialized Transportation
Other Standard *(specify):*
Same as Specialized Transportation
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of indiidual providers takes place through a centralized sysem using a State-approved process completed by the participant's chosen F/EA. Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
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 Transportation

HCBS Taxonomy:

Category 1:	Sub-Category 1:
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Service Definition *(Scope):*

Specialized transportation services are intended to maintain or improve the participant's mobility in the community, increase independence and community participation and prevent institutionalization. Community should be broadly defined and should not be limited to the boundaries of any particular municipality.

Specialized transportation provides transportation for participants who do not have access to unpaid transportation and are unable to safely transport themselves. IRIS Specialized transportation is for non-medical, non-emergency, non-Medicaid transportation.

Natural or community supports should first be accessed to provide transportation services. Specialized transportation is an allowable IRIS Program service when unpaid transportation is not available to participants to allow the participant access to the community to obtain services, to use necessary community resources, and to participate in community life.

Specialized transportation services may include the pre-purchase or provision of such items as bus tickets, train passes, taxi vouchers or other fare medium or may include a direct payment to providers covering the cost of conveyance. Services may include payment of a participant account between the participant and the transportation provider who provides documentation of the trips provided for the specific time period.

Specialized transportation may also be approved as mileage according to the Federal IRS rules related to mileage reimbursement and DHS established limits. Mileage is calculated based on the starting and ending points and is approved by the number of miles needed. Mileage when transporting more than one IRIS participant must be split between the plans such that one mile is only billed once. The IRIS mileage rate includes the cost of all gasoline, oil, insurance and all other car maintenance costs. The mileage rate does not include other costs such as wages paid to the driver or an attendant.

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

Specialized transportation cannot be used to pay for transportation that is the obligation of the school district.
Specialized transportation is not the participant driving himself/herself to a location.
The mileage reimbursement rate may not be supplemented to cover vehicle operating, maintenance or repair costs.
Vehicle adaptations and modifications are excluded. (They would be adaptive aids.)
Specialized transportation excludes transportation mileage and other related expenses when the destination is a vacation. Renting a vehicle while on vacation is not an allowable expense.

Specialized transportation excludes the mileage incurred when a caregiver runs errands and the participant is not in the vehicle.
Excludes transportation services to and from Medicaid Medical providers as this is funded by the participant's Medicaid

ForwardHealth Card through the State's transportation broker.

Costs for the participant or their family to maintain a vehicle are excluded.

IRIS Specialized transportation is for non-medical, non-emergency, non-MA transportation.

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

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

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	Mass transit provider, taxi or common carrier, specialized transportation provider
Individual	Individual provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Transportation

Provider Category:
Agency
Provider Type:
Mass transit provider, taxi or common carrier, specialized transportation provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*
Mass transit - Chapter 85.20 Wisconsin Statutes
Taxi or common carrier - Chapter 194 Wisconsin Statutes
Specialized transportation provider - Chapter 85.21 Wisconsin Statutes, HFS 61.45 Wisconsin Administrative Code
Other Standard *(specify):*
Providers must provide evidence that the vehicle style and condition can provide transportation safely.

Commercial carriers are those that provide public transportation (excluding city buses) and private transportation with an emphasis on only providing transportation as a service. Agency providers are those that provide transportation and other services, such as day services, prevocational services, residential services, etc.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Transportation

Provider Category:
Individual
Provider Type:
Individual provider
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Other Standard *(specify):*
Authorized providers of this service include individuals with a valid driver's license and proof of current automobile insurance. Providers must provide evidence that the vehicle style and condition can provide transportation safely.
1. Individual or volunteer providers of transportation services must provide documentation of current liability insurance coverage, possess a valid driver's license and provide written assurance of the following:
a. The vehicle used is mechanically sound, has properly functioning lighting, safety, ventilation and braking systems, and
b. The vehicle has tires that are properly inflated, without excessive wear.

2. All transportation providers that meet the definition of caregiver are subject to the required criminal, caregiver and licensing background checks.

3. Providers of specialized transportation services to SDS participants must communicate with other providers within confidentiality laws about any incidents or situations regarded as Critical Incidents.

4. Providers of specialized transportation services to SDS participants must promptly communicate with the independent consultant and/or the county adult protective services unit regarding any incidents or situations or conditions that have endangered or, if not addressed, may endanger the health or safety of the participant .
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.
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:
Support Broker

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A support broker is an individual who assists a participant in planning, securing, and directing self-directed supports. The services of a support broker are paid for from the participant's self-directed supports budget authority. Support brokers are subject to criminal background checks and must be independent of any other waiver service provider. A support broker shall be knowledgeable of the local service delivery system and local community-integrated services and resources available to the participant. A support broker shall also be knowledgeable of the typical kinds of needs of persons in the participant's target group. The participant and the ICAs are responsible to assure that a support broker selected by the participant has the appropriate knowledge.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes activities included under IRIS Consultant Services.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

Provider Category:
Individual
Provider Type:
Individual Support Broker
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Knowledge of the unique needs/preferences of the participant and the service system.

An individual may be qualified to be a support broker only when they have adequate knowledge of the unique needs / preferences of the participant and their specific target group and that they have knowledge of the local service delivery system and local resources available to the participant. Criminal and Caregiver background checks are required. The participant can decide the amount and type of training they require of the provider.

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Support Broker

Provider Category:
Agency
Provider Type:
Support Broker Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Knowledge of the unique needs/preferences of the participant and the service system.

An individual may be qualified to be a support broker only when they have adequate knowledge of the unique needs / preferences of the participant and their specific target group and that they have knowledge of the local service delivery system and local resources available to the participant. Criminal and Caregiver background checks are required. The participant can decide the amount and type of training they require of the provider.

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers will be validated and maintained by the Third Party Administrator.
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:**
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

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

Service Definition *(Scope):*
Supportive Home Care (SHC) is the provision of a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and permit safe access to the community.

Supportive home care services include:
1. Personal Services
a. Assistance with activities of daily living such as eating, bathing, grooming, personal hygiene, dressing, exercising, transferring and ambulating;
b. Assistance in the use of adaptive equipment, mobility and communication aids;
d. Assistance with medications that are ordinarily self-administered;
e. Assistance with making and attending appointments;
f. Attendant care;
g. Supervision and monitoring of participants in their homes, during transportation (if not done by the transportation provider) and in community settings;
h. Reporting of observed changes in the participant's condition and needs; and
i. Extension of therapy services. "Extension of therapy services" means activities by the SHC worker that assist the participant with a Physical Therapy (PT) / Occupational Therapy (OT) or other therapy/treatment plan. Examples of these activities include assistance with exercise routines, range of motion exercises, standing by during therapies for safety reasons, having the SHC worker read the therapist's directions, helping the participant remember and follow the steps of the exercise plan or hands on assistance with equipment/devices used in the therapy routine. It does not include the actual service the therapist provides. Also included in this category of services are medication reminder services and electronic support equipment. These can be provided via a phone call, text message, or electronic notification in the home.

2. Household Services
a. Performance of household tasks and home maintenance activities, such as meal preparation, shopping, laundry, house cleaning, simple home repairs, snow shoveling, lawn mowing and running errands, paying bills (at the direction of the participant);
b. Assistance with packing/unpacking and household cleaning/organizing when a participant moves.

Different levels of Supportive Home Care services are available:
1. Routine
a. Routine care services are both personal services and household services listed above. They are generally hands-on services and are provided on a scheduled basis. Participants may employ providers of routine services or may hire them through an agency.
2. Chore
a. Chore care services are specific tasks that are performed and completed. These typically include lawn care, snow removal, laundry services, and house cleaning. Chore services may be paid with a flat rate for the service or on an hourly basis. Participants may employ providers of chore services or may hire them through an agency.
3. Supervision
a. Supervision care services are services provided as an oversight to the participant. The participant can complete tasks themselves but need oversight and guidance to complete the task properly and safely.
4. Companionship
a. Companionship care services are services provided as in home support to participants who do not need hands-on care but who would like someone in attendance should support be needed. Generally, the rate paid for companionship care is lower than the other Supportive Home Care services.
5. Community Integration Events (CIE): CIE – worker expense reimbursement provides reimbursement for participant-hired workers that attend CIEs with a participant, because the participant has long-term care needs that necessitate the worker's presence at the event. This reimbursement is limited to the workers expense only, the participant portion of the expense is the responsibility of the participant. Reimbursement is issued directly to the IRIS participant-hired workers. Allowable expense reimbursement for CIE is defined as the following:

Parking
If it is necessary for the participant-hired worker to drive a separate vehicle to the event and the event requires a parking fee, the support worker is eligible for parking reimbursement. Attending an event with the participant in the same vehicle regardless of the owner of the vehicle does not constitute worker expense reimbursement.

Meals
If the CIE necessitates a meal be purchased at the event and if the event rules restrict outside food being brought into the event, the support worker is eligible for meal reimbursement. A participant eating a meal at a restaurant as a CIE, in and of itself, does not meet the qualifications of an event necessitating a meal be purchased by the support worker and this is not an

allowable staff reimbursement expense. Similarly, CIEs such as planned meals including but not limited to celebrations or other family traditions (e.g. birthday meals, anniversary meals, holiday meals, Sunday brunch) also do not meet the criteria of an allowable staff meal reimbursement expense.

Admission
If the CIE does not allow participant hired worker support staff free admission to the event, the support worker is eligible for admission reimbursement. This reimbursement is strictly limited to the cost of admission to the CIE and any other costs associated with attending the event are not eligible for reimbursement.

The Department has defined the following as allowable staff reimbursement costs:
• the CIE addresses a participant's assessed long-term support need;
• the CIE enhances the participant's opportunities to achieve long-term support outcomes related to living arrangement, relationship, community inclusion, work and functional or medical status with respect to a long-term support need; and,
• Participants have CIE – worker expense reimbursement approved on their ISSP.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes services available through the Medicaid State Plan. Excludes training provided to a participant intended to improve the participant's ability to independently perform routine daily living tasks, which may be provided as daily living skills training. This service may not duplicate any service that is provided under another waiver service definition. Shared household services are excluded such as grocery shopping, meal preparation, laundry, yard work, and cleaning that are not for the exclusive benefit of the participant are excluded.
This service excludes "Live-In Caregiver" services as this is a separate service type. The service also excludes Representative Payee services. Agencies are excluded from worker expense reimbursement. Payroll bonuses are not allowed.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual worker
Agency	Supportive Home Care agency, Home Health Care agency

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):*
Supportive Home Care agencies and Home Health Care agencies may provide services compliant with Wisconsin Administrative code 105.17.

Participant-hired workers may provide services only after they have been sufficiently trained and provided an orientation by their employer. The must also meet all other employment eligibility requirements including successfully passing a caregiver and criminal background check at employment and every four years thereafter.

Electronic support equipment should be installed and repairs made only by individuals adequately trained in the installation or repair of the equipment or according to manufacturer's instructions.

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen F/EA.

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:

Agency

Provider Type:

Supportive Home Care agency, Home Health Care agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

DHS 105.17 Wisconsin Administrative Code

Other Standard *(specify):*

Qualifications and requirements for electronic support equipment vendors include that they are a Medicaid certified provider. The devices must meet all applicable laws, regulations and standards for the manufacture and design for safety and utility. If the device requires installation or repair, the work should be completed by an adequately trained / professional mechanic. Electronic support equipment should be installed and repairs made only by individuals adequately trained in the installation or repair of the equipment or according to manufacturer's instructions.

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

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:

Vocational Futures Planning

HCBS Taxonomy:

Category 1:	Sub-Category 1:

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

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

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

Service Definition *(Scope):*
Vocational futures planning and support (VFPS) is a person-centered, team-based comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in employment or self-employment. The agency providing VFPS services will ensure that the following service strategies are available as needed to the participant:

Development of an employment plan based on:
- an individualized determination of strengths, needs and interests of the individual with a disability,
- the barriers to work, including an assistive technology pre-screen or in-depth assessment,
- identification of the assets a member brings to employment;
- benefits analysis and support;
- resource team coordination;
- career exploration and employment goal validation;
- job seeking support; and,
- job follow-up and long-term support.

VFPS must be provided by qualified professionals that include, for example, an employment specialist, a benefits specialist and an assistive technology consultant. When this service is provided the 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 on-going support and provided to the participant. The IRIS Consultant will ensure that these reports are included as part of the participant's record.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
VFPS furnished under the waiver excludes services available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17). VFPS excludes services that could be provided as prevocational or as supported employment. Such services may be used to supplement, but may not duplicate any VFPS services provided under the waiver.

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

- [x] **Participant-directed as specified in Appendix E**
- [ ] **Provider managed**

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	Aging and Disability Resource Center, Employment agency, Supportive Employment agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vocational Futures Planning

Provider Category:
Agency
Provider Type:
Aging and Disability Resource Center, Employment agency, Supportive Employment agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

VFPS must be provided by qualified professionals that include, for example, an employment specialist, a benefits specialist, and an assistive technology consultant.

Providers of vocational services must meet the applicable standards and process requirements set by the Wisconsin Department of Workforce Development, Division of Vocational Rehabilitation (WI DVR). Information on the provider requirements for WI DVR can be found at: https://dwd.wisconsin.gov/dvr/service_providers/agreement_for_services.pdf.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.

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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- **As an administrative activity.** *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:

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. The requirement for the completion of caregiver and criminal background checks applies to all paid providers listed on the individual service plan who have regular, direct contact with waiver participants. "Regular" contact includes scheduled, planned, expected or otherwise periodic contact. "Direct" means face-to-face physical proximity to a participant that may afford the opportunity to commit abuse or neglect or to misappropriate property.

b. The caregiver background checks required include all of the following: 1) a criminal history search of a predetermined set of criteria from the records of the Wisconsin Department of Justice (when the subject recently resided in a different state, the search must also include that state); 2) a search of the Caregiver Registry maintained by the Wisconsin Department of Health Services; and, 3) a search of the status of credentials and licensing from the records of the applicable licensing/regulation entity, if applicable. Wisconsin statutes and administrative codes identify which criminal or caregiver offenses always preclude employment as a caregiver and which allow the potential caregiver to still be considered for employment.

c. The IRIS Consultant Agencies are required by contract to ensure that all persons working as paid caregivers have had required background checks completed. The IRIS Consultant Agencies will conduct background checks for participant-hired workers and will verify that agency providers comply with background check requirements. The SMA conducts reviews of the contract agency reports to determine whether required background checks have been completed.

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; and, (c) the process for ensuring that mandatory screenings have been conducted. 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 Wisconsin Administrative Codes Chapter DHS 12 and 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 DHS 12 document lists Wisconsin crimes and other offenses that the Wisconsin State Legislature, under the Caregiver Law, ss. 48.685 and 50.065, Stats., has determined either require rehabilitation review approval before a person may receive regulatory approval, may work as a caregiver, may reside as a non-client resident at or contract with an entity, or that act to permanently bar a person from receiving regulatory approval to be a foster parent. Anyone conviction on the permanently bar list the worker will not be paid with IRIS or Medicaid funds. The convictions on this list include:
□ First Degree Reckless Homicide, Felony Murder, First or Second Degree Intentional Homicide or Assisting Suicide;
□ First, Second or Third Degree Sexual Assault;
□ Sexual Exploitation by a Therapist or Failure to Report by a Therapist;
□ Physical Abuse of a Child □ Intentional □ Cause Great Bodily Harm;
□ Abuse or Neglect of Vulnerable Adults, Patients or Residents (misdemeanor or felony);
□ Abuse of a Penal Facility Resident;
□ Finding by a Governmental Agency of Neglect or Abuse of a Client or of a Child;
□ Misappropriation of a Client's Property;
□ Theft, Robbery, Identity Theft or Financial Card Transaction Crimes;
□ Certain Drug Crimes;
□ Battery (felony); or
□ Medicaid Fraud

DHS Chapter 13 "Reporting and Investigation of Caregiver Misconduct" is promulgated
under the authority of ss. 146.40 (4g) and (4r) and 227.11 (2), Stats., to protect clients served in specified department-regulated programs by establishing a process for reporting allegations of abuse or neglect of a client or misappropriation of client's property to the department, establishing a process for the investigation of those allegations and establishing the due process rights of persons who are subjects of the investigations.

The ICAs and F/EAs, as well as all other entities that are licensed or certified by or registered with the department to provide direct care or treatment services to clients, are required to report to the SMA any allegation of abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity.

b. Positions for which abuse registry screenings must be conducted include all waiver service providers, paid or unpaid, listed on the individual 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 department to provide direct care or treatment services to clients,

c. The Fiscal/Employer Agents are required by contract to ensure that all persons working as caregivers have had required

registry checks completed. The Fiscal/Employer Agents will conduct registry checks for participant-hired workers and will verify that agency providers comply with registry check requirements.

The SMA conducts reviews of the contract agency reports to determine whether required registry checks have been completed and a related performance measure is in place to evaluate compliance with this activity.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

i. Types of Facilities Subject to §1616(e). Complete the following table for each type of facility subject to §1616(e) of the Act:

Facility Type	
1 to 4 Bed Adult Family Homes	
Community Based Residential Facility (CBRF)	
Residential Care Apartment Complex (RCAC)	

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

RCACs are certified under Chapter 89 of the Wisconsin Administrative Code and are by definition, "a place where 5 or more adults reside that consists of independent apartments, each of which has an individual lockable entrance and exit, a kitchen, including a stove, and individual bathroom, sleeping and living areas, and that provides, to a person who resides in the place, not more than 28 hours per week of services that are supportive, personal and nursing services." [HFS 89.13 (1). By definition an RCAC is like a home and is community based.

RCACs are apartment buildings with people other than waiver participants residing in this setting. As required by Wisconsin administrative rule these settings are integrated in the community.

A limited number of IRIS participants are residing in such facilities. Individuals use these facilities when they first come into the program because they were already living in these facilities before they become eligible for Medicaid. Individuals will move to these types of facilities because of the assurance of the availability of a 24 hour staff available if necessary. Others will choose this living arrangement because family members feel the individual will be safer with some level of supervision.

Most people in the IRIS waiver will choose to live in their own home or apartment so they can choose and direct all of their services. Most will only use regulated residential care facilities on a temporary basis as part of a back-up plan, for recuperative care or when they initially come into the program.

The IRIS participant, with support as needed from the IRIS Consultant, will assure that the setting remains consistent with self-directed supports.

Further clarification of the requirements that these settings be home-like are as follows:

RCAC Administrative code HFS 89 requires this. DQA will monitor and responds to complaints. "This chapter is intended to ensure that all residential care apartment complexes provide each tenant with an independent apartment in a setting that is home-like and residential in character; make available personal, supportive and nursing services that are appropriate to the needs, abilities and preferences of individual tenants; and operate in a manner that protects tenants' rights, respects tenant privacy, enhances tenant self-direction, self-reliance and supports tenant autonomy in decision-making including the right to accept risk.

The three month stay is not a limit if the person is able to manage within their approved individual budget for the use of this service. This is because people with high care need levels will have an adequate budget to reside in this setting on a long-term basis. DHS will establish a method to distinguish short-term use of this setting from long-term usage.

The IRIS participant is able to assure that the setting remains consistent with self-directed supports through the following mechanisms: The participant is given information on how to contact his or her IRIS Consultant, the state's licensing agency (DQA) and or file a consumer complaint. The IRIS Consultant also meets, in-person, with the participant on a regular basis to assist with the contacts necessary to bring about improvements. The SMA monitors this through record reviews and through evaluation of complaints/requests by participants and the results of interventions that occurred.

Appendix C: Participant Services

C-2: Facility Specifications

Facility Type:

1 to 4 Bed Adult Family Homes

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Respite	☑
3-4 Bed Adult Family Home	☐
Supported Employment	☐
1-2 Bed Adult Family Home	☐
Nursing Services	☑
Vocational Futures Planning	☐
Communication Aids Vendors/Interpreter Services	☑
Customized Goods and Services	☑
Home Delivered Meals	☐
Housing Counseling	☐
Home Modification	☐
IRIS Consultant Services	☐
Personal Emergency Response System	☑
Fiscal / Employer Agent Services	☐
Adult Day Care	☐
Specialized Medical Equipment and Supplies	☑
Specialized Transportation 2	☐
Relocation - Housing Start Up and Related Utility Costs	☐
Support Broker	☑
Supportive Home Care	☐
Consumer Education and Training	☑
Specialized Transportation	☐
Counseling and Therapeutic Services	☑
Adaptive Aids	☑
Daily Living Skills Training	☑
Day Services	☐
CBRF	☐
Prevocational Services	☐
Live-in Caregiver (42 CFR §441.303(f)(8))	☐

Waiver Service	Provided in Facility
Residential Care Apartment Complex	☐

Facility Capacity Limit:

4

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:

Community Based Residential Facility (CBRF)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Respite	☑
3-4 Bed Adult Family Home	☐
Supported Employment	☐
1-2 Bed Adult Family Home	☐
Nursing Services	☑
Vocational Futures Planning	☐
Communication Aids Vendors/Interpreter Services	☑
Customized Goods and Services	☑
Home Delivered Meals	☐
Housing Counseling	☐
Home Modification	☐

Waiver Service	Provided in Facility
IRIS Consultant Services	☐
Personal Emergency Response System	☑
Fiscal / Employer Agent Services	☐
Adult Day Care	☐
Specialized Medical Equipment and Supplies	☑
Specialized Transportation 2	☐
Relocation - Housing Start Up and Related Utility Costs	☐
Support Broker	☑
Supportive Home Care	☐
Consumer Education and Training	☑
Specialized Transportation	☐
Counseling and Therapeutic Services	☐
Adaptive Aids	☑
Daily Living Skills Training	☑
Day Services	☐
CBRF	☐
Prevocational Services	☐
Live-in Caregiver (42 CFR §441.303(f)(8))	☐
Residential Care Apartment Complex	☐

Facility Capacity Limit:

none

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:

Residential Care Apartment Complex (RCAC)

Waiver Service(s) Provided in Facility:

Waiver Service	Provided in Facility
Respite	☑
3-4 Bed Adult Family Home	☐
Supported Employment	☐
1-2 Bed Adult Family Home	☐
Nursing Services	☑
Vocational Futures Planning	☐
Communication Aids Vendors/Interpreter Services	☑
Customized Goods and Services	☑
Home Delivered Meals	☐
Housing Counseling	☑
Home Modification	☑
IRIS Consultant Services	☐
Personal Emergency Response System	☑
Fiscal / Employer Agent Services	☐
Adult Day Care	☐
Specialized Medical Equipment and Supplies	☑
Specialized Transportation 2	☐
Relocation - Housing Start Up and Related Utility Costs	☐
Support Broker	☑
Supportive Home Care	☐
Consumer Education and Training	☑
Specialized Transportation	☑
Counseling and Therapeutic Services	☑
Adaptive Aids	☐
Daily Living Skills Training	☑
Day Services	☐
CBRF	☐
Prevocational Services	☑
Live-in Caregiver (42 CFR §441.303(f)(8))	☐
Residential Care Apartment Complex	☐

Facility Capacity Limit:

None

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: 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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *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 legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure 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.*

Legally responsible persons who may be paid include relatives, spouse and guardians. These individuals may provide specific services as noted by the checkbox as noted in service specifications within Appendix C provided they meet specified qualifications. Specifically, these services are: Daily Living Skills Training, Respite Care, Supported Employment, Nursing Services, 1-2 bed Adult Family Home, Customized Goods and Services, Specialized Transportation, Specialized Transportation 2, and Supportive Home Care.

Services that are considered to be similar to personal care are defined as those services that are scheduled and planned, and occur with face-to-face physical proximity to a participant for the purpose of completing or assisting with an activity of daily living or an instrumental activity of daily living. In situations where the participant resides with their spouse or relatives, they would only be paid for services and supports to the participant for needs that exceed normal household or family support functions as part of a shared household such as meal prep and clean up, general household upkeep, or lawn mowing. However if the participant has needs that exceed these norms such as having daily incontinence requiring daily laundry, or assistance or supervision with eating these supports/services could be paid for when provided by a spouse, relative, or legal representative (guardian or power of attorney). Additionally, IRIS has a conflict of interest policy that addresses situations where household

members are being paid more than 40 hours a week to monitor and ensure that the provision of services is in the best interest of participants.

Controls employed include:
 Payment will be less than or equal to the expense when provided by a typical provider agency.
 Provider will still meet all other background and employment verifications/checks, and that each situation will engage acceptable employment practices (job description, time sheets, and random, unannounced visits).
 When the service provided is a service that may only be provided by a licensed/credentialed individual that such provider actually possess such required credential.
 Agree to a risk assessment by the ICA and an evaluation of conflict of interest. If risks or conflicts of interest are identified, then these must be mitigated prior to the delivery of the service.

The participant's chosen ICA is responsible to monitor that the services purchased from the parent, guardian or spouse are actually delivered. This is accomplished through requiring signed timesheets and other strategies, including unannounced visits. In addition, the SMA will incorporate a question within its record review process to ensure that the ICAs carry out this monitoring when it is applicable.

Additionally, the ICAs institute an additional review and oversight of all required practices anytime the number of care giving hours exceeds 40 hours per week. This includes the following:
1) The IRIS Consultant will discuss whether the proposed caregiving structure adequately addresses care needs and meets health and safety assurances.
2) The IRIS Consultant assures that payment is only made for services which do not overlap.
3) The IRIS Consultant assures that any conflict of interest is identified and addressed in accordance with IRIS Policy.
4) The IRIS Consultant assures that the participant's unique emergency back-up plan addresses potential changes in caregiving provisions.
5) The IRIS Consultant assures that participants are informed of the risk assessment and potential for abuse and neglect based upon increased hours of service provision and based on their individual plan.
6) The IRIS Consultant reviews with the participant that he or she is afforded choice between/among providers.
7) The IRIS Consultant reviews that there will be increased monitoring of service delivery including unannounced visits.
8) The IRIS Consultant will assure that provision of services do not hinder the person's access to the community and community participation.

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 specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls 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.

  Individuals who may be paid include relatives, spouses and guardians. Relatives include blood or adoptive relatives and those individuals related by marriage such as step-parents, step-siblings, step-grandparents, step-aunts/uncles/cousins etc. These individuals may provide specific services as noted by the checkbox as noted in service specifications within Appendix C provided they meet specified qualifications. Specifically, these services are: Daily Living Skills Training, Respite Care, Supported Employment, Nursing Services, 1-2 bed Adult Family Home, Customized Goods and Services, Specialized Transportation, Specialized Transportation 2, and Supportive Home Care.

  Services that are considered to be similar to personal care are defined as those services that are scheduled and planned, and occur with face-to-face physical proximity to a participant for the purpose of completing or assisting with an activity of daily living or an instrumental activity of daily living. In situations where the participant resides with their spouse or relatives, they would only be paid for services and supports to the participant for needs that exceed normal household or family support functions as part of a shared household such as meal prep and clean up, general household upkeep, or lawn mowing. However if the participant has needs that exceed these norms such as having daily incontinence requiring daily laundry, or assistance or supervision with eating these supports/services could be paid for when provided by a spouse, relative, or legal representative

(guardian or power of attorney). Additionally, IRIS has a conflict of interest policy that addresses situations where household members are being paid more than 40 hours a week to monitor and ensure that the provision of services is in the best interest of participants.

Controls employed include:
 Payment will be less than or equal to the expense when provided by a typical provider agency.
 Provider will still meet all other background and employment verifications/checks, and that each situation will engage acceptable employment practices (job description, time sheets, and random, unannounced visits).
 When the service provided is a service that may only be provided by a licensed/credentialed individual that such provider actually possess such required credential.
 Agree to a risk assessment by the ICA and an evaluation of conflict of interest. If risks or conflicts of interest are identified, then these must be mitigated prior to the delivery of the service.

The participant's chosen ICA is responsible to monitor that the services purchased from the parent, guardian or spouse are actually delivered. This is accomplished through requiring signed timesheets and other strategies, including unannounced visits. In addition, the SMA will incorporate a question within its record review process to ensure that the ICAs carry out this monitoring when it is applicable.

Additionally, the ICAs institute an additional review and oversight of all required practices anytime the number of care giving hours exceeds 40 hours per week. This includes the following:
1) The IRIS Consultant will discuss whether the proposed caregiving structure adequately addresses care needs and meets health and safety assurances.
2) The IRIS Consultant assures that payment is only made for services which do not overlap.
3) The IRIS Consultant assures that any conflict of interest is identified and addressed in accordance with IRIS Policy.
4) The IRIS Consultant assures that the participant's unique emergency back-up plan addresses potential changes in caregiving provisions.
5) The IRIS Consultant assures that participants are informed of the risk assessment and potential for abuse and neglect based upon increased hours of service provision and based on their individual plan.
6) The IRIS Consultant reviews with the participant that he or she is afforded choice between/among providers.
7) The IRIS Consultant reviews that there will be increased monitoring of service delivery including unannounced visits.
8) The IRIS Consultant will assure that provision of services do not hinder the person's access to the community and community participation

○ **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:

In their Individual Support and Service Plan, participants will identify needed services and the appropriate providers from which to purchase those services. IRIS Waiver participants may choose to hire any and all willing and qualified providers. Lists of providers are maintained by the Aging and Disability Resource Center, the Fiscal/Employer Agents, and IRIS Consultant Agencies and made available to participants and consultants.

All willing and qualified providers are eligible to serve IRIS participants, but must be enrolled as Medicaid-participating providers. Provider eligibility requirements for each waiver service are identified in Appendix C-3 of the IRIS Waiver application. The IRIS Consultant Agencies' and Fiscal/Employer Agents' contracts each specify that those organizations be familiar with provider enrollment procedures and timelines, and that they verify waiver provider qualifications. The IRIS Consultant Agencies will certify that providers meet IRIS Waiver provider standards for the specific IRIS Waiver service using the Wisconsin Provider Index (WPI) which is expected to be available in mid-2014, and execute Medicaid provider agreements on behalf of the State Medicaid Agency.

Most providers of service to IRIS participants are identified by the participant or his or her legal guardian. The IRIS Consultant is also able to provide support in locating providers, as is a Support Broker.

The participant's chosen IRIS Consultant Agency supports each individual in working with selected providers to complete provider enrollment and qualification verification, including all required background checks. This process is typically completed within two weeks of identification of a new provider. The ICA maintains information on providers that are already registered and in this instance the provider is immediately available to the participant.

The SMA is working to produce a consistent, accessible, transparent, comprehensive and uncomplicated standard operating procedure for use by all groups involved with the IRIS program. The IRIS Section is working towards compiling current IRIS policy as it exists in different formats and converting the various polices and documentation into a single standard program wide manual. Through this initiative IRIS will be able to identify any areas within the program that have evolved and policy needs to be

updated as well as areas that may be unaddressed or need development based on the changing landscape of self-directed programs. A critical area of this initiative is the Work Instructions which will clearly define the roles and responsibilities of all groups involved in the IRIS program including, the participant, contracted agencies and the department. The Work Instructions will also include systematic instructions for all aspects of the IRIS program including for example, areas such as enrollment, plan amendments, flexible spending and home or vehicle modifications. This manual is critical to the future of IRIS as we prepare to offer more choice of contracted agencies and introduce the centralized IT system. This on-line IRIS Policy Manual is expected to be fully implemented by July 1, 2014.

Lists of providers are made available upon request of the participant. However, as noted previously, most participants have selected the self-direct supports waiver so that they can individually recruit and select their providers.

DHS has added a performance measure to demonstrate that the SMA monitors the ICAs' execution of Medicaid provider agreements.

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:
Number and percent of new providers that meet required licensure or certification standards prior to furnishing waiver services, as verified by the TPA. Numerator/Denominator: Number of new licensed/certified providers that hold the required licensure/certificate for the service(s) being provided over the total number of new providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
TPA reports

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**	☐ **Annually**	☐ **Stratified**

Specify: TPA		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: TPA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of providers who continue to meet required licensure or certification standards as confirmed by the TPA every four years. Numerator/Denominator: Number of providers with licensure/certification confirmed over the number of providers requiring their licensure/certification to be confirmed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
TPA reports

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: TPA	☐ **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: TPA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of licensed/certified providers employed directly by the participant with current completed criminal background and caregiver registry checks.
Numerator/Denominator: The number of licensed/certified providers employed directly by the participant for whom each F/EA has completed current criminal background and caregiver registry checks over the number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
F/EAs reports

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: F/EAs	☐ **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: F/EAs	☐ **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:
Number and percent of non-licensed/non-certified particpant-hired workers with current criminal background and caregiver registry checks. Numerator/Denominator: The number of non-licensed/non-certified. Participant-Hired Workers for whom the F/EA has completed criminal background and caregiver registry checks over the number of providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
F/EA reports

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: F/EA	☐ **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: F/EA	☐ **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.

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 Fiscal/Employer Agents perform criminal background checks, caregiver registry checks, ensures all providers (individual or agency) sign Medicaid provider agreements on behalf of the SMA, and checks the Statewide Provider Registry for any individuals or agencies being hired by the participant. Verification of any licensure/certification requirements or required standards of individuals or agencies being hired by the participant will take place through a centralized system using a common process. The ICAs collect employment related paperwork for employees directly hired by IRIS participants such as I-9s and ensure that the paperwork is completed correctly. The Third Party Claims Administrator processes providers' invoices/ claims. The Fiscal/Employer Agents process timesheets/payroll for participant employees and ensure that all proper taxes are withheld. Each contracted agency is responsible for maintaining all of these records for participants and entering the appropriate information into the centralized IT system and Encounter to populate

reports for the participant through the centralized IT system informing them of their service utilization and budget. The centralized IT system will house all information and data from contracted agencies - this enables the Department to conduct administrative oversight of these activities and participants to have access to their budget information. The Department will work with all contract agencies to refine the data collection and reporting process related to performance measures above.

The Fiscal/Employer Agents document in the centralized IT system whether or not background checks are completed for each participant employee. This process is monitored through reports from the Fiscal/Employer Agents which correspond to performance measures in the QIS under Worksheet C.

The Fiscal/Employer Agents will provide a report to the SMA on results of its internal QA process following each payroll on a quarterly basis. Through these discovery methods, the SMA will be able to determine if there are any issues or concerns with the F/EAs in implementing this process effectively or in documentation requirements. The SMA will address any issues identified through this discovery with the F/EAs and require remediation or corrective action as needed.

Data Sources and Performance Measures
The TPA reports are generated from the TPAs claims adjudication system. The F/EA reports are generated from the F/EAs payroll system. The TPA and the F/EA system is populated from prior authorization information entered into the States centralized IT system. The validation of this data is obtained through workflows, business rules, alerts and other technology built into the system to ensure the accuracy of the prior authorizations produced.

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. In addition, provide information on the methods used by the State to document these items.
Any quality issues or not meeting these measures at 100%, the contracted agencies are responsible for remediation of individual issues. The IRIS Quality Management Team and/or IRIS Section Chief will ensure that the contracted agencies perform identified corrections and provide follow up as needed.

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: F/EAs	☐ **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.

All IRIS participants will be approved for additional funding in their individual budget for temporary regulated residential care in the following circumstances:

 Residential care is needed as part of the back-up plan when primary services/supports are not available. The residential care add-on would be authorized for a limited time until approved care plan services are resumed/replaced.
 Residential care is needed temporarily for recuperative purposes. The residential care add-on will be authorized for a limited time until the person can return to his/her own home/apartment.
 The person is living in residential care when coming onto the IRIS waiver, but signs an agreement that s/he wants to move to his or her own apartment/home. A residential add-on will be approved for up to three months while the person develops necessary services and transitions to the community.

☐ **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.

☑ **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.

Each participant in the IRIS waiver will have an individual budget determined based on participant-specific-data from the automated Long Term Care Functional Screen (LTCFS) applying a methodology similar to that used to establish rates for Family Care. This calculation will be based on the needs of the individual and the historical experience of the Family Care program in serving like individuals. Family Care waiver services that will be covered as administrative activities under the SDS waiver will be excluded when calculating the individual budget. Medicaid card services that are covered under the 1915 (b) waiver in that program are not be included in the calculation.

The amount of the individual budget will be made available to the applicant when he or she is making the decision to participate in IRIS, enroll in Family Care or use only Medicaid fee-for-service State Plan services. The Aging and Disability Resource Center will be responsible for providing this information to the applicant.

All waiver services listed in Appendix C will be included in the individual budget with the following exceptions:
 It would be difficult to account for one-time high cost needs in the individual budget since these expenses are episodic and not easily predicted for a given individual. Rather than pro-rating the cost experience from Family Care across all participants, funds will be set aside from the calculation to create an availability of funds from which IRIS waiver participants can draw to pay for items that would be beyond the capacity of the individual budget.

 This same approach will also be used for residential services. Less than 5% of participants IRIS use residential services. Pro-rating those services based on Family Care's data across all IRIS participants would result in too high a budget for some and too low a budget for others. Participants who need residential care will not be able to request additional funding for that purpose.

If a person needs additional services as the result of a change in condition, the participant will report the change in condition to the IRIS Consultant and the Department will determine the impact on the individual budget after completing a change in condition Long Term Care Function Screen.
If a participant disputes the amount of the individual budget the first course of action is to request a review of his or her

LTCFS that is used as the basis of the budget calculation. A review of the screen may still result in a budget that the participant believes is too low. The participant will be able to request a budget amendment from the DHS. If denied, then the participant may appeal the budget amount using the Medicaid fair hearing process.

☐ **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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.
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 ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Individual Support and 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 *(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.** *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.

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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.

Participants must have ready access to on-going education, training, information, tools, and support related to all aspects of SDS, which includes but is not limited to information about: basic core values and philosophy of self-direction; person-centered guiding principles and processes; rights, risks, and responsibilities; range of services and supports; finding, training and managing service providers; complaint process and incident reporting; individual budgeting and paying for services and supports; and working with the IRIS Consultant and their chosen Fiscal/Employer Agent.

Prior to enrollment, a multifaceted approach is utilized to communicate SDS information, such as easy to understand written materials, website information, and alternative formats as available. Materials and activities are developed in collaboration with and through contribution from participants, advocates and families, so that information is as clear as possible.

Upon enrollment, the participant is referred to the IRIS Consultant Agency they choose as part of enrollment counseling at the ADRC. In working with the IRIS Consultant, the participant identifies who is to be involved in the development of the plan. The IRIS Consultant helps the participant in exploring options and making informed choices.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. 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; and, (g) how and when the plan is updated, including when the participant's needs change. 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 individual support and service plan (ISSP) contains: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration, and the type of provider who 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 and Long Term Care outcomes of the participant.

The person-centered ISSP revolves around the individual participant and reflects his or her chosen lifestyle, culture, and functional and social needs for successful community living. The goal of the planning process is for the participant to have his or her long-term support needs met and to achieve a meaningful life in the community.

Upon enrollment in the IRIS Waiver, the participant receives an individual budget and information and support from the IRIS Consultant regarding waiver services that are available to the participant, including the potential of purchasing support broker services to assist in planning. The IRIS Consultant provides additional information about person-centered planning processes, the individual budget, the waiver services available, the services covered by the Medicaid ForwardHealth card and the need to develop the content of the ISSP.

Person-centered planning includes a discovery process, e.g., assessment process. There are tools, resources, and information that are currently available to help participants express themselves and the IRIS Consultant will assist the participant in using a risk assessment to identify strengths and weaknesses that may impact the participant’s health and welfare. In addition to the discovery process, participants and IRIS Consultants may have access to information from the LTC Functional Screen assessment and content area experts. All ICAs will have initial conversations with participants to explore the following areas:

1. Long term care outcomes for the future;

2. Strengths and capacities, e.g., what the participant believes he/she does best and the natural supports and other resources are available;
3. Accomplishments, e.g., areas of skill;
4. Personal relationships with family and friends;
5. Community life, memberships, associations, and faith communities;
6. Work, school or other daily activities;
7. Health status and service needs; and
8. Risk factors.

As needed, the IRIS Consultant explains to the participant how the ISSP addresses needs identified in the LTC Functional Screen assessment and the discovery process, interprets the assessment, and identifies links to the ISSP. The ISSP identifies how the goals and services address the participant's long-term support and health and safety needs as identified through assessment and discovery processes.

The participant takes the lead, directs development of the plan, involves family members or other individuals, as desired. The IRIS Consultant is available to assist the participant with plan development to whatever degree required by the participant. The participant directs the design of the ISSP, which includes the following components:

1. Identification of needs to be addressed by the waiver and by informal supports and other community resources.
2. Selection of waiver and other services, including provider type, amount, frequency, and duration of each service; goods and supports; and the desired outcome of each.
3. Methods for coordination with State plan services and other public programs.
4. Methods for addressing health care needs, when relevant to the participant.
5. Methods for monitoring implementation, determining life satisfaction, measuring quality,
and making continual improvement.
6. Tools, resources, information, or training needed by the participant and service providers.
7. How the plan will stay within the Individual Budget amount.
8. Methods to address the participant''s health and safety, such as 24-hour emergency and back-up services.
9. Methods for on-going monitoring of the plan''s implementation and at least an annual review.

The ICAs are responsible for ensuring that the participant develops the ISSP within the available budget. Service authorizations reflecting chosen services are submitted to the Fiscal/Employer Agent and/or Third Party Administrator.

The centralized IT system will contain controls to help ensure that rates, numbers of hours, and services selected meet criteria established within the Waiver and fall within certain parameters. This will afford the participant the opportunity to have decisions made at the “kitchen table”. The IRIS Consultant Agencies use a plan review process to ensure that all IRIS participant plans (initial, annual, or updated) meet service definition criteria, address the person’s needs and long term care outcomes, and the participant or legal decision-maker has signed the plan before the services on the plan are authorized. Plan review process conducted by ICAs:
- After the IRIS Consultant works with the participant to develop a plan addresses the participants’ desired outcomes and meets their needs within the budget, the plan is submitted to the participant’s chosen IRIS Consultant Agency.
- Within five business days, the ICA will review the plan to ensure services address the person’s identified outcomes and needs and is within the individual budget, and that the services meet waiver definitions and criteria as outlined in the application. If the above criteria are met, the plan is approved by the ICA and the participant’s signature on the plan is obtained. The Fiscal/Employer Agent and Third Party Administrator will have access to the participant’s plan through the centralized IT system so that claims/billing/payroll can be processed according to the plan.
- If any of the above criteria are not met, the participant’s chosen IRIS Consultant Agency will follow up with the IC and Participant to address the criteria not met and make updates/changes as needed to correct. Once the Centralized IT system is in place the above protocol will happened electronically and there will be automated workflows in place to increase efficiency in plan submittal and approval.

As an integral component of self direction, the participant determines how waiver and other services are coordinated. The participant directs and monitors the implementation of the initial plan and any revisions to the plan that are necessary to meet changes in circumstances and needs, with the assistance of the IRIS Consultant. The participant may purchase support broker services to assist in these processes. As described in Appendix H, the IRIS Consultant''s quality assurance activities include: ensuring that all applicable procedures related to plan and budget development occur; monitoring implementation of the plan; communicating with the Fiscal/Employer Agent and Third Party Administrator to monitor appropriate use of the authorized budget, according to the ISSP; supporting the participant in developing and implementing his/her individual quality assurance plan; and supporting the participant in revising the ISSP and budget, as indicated, to meet the participant''s changing circumstances and needs. Progress towards outcomes and appropriateness of services/supports are reviewed at each contact. At a minimum, the plan is reevaluated, at a minimum, on an annual basis.

The IRIS Consultant is responsible for service plan development with the participant. The IRIS Consultant assists the participant with assessing risk. The IRIS Consultant assists with the identification of needed services, including the frequency and duration to address the participant's unique outcomes and support needs. The participant is informed of his/her rights and responsibilities including choice of service providers. The IRIS Consultant and/or IRIS Consultant Agencies are not permitted to be service

providers and therefore do not have a conflict of interest with regard to assisting the participant, if needed in locating and choosing providers. The IRIS Consultant offers a variety of ideas and tools for the participant to complete the service planning process and DHS establishes that the plan be developed and implemented as quickly as possible while honoring the participant's wishes and no later than 45 days after the enrollment and orientation meeting. The IRIS Consultant assists the participant in understanding all service options and any waiver rules or limitations related to each service.

Timelines
The initial welcome call to the participant is due within 3 business days of the referral date. The IRIS Consultant selection should be indicated by the participant by the third business day from the welcome call. If a participant does not choose an IRIS Consultant or does not have a preference in their IRIS Consultant, an IRIS Consultant will be auto-assigned to the participant on the fourth business day after the welcome call. The Initial Visit between the participant and the IRIS Consultant will be within fourteen calendar days from the referral date. The Initial Plan must be completed within 30 calendar days from the initial visit. The date of the implementation of the plan must be within 45 calendar days of the initial visit. The participant's "start date" in the program is equivalent to the participant's "plan implementation" date.

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 IRIS Waiver presents participants with both new opportunities and risks. Finding the right balance between the participants' right to make choices with the SMA's obligation to ensure participant safety requires special consideration and careful planning. The Long Term Care Functional Screen and a risk assessment tool are available to help identify health and risk-related strengths and needs. The record review process has indicators in place that ensure that all health and safety needs are addressed. Health and safety issues must be addressed in the ISSP based on the participant's needs and preferences, including 24-hour emergency back-up plans in the event that needed services are for any reason not accessible. The IRIS Consultant's quality assurance activities include oversight of the planning and implementation process including the monitoring of back-up plans. As part of the participant's quality assurance plan, the participant must have an effective, current emergency back-up plan with key information that is kept up-to-date such as back-up service/support contact names, phone numbers and emergency contact numbers, availability, etc. The IRIS Consultant will review the participant's emergency back-up plan with the participant during their contacts/visits to determine that it is up-to-date and adequate.

The emergency/back-up plan is the method used to identify supports if the participant's usual plan fails in any way, including unexpected illness of a provider or the failure of a provider to show up. The IRIS Consultant Agencies have staff to support each IRIS Consultant in assessing participant risk and ensuring that back-up plans are appropriate and robust.

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 Consultant Agencies will assist participants, as requested, in identifying qualified providers and vendors, including making available a list of providers and vendors in their area as well as information about other provider options; participants make decisions about hiring.

Most IRIS participants select their own providers to deliver supports and services. The The IRIS Consultant assists with the necessary employer and provider qualification requirements. If participants wish to have in-depth, ongoing support with this critical function, Support Broker services are an option.

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):

The participant, with the assistance of his/her consultant, submits the Individual Support and Service Plan (ISSP) and budget to the IRIS Consultant Agencies for approval. (See Appendix H for oversight activities.)

On behalf of DHS, the ICA approves each participant's ISSP annually or more often if there is a change in the participant's needs or circumstances. The ICAs are required to monitor approval accuracy and compliance with criteria during its monthly quality assurance activities and report findings to DHS quarterly. DHS reviews the ICAs' approvals during the annual contract compliance

review. DHS also completes record reviews on a random sampling basis. The sample size of approvals will meet the CMS sampling requirements. If DHS identifies any issues that are inconsistent with Medicaid requirements at any time, DHS ensures that the ICAs or Fiscal/Employer Agents correct the problem.

DHS or the ICAs reviews all requests for service plans are proposed that would that exceed the individual budget through a formal budget amendment process.

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 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:

IRIS Consultant Agencies

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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The participant, in collaboration with the IRIS Consultant, is responsible for monitoring the Individual Support and Service Plan implementation, whether the services and supports are meeting the participant's needs, and if the back-up plan is satisfactory. The participant and IRIS Consultant work together, face-to-face during the initial planning phase and during plan implementation to do a thorough face-to-face consultation and the IRIS Consultant is available as needed on an ongoing basis.

The participant will have an overall plan developed with support of the IRIS Consultant, as needed, that will be comprised of: the Individual Support and Service Plan; health and safety risk assessment; emergency back-up plan including emergency preparedness plan; provider agreements/background screening; and other information as relevant to the participant.

The participant's IRIS Consultant also monitors implementation and management of the Individual Support and Service Plan and Individual Budget This includes the IRIS Consultant's quality assurance activities, e.g. ensuring that all applicable procedures related to plan development occur, including the procedures for payment of legally responsible individuals; monitoring implementation of the approved plan; communicating with the Fiscal/Employer Agent and/or Third Party Administrator to monitor appropriate use of the authorized budget according to the ISSP; supporting the participant as appropriate in developing and implementing his/her individual quality assurance plan.

The participant's IRIS Consultant will track and notify the participant when s/he is due for a redetermination of functional and financial eligibility on an annual basis. During contacts with the participant and through other available information, the IRIS Consultant will also monitor with the participant when the participant's circumstances and/or needs are changing and refer the participant for a new Long Term Care Functional Screen assessment and potential budget recalculation if the Long Term Care Functional Screen indicates the need.

Individual Support and Service Plan (ISSP) Review and Monitoring

The participant creates an individual support and service plan, with support from the IRIS Consultant as needed, and includes his/her long term care outcomes as a part of the process. Services and supports listed on the plan are intended to assist the participant to achieve his/her outcomes. The participant, in collaboration with the consultant, formally reviews the ISSP at least annually. Informal reviews of the progress on the outcomes and continued appropriateness of the services and supports will occur during each contact.

The participant, in collaboration with the IRIS Consultant, maintains an overall plan and reviews the emergency back-up plan to ensure that it is effective and contains up-to-date information about back-up emergency services and supports with current contact and other information and other emergency preparedness information.

The Fiscal/Employer Agent and/or Third Party Administrator track the disbursing of funds as authorized by the participant via signed timesheets and claims forms. The Fiscal/Employer Agent and/or Third Party Administrator ensures that the disbursements are paid at the correct rate and align with the Department's Flexible Spending policy.

In addition, DHS IRIS Quality Assurance staff together conducts a quarterly review of a random sample of participant records to verify:
1. Plans and budgets are developed according to IRIS policies and procedures;
2. Plans and budgets are updated/revised, as indicated by participant need;
3. Participant has a LTC Functional Screen assessment at least annually or when participant need changes and financial (MA) eligibility is re-determined as required;
4. Services are being received according to the plan and budget;
5. Emergency back-up plans are current and effective;
6. If and why services or supports received were not authorized; and
7. If and why a service or support was refused.

The review is summarized and analyzed, strategies for improvement are identified, and timely program changes are made, as indicated. DHS may also conduct a targeted review if warranted based on information obtained from any source in the discovery process.

DHS also conducts an annual review of the IRIS Consultant Agencies, the Fiscal/Employer Agents, the Third Party Administrator, and other IRIS contractors to determine compliance with their respective contracts and adherence to policies and procedures related to Individual Support and Service Plan monitoring, Individual Budget management and participant health and safety. Performance adjustments are written into the contract language of all contracted agencies to help drive quality in the aspect of contract compliance.

DHS annually reviews the following information regarding ISSPs and budgets:
- aggregate operational data that must be tracked and reported
- action plans developed by DHS in order to address areas of improvement identified through the data reviews; and,
- effectiveness of the action plans to improve the program. Timely program changes are made, as indicated in the action plan, in collaboration with and oversight by DHS.

If any issues that are inconsistent with Medicaid requirements are identified at any time, DHS will ensure that they are corrected.

Further detail related to health and safety and contracted agency roles is as follows:
The Fiscal/Employer Agents complete all background checks - criminal and caregiver. Verification of any required licensure or certifications will take place through a centralized system using a common process. The IRIS participant is informed of the result of these activities and if an adverse finding is substantially related to the provision of services, the participant may not utilize a selected provider. Further, the Fiscal/Employer Agents monitor all billing for waiver services to assure that these are consistent with the approved plan and reports any over or under utilization of services to the ICAs for follow up.

The Fiscal/Employer Agents ensure that that all persons working as caregivers and employed by the participant using IRIS Waiver funds have had the background checks completed. The background check process is starts when the prospective caregiver submits a completed Background Information Disclosure form (The F- 82064 form, available from the DHS forms library) to their chosen IRIS Consultant Agency. The IRIS Consultant Agencies facilitate submission of all participant-hired worker paperwork to the Fiscal/Employer Agents. The Fiscal/Employer Agents retain the F- 82064 form and submit a Criminal History Record Request form to the Department of Justice, Crime Information Bureau. The Fiscal/Employer Agents must check the Caregiver box on the form to receive a complete criminal background check report. The Department of Justice will send written results of the record search to the participant's chosen Fiscal/Employer Agent.

IRIS Medicaid Waiver funds may not be used to pay for services provided by individuals who do not pass the required criminal background check.

Disclosure: Under 2007 Wisconsin Act 172 and effective November 1, 2008, certain covered entities must disclose in writing to participants and/or their guardians all information obtained regarding background check results revealing conviction of a crime listed in DHS 12.115 and, if the caregiver has received rehabilitation approval, notice of that fact. (See s. 50.065 (1) (c) and s. 50.65

(2m) (a).)
By statute (s. 50.065 (1) (cr), these entities include a hospital, a licensed home health agency and a temporary employment agency that provides caregivers to another entity. The statute does not name personal care agencies as a covered entity.

Review/Reconsideration
The caregiver may request a review and reconsideration of the decision. The Fiscal/Employer Agents shall coordinate a process with the DHS. The process must be applied in a uniform manner and should mirror the process outlined in DHS 12.12 (See dhs012.pdf.) A caregiver denied employment due to a negative background check finding who successfully completes the review/reconsideration process may become a qualified provider after all other applicable service standards are met. All decisions made by Fiscal/Employer Agents are subject to DHS review.

The ICAs have the following risk assessment procedure:
Steps of the Process

1. The IRIS Consultant is required to observe and gather information related to any possible risk to participant health or safety. ICA staff also assesses this information through various participant contacts. The IC and/or ICA staff observe and gather information about possible health and safety risks at scheduled visits and contacts with participants. This is done through observation and discussion with the participant.
a. If ICA staff receive initial information on a possible risk situation from a participant or other involved person; they contact the IC and any other ICA staff as needed.
b. Once the IC receives information on possible risk through the ICA or identifies risk through direct participant contact, the IC reviews the following resources to determine if this is a health and safety risk:
i. Incident Report requirement located at: Wisconsin-IRIS Incident Report for the list of required reportable events.
ii. Operational Guideline: Incident Report: Event/Allegation Definitions.

2. The IRIS Consultant Agencies initiate the appropriate course of action.
a. Further contact with the participant or guardian to determine if there is a health risk.
b. Decide if more information is needed.
c. Determine if a verbal or written risk agreement is necessary. The IC initiates a discussion with the participant/guardian and any support people identified by participant to address the risk. The IC uses the Risk Agreement to:
i. Serve as a guide for the discussion to address and manage the risk.
ii. If a written agreement is necessary, the Risk Agreement serves as a signed agreement between the ICA and participant to identify a risk mitigation plan and indicate the participant accepts responsibility for the risk.
d. Identify whether this is a reportable incident.
e. If it is a reportable incident, the IC:
i. Initiates an Incident Report.
ii. Sends the Incident Report to the participant's chosen IRIS Consultant Agency who reviews and completes the necessary report.
iii. The ICAs utilize a SharePoint system and/or module in the centralized data system to report the incident to Department of Health Services (DHS) within 3 days and completes the final Incident Report with the IC and sends to DHS within seven days. DHS reviews the report in the SharePoint system and requests additional information through the system. DHS closes the report/investigation when both the immediate and ongoing health and welfare of the participant have been ensured.

3. Document findings in case notes and any indicated risk forms.
The IRIS Consultants and IRIS Consultant Agencies' staff document the following information as a case notes in the centralized IT system and, if necessary, initiates an Incident Report.
a. The IC/ICA staff documents the following :
i. Description of the incident and all contacts with involved parties.
ii. Actions taken to resolve the incident.
iii. Changes made or attempted to assure safety.
b. If it is a reportable incident, the IC:
i. Obtains initial information for an Incident Report.
ii. Sends the information for the Incident Report to their assigned IRIS Consultant Agency who reviews and completes the necessary report, and enters it into the SharePoint system and/or incident reporting module in the centralized IT system.

b. Monitoring Safeguards. *Select one:*

- (○) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant.
Specify:

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 participants' 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:
Number and percent of participants with service plans that address participant needs as indicated by the Long-Term Care Functional Screen. Numerator/Denominator: Number of plans reviewed that addressed participant needs over the number of plans 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:	☐ **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 participants whose identified health and safety risks are addressed in their service plan. Numerator/Denominator: Number of participants reviewed who have service plans with identified health and safety risks that are addressed over the number of service plans reviewed with identified health and safety risks.

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:	☐ **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**

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

Performance Measure:
Number and percent of service plans that address participant identified outcomes/goals.
Numerator/Denominator: Number of plans that address participant identified outcomes over the number of plans 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:	☐ **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**

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

b. ***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:
Number and percent of service plans that were developed in consultation with qualified IRIS staff. Numerator/Denominator: Number of service plans that were developed in consultation with qualified IRIS staff over the total number of service plans 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:	☐ **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 initial service plans that were developed and approved in accordance with Waiver timelines (within 62 days of the referral date). Numerator/Denominator: Number of initial service plans that were developed within 62 days of the referral date over the total number of service plans developed within the designated time period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Service plan data

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: ICA	☐ **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: ICA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of most recent service plans that were signed by the participant or legal representative. Numerator/Denominator: Number of current service plans that were signed by the participant or legal representative over the number of service plans 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:	☐ **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:

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

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:
Number and percent of participant service plans that were reviewed/updated annually.
Numerator/Denominator: Number of service plans with a timely annual review over the number of service plans requiring annual review during the designated time period.

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:	☐ **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: ICA	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of participant service plans that were reviewed/updated when warranted. Numerator/Denominator: Number of service plans reviewed/updated when warranted over the number of participant service plans reviewed in which changing needs requiring the service plan to be reviewed//updated were identified.

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:	☐ **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: 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:
Number and percent of participants who received services within the approved individual budget. Numerator/Denominator: Number of participants reviewed who reported claims paid were under the current approved individual budget during the designated time period over the total number of participants 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:	☐ **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: Participants are afforded choice: Between waiver services and institutional care; and 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:
Number and percent of participants that have a current signed choice form that specifies choice was offered between institutional care and waiver services. N/D: Number of service plans reviewed with a signed signature page on the current service plan or choice form that indicates choice was offered between institutional care and waiver services over the total number of service plans 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:	☐ **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 participants that have a current signed choice form that specifies choice was offered among waiver services and providers. Numerator/Denominator: Number of signed service plans or signed choice forms reviewed that indicates choice was offered among waiver services and providers over the total number of 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**	☐ **Annually**	☐ **Stratified**

Specify:		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.
The IRIS Consultant Agencies are responsible for administering all aspects of service plan development, service authorization within individual budget and waiver service definitions, annual plan updates, and change in needs plan updates. Individual participants work with IRIS staff to create their individual support and service plan. Documentation of the service planning process is captured and stored at the IRIS Consultant Agencies. The Department has administrative oversight over the IRIS Consultant Agencies and monitors these processes through related performance measures, record review indicators, and other reporting conducted by the IRIS Consultant Agencies. The primary discovery method used by the Department in overseeing service plans is the participant record review. DHS quality specialists review service plans and other key documents contained in the participant's electronic record to answer several questions related to service plan quality and related performance measures. The results are aggregated and analyzed on a quarterly and yearly basis by the SMA/DHS to identify patterns and trends.

In addition to the record review, the IRIS Consultant Agencies compile service plan process data, such as dates, case notes, and contact types. Some of this data is aggregated electronically and exported into reports. These reports are submitted to the Department on a regular basis and are reviewed by the IRIS Quality Management team. Participant complaints related to service planning process is another method for discovery. These issues are resolved through a grievance process and are addressed by the participant's chosen IRIS Consultant Agency, chosen Fiscal/Employer Agent, or an external agency contracted by DHS to resolve participant complaints/grievances (MetaStar). Data is collected regarding participant complaint resolution.

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. In addition, provide information on the methods used by the State to document these items.

The IRIS Consultant Agencies are primarily responsible for remediating individual negative findings, but the Fiscal/Employer Agents may be involved in the process as well. The IRIS Quality Management Team tracks the remediation of issues that are discovered through the participant record review. Other remediation efforts are tracked through review of subsequent reports. The IRIS Quality Management Team will ensure that the IRIS Consultant Agencies perform identified corrections and provide follow up as needed. Participant complaints received by the IRIS Consultant Agencies are documented in database that includes what steps were taken to resolve the complaint and results of remediation.

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. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

○ **Yes. The State requests that this waiver be considered for Independence Plus designation.**

◉ **No. Independence Plus designation is not requested.**

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.

Individuals who participate in the IRIS waiver have made a choice to self-direct all their services and supports. This provides participants a high degree of choice and control over services and supports delivered. The vision for participants, who utilize the IRIS Program, is as follows:
o All participants have value and potential.
o Participants shall:
o Be viewed in terms of their abilities;
o Have the right to participate and be fully included in their communities; and
o Have the right to live, work, learn, and receive all services in the most integrated and least restrictive settings within their communities.

This waiver recognizes the essential leadership role of participants in planning and purchasing of services and supports. To assume this leadership role and be successful in self-direction, participants must have the requisite on-going education, training, information, tools, and support related to SDS, which includes but is not limited to information about: basic core values and philosophy of self-direction; SDS guiding principles and processes; rights, risks, and responsibilities; independent living; disability rights; understanding the range of services and supports; finding, training and managing providers and employees; having access to complaint processes and incident reporting; individual budgets for use in paying for services and supports; working with the IRIS Consultant and F/EA; and participating directly in quality monitoring.

Participants develop their individualized support and service plans, within their established individual budgets, and direct all services and supports identified in their plans, excluding Medicaid ForwardHealth card services. Participants do have the additional option to self-direct Personal Care services through an s. 1915(j) state Plan Amendment for Self-Directed Personal Care, but are not obligated to exercise this option. The services in the individual support and service plan include all waiver services, Medicaid ForwardHealth card services and other supports and services necessary for participating individuals to live at home, go to school, work and integrate into the community as independently as possible. The breadth of services and supports must reflect all aspects of a participant's life, including but not limited to home, love, friendship, community, school, work and productive activity. Using the person-centered approach, the Individual Support and Service Plan revolves around the individual participant and reflects his or her chosen lifestyle and culture. Planning occurs where, when and with whom the participant chooses. The participant directs development of the Plan, which serves as the foundation for participation in this waiver.

In the event a person wants to reside in a residential facility, the participant exercises self-direction by making the decision to reside in a residential facility of their choosing (as long as it is within the IRIS Waiver limitations) and entering into an agreement with the provider. Participants must be afforded the opportunity to self-direct as much of their day-to-day services as possible within the facility. Participants must be able to self-direct any waiver service(s) needed that are not provided through the facility rate. These services might include transportation, day services, and supported employment as examples. The Department will establish a criteria by which self-direction in these facilities will be evaluated.

IRIS Consultants and the F/EA support participants in self-direction. Participants identify the individuals they want to be involved in the development of their plans, and the IRIS Consultant helps participants explore options and make informed choices, based on their individual needs. IRIS Consultants also help participants to negotiate with family members, providers, and others and build consensus. Consultants are trained in, and must demonstrate understanding of, all aspects of the IRIS Waiver Program, such as the guiding principles for self-direction, role of the participant in the person-centered planning process, available service and support options, locating and securing services and supports, and development and management of the individual budgets. IRIS Consultants must have knowledge about community resources and how to seek out resources.

The F/EAs are independent of the entities/persons delivering services or supports to avoid conflicts of interest. The F/EAs are trained in and must demonstrate understanding of all aspects of the waiver as it relates to the planning process and development and managing the individual budget. Based on the participant's Individual Support and Service Plan budget, the F/EAs set up an individual account, makes expenditures that follow the authorized budget, handles all payroll functions on behalf of participants who hire service providers and other support personnel, provides the participants and their chosen IRIS Consultant Agency with a monthly report of expenditures and budget status, answers inquiries, solve related problems, and provides the State with a quarterly documentation of expenditures. Reports from the F/EA to the participant, ICAs, and the Department will be carried out through the centralized data system.

Further detail related to health and safety and contracted agency roles is as follows:
The F/EAs complete all background checks - criminal and caregiver, as well as licensure or certifications and ensures that that all persons working as caregivers and employed by the participant using IRIS Waiver funds have had the background checks completed. The IRIS participant is informed of the result of these activities and if an adverse finding is substantially related to the provision of services, the participant will not utilize a selected provider. Further, the IRIS Consultant Agencies monitor all billing for waiver services to assure that these are consistent with the approved plan and reports any over or under utilization of services to the IRIS Consultants for follow up. The background check process starts when the prospective caregiver submits a completed Background Information Disclosure form (The F- 82064 form, available from the DHS forms library) to their chosen IRIS Consultant Agency. The IRIS Consultant Agencies facilitate the submission of all participant-hired worker paperwork to the participant's chosen Fiscal/Employer Agent. The Fiscal/Employer Agent then retains the F- 82064 form and submits a Criminal History Record Request form to the Department of Justice, Crime Information Bureau. The Department of Justice will send written results of the record search to the IRIS Consultant Agencies.

IRIS Medicaid Waiver funds will not be used to pay for services provided by individuals who do not pass the criminal background check.
Disclosure: Under 2007 Wisconsin Act 172 and effective November 1, 2008, certain covered entities must disclose in writing to participants and/or their guardians all information obtained regarding background check results revealing conviction of a crime listed in DHS 12.115 and, if the caregiver has received rehabilitation approval, notice of that fact. (See s. 50.065 (1) (c) and s. 50.65 (2m) (a).) By statute (s. 50.065 (1) (cr), these entities include a hospital, a licensed home health agency and a temporary employment agency that provides caregivers to another entity. The statute does not name personal care agencies as a covered entity.

The Department is also working with the DHS Office of Inspector General to ensure that the IRIS program is in compliance with all components of the Affordable Care Act of 2010 regarding the suspension of Medicaid funds to any health care provider pending an investigation of a credible allegation of fraud.,

Review/Reconsideration
When an applicant's criminal background contains convictions that are not permitted per Department policy, the caregiver is considered "unqualified" by the IRIS program to be hired directly as a participant-hired worker. Participants and caregivers do have the option to try to be hired through an agency and provide cares under the supervision of the agency. In some cases, the caregiver may be required by the agency to complete the agency-directed rehabilitation process and produce documentation of completion of the agency's rehabilitation process prior to being eligible to be considered qualified by the agency to provide direct care. There is not a rehabilitation process through the IRIS program available to participant-hired workers.

The ICA has the following risk assessment procedure:
1. The IRIS Consultant is required to observe and gather information related to any possible risk to participant health or safety. ICA staff also assesses this information through various participant contacts. The IC and/or ICA staff observes and gather information about possible health and safety risks at scheduled visits and contacts with participants. This is done through observation and discussion with the participant.
a. If staff with the IRIS Consultant Agencies receive initial information on a possible risk situation from a participant or other involved person; they contact the IC and any other ICA staff as needed.
b. Once the IC receives information on possible risk from the IRIS Consultant Agency or identifies risk through direct participant contact, the IC reviews the following resources to determine if this is a health and safety risk:
i. Incident Report requirement located at: Wisconsin-IRIS Incident Report for the list of required reportable events.
ii. Operational Guideline: Incident Report: Event/Allegation Definitions.
2. The ICA initiates the appropriate course of action.
a. Further contact with the participant or guardian to determine if there is a health risk.
b. Decide if more information is needed.
c. Determine if a verbal or written risk agreement is necessary. The IC initiates a discussion with the participant/guardian and any support people identified by participant to address the risk. The IC uses the Risk Agreement to:
i. Serve as a guide for the discussion to address and manage the risk.
ii. If a written agreement is necessary, the Risk Agreement serves as a signed agreement between the ICA and participant to identify a risk mitigation plan and indicate the participant accepts responsibility for the risk.
d. Identify whether this is a reportable incident.
e. If it is a reportable incident, the IC:
i. Initiates an Incident Report.
ii. Sends the Incident Report to the ICA who reviews the report.
iii. The ICA notifies the Department of Health Services (DHS) within 3 days and completes the final Incident Report with the IC and sends to DHS within seven days. The IRIS Consultant Agencies enter the incident reporting information into the SharePoint site and/or the incident reporting module in ISITS.
3. Document findings in case notes and any indicated risk forms.
The IC and ICA staff document the following information in a case note in ISITS and, if necessary, initiates an Incident Report.
i. Description of the incident and all contacts with involved parties.
ii. Actions taken to resolve the incident.
iii. Changes made or attempted to assure safety.
b. If it is a reportable incident, the IC:
i. Obtains initial information for an Incident Report.
ii. Sends the information for the Incident Report to the ICA who reviews the report, and attaches it to the participant's record in the centralized IT system and enters the information into the SharePoint site or the incident reporting module in the centralized IT system.
iii. The Department reviews the information in SharePoint and/or the critical incident reporting module in the centralized IT system and approves the investigation when evidence has been documented that the participant's immediate and ongoing health and welfare has been ensured.

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:

Residential Care Apartment Complex (RCAC) and 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.

Aging and Disability Resource Centers (ADRC) provide potential enrollees with specific information about the IRIS SDS waiver; Family Care Managed Care; and Medicaid Fee for Service in order to assist the person in making an informed choice about his or her long-term support program. This includes the provision of information on the benefits of participant direction in the IRIS program including the participant's rights and responsibilities. The ADRC also coordinates with the county Economic Support Unit to assist participants with the Medicaid financial eligibility processes as needed; and administers the Long Term Care Functional Screen (LTCFS) to determine initial functional eligibility and level of care.

The individual budget calculation for IRIS is based upon characteristics and long-term support needs as collected on the Long Term Care Functional Screen (LTCFS). A profile of the individual is developed based upon this information and that profile will be used to determine the projected cost of services and supports for that individual if he or she were enrolled in Family Care. Only services that are included in the IRIS Waiver are included in this calculation. The prospective participant will know this budget amount when deciding whether to participate in IRIS or another Long Term Care Program.

The IRIS Referral Form – accessed through this website: http://www.dhs.wisconsin.gov/LTCare/adrc/professionals/forms/index.htm this provides the information related to the participants choice about whether or not to complete enrollment in IRIS. The

comprehensive Guide related to Enrollment Counseling is located at this link:
http://www.dhs.wisconsin.gov/LTCare/adrc/professionals/referencetools/rcdta/enrollcounsl/rcd0901.pdf

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:

Formal legal sign-off of the individual support and service plan is limited to the legal guardian, but other people may assist the person in direction of his or her care with guardian consent. When a participant has had a legal guardian assigned by the courts, then only that individual's signature may demonstrate the participant's formal/legal agreement with the service plan. However, the form also includes a place for the participant to indicate his or her agreement. The guardian's ability to support the person in self-direction is recognized within this self-direct waiver. However, it is important that the IRIS Consultant ensure that the participant's voice is always heard. The participant and guardian may elect to involve others, such as a Circle of Support in plan development. The sign off on timesheets is to verify that services were provided. This is also subject to both Fiscal/Employer Agent and IRIS Consultant Agency review.

The participant is able to include whoever they want in their Circle of Support and can determine the level of involvement of those individuals either as a group or as individuals. For example, a participant may include both his mother and his brother in his Circle of Supports but only choose to allow his mother to be part of the development of his service plan. Releases of information must be signed by the participant for those individuals with whom the participant wants to allow the consultant to interact. These releases of information can be rescinded by the participant at any time for any reason. Non-legal representatives do not have any authority in the decision-making process. They may offer guidance to the participant that he or she may consider in making decisions. The consultant must be careful to ensure that no non-legal representative is exercising rights afforded to legal representatives. Non-legal representatives may not make decisions on behalf of the participant and may only provide encouragement, support, and advice. In situations where non-legal representatives are overstepping their role in the participant's Circle of Support, the participant's consultant will discuss the issue with the non-legal representative. The discussion will focus on an education sheet describing the role of a non-legal representative including a comparison with the role of a legal representative. In addition, the consultant will meet privately to ensure that the participant still wants the individual to participate in planning meetings, etc. Consultants are required to honor the participants' wishes regarding the level of involvement, or non-involvement, of non-legal representatives regardless of how helpful the consultant believes they are.

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.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Respite	☑	☑
3-4 Bed Adult Family Home	☐	☑
Supported Employment	☑	☑
1-2 Bed Adult Family Home	☐	☑
Nursing Services	☑	☑
Vocational Futures Planning	☐	☑
Communication Aids Vendors/Interpreter Services	☐	☑
Customized Goods and Services		

Participant-Directed Waiver Service	Employer Authority	Budget Authority
	☑	☑
Home Delivered Meals	☐	☑
Housing Counseling	☐	☑
Home Modification	☐	☑
IRIS Consultant Services	☑	☐
Personal Emergency Response System	☐	☑
Fiscal / Employer Agent Services	☑	☐
Adult Day Care	☐	☑
Specialized Medical Equipment and Supplies	☐	☑
Specialized Transportation 2	☑	☑
Relocation - Housing Start Up and Related Utility Costs	☐	☑
Support Broker	☑	☑
Supportive Home Care	☑	☑
Consumer Education and Training	☐	☑
Specialized Transportation	☑	☑
Counseling and Therapeutic Services	☐	☑
Adaptive Aids	☐	☑
Daily Living Skills Training	☑	☑
Day Services	☐	☑
CBRF	☐	☑
Prevocational Services	☑	☑
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	☑
Residential Care Apartment Complex	☐	☑

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 Services

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:

The IRIS Fiscal / Employer Agent (F/EA) Services (Reference Appendix C – IRIS Fiscal / Employer Agent Services for service definition) are required services for those participants who choose to employ participant-hired workers to provide services within their approved Individual Support and Service Plan (ISSP). F/EAs will be certified through a predefined set of service delivery and financial solvency criteria (Reference Attached F/EA Certification Criteria). These criteria emphasize the core functional requirements F/EAs must possess to deliver high-quality fiscal services to IRIS Participants. These criteria require F/EAs to demonstrate that their business philosophy, goals, and model align with the core principles of self-direction and the values of the IRIS Program. These criteria also require the F/EA to demonstrate that the F/EA has a comprehensive understanding of the financial service responsibilities required to be a Fiscal / Employer Agent for IRIS participants. The F/EA must also demonstrate evidence of the required business infrastructure, IT infrastructure, qualified personnel requirements, and financial solvency to provide IRIS F/EA services with the highest quality and program integrity. Similar to the ICA certification process, this process includes mechanisms to allow F/EAs to become certified through successful demonstration of the core requirements of F/EA functions while allowing the Department to impose Certification Criteria Improvement Plans (CCIP). CCIPs are only applied to those areas that are not core F/EA services or related to the waiver assurances. CCIPs can be imposed by the Department - to ensure that any non-core functional areas of the F/EA service that do not meet the Department's requirements are brought up to standard in a timely manner regulated by the Department. As part of successful completion of the certification criteria, F/EAs will be required to provide all ICAs in the IRIS region they intend to serve with Department-approved and predefined information about their agency. This information will include general information such as physical office locations and hours, as well as years of experience as a fiscal / employer agent. It will also include any specific technological capacities the F/EA utilizes such as electronic time sheet submittal, mobile phone applications, direct deposit, debit card deposits, or electronic confirmation of timesheet receipt and/or payment deposit. This information will also include data compiled from customer satisfaction surveys completed by other IRIS participants for whom the F/EA provides services. This data will rate the F/EA in different core areas of services, such as customer service, responsiveness, payment accuracy, and issue resolution. This information will be consistent in form and format and will be provided to potential IRIS participants during their orientation meeting with their chosen ICA. This ensures that IRIS participants have the tools, resources, and information to make the most informed decision regarding their choice of F/EA. If a participant has no preference on selecting their F/EA, an F/EA will be auto-assigned to the participant based on F/EA availability in that region and capacity (if applicable). When the participant chooses an F/EA, the IRIS Consultant processes the referral accordingly.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

Fiscal/Employer Agent Services are no longer an administrative service and are provided as a waiver service (see Appendix C). All F/EA functions are included in the waiver service. The F/EA will be reimbursed a monthly rate of service for each participant that utilizes their agency for F/EA services. This monthly rate of service was developed by the Department based on historical costs and enrollment in the IRIS program. The Department will track and monitor the number of participants being served by each individual F/EA on a monthly basis and will provide each F/EA with their reimbursement based on monthly enrollment. Because these services are required as a part the IRIS program model, these monthly rates will not be charged against the participant's budget.

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:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [ ] **Other**

Specify:

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **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:

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 DHS monitors the Fiscal/Employer Agents (F/EAs) at least quarterly. Oversight and monitoring activities include:
Agency Operations Data
• Phone tracking log (calls into a statewide toll-free line)
• Complaint tracking log (complaints of participants regarding experience with Fiscal/Employer Agents)
• Fair Hearing and Appeals Reports (formal complaints, including number, type, pattern, results of appeals)
• Contract Reviews
• Financial record reviews
• Providers and vendors of goods and services qualification review information maintained by Fiscal/Employer Agents (F/EAs)
• Division IRIS Management Team Oversight
• DLTC Bureau of Financial Management Services Oversight of Encounter reporting and periodic, comprehensive audit of Encounter Reporting
• IRIS Advisory Committee reports and input

IRIS Quality and Data Management staff aggregate data, identify trends, and make recommendations for improvements, as indicated.

The IRIS Quality Management Team implements systems improvement activities, using information derived from multiple discovery activities, identifying trends that affect IRIS Waiver participants as a group; designs improvements to the system to prevent or reduce future occurrences of quality issues.

DHS and Fiscal/Employer Agent(F/EA)staff meet and collaborate with the IRIS Advisory Committee monthly and the data and Individual budget subcommittee monthly. The IRIS Advisory Committee will meet bimonthly in the future. DHS staff are responsible on an annual basis, and more frequently if necessary, to monitor and develop system improvement plans.

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:

The IRIS Consultant Agency (ICA) Services (Reference Appendix C – IRIS Consultant Services for service definition) are required services within the IRIS Program. ICAs will be certified through a predefined set of service delivery and financial solvency criteria (Reference Attached ICA Certification Criteria). These criteria emphasize the core functional requirements ICA's must possess to deliver high quality consulting services to IRIS Participants. These criteria require ICA to demonstrate their business philosophy, goals and model align with the core principles of self direction and the values of the IRIS Program. These criteria also requires the ICA to demonstrate the ICA has a comprehensive understanding of the consultant service responsibilities as well as well as the business infrastructure, IT infrastructure, qualified personnel, and financial solvency to provide IRIS consulting services with the highest quality and program integrity. The certification process includes mechanisms to allow ICAs to become certified through successful demonstration of the core requirements of ICA functions while allowing the Department to impose Certification Criteria Improvement Plans (CCIP). CCIPs are only applied to those areas that are not core to the ICA services and waiver assurances. CCIPs can be imposed by the Department to ensure that any non-core functional areas of the ICA service that do not meet the Department's requirements are brought up to standard in a timely manner regulated by the Department.

As part of successful completion of the certification criteria, ICAs will be required to provide all ADRCs in the IRIS region they intend to serve with Department-approved and predefined information about their agency. This information will include general information such as physical office locations and hours, as well as years of experience in case management or consulting. It will also include any specific licensing or certification the agency or members of their staff hold such as registered nurses on staff, specially trained or experienced staff in areas such as dementia or autism, or staff experience with certain target groups served through the IRIS program. This information will also include data compiled from the results of customer satisfaction surveys completed by other IRIS participants for whom the ICA provides consulting services.. This data will rate the ICA in different core areas of services, such as customer service, responsiveness, program knowledge, issue resolution, and accuracy of information provided. The Department-approved information developed by each ICA will be consistent in form and format and will be given to potential IRIS participants after they have completed enrollment counseling at the ADRC. This information serves to ensure that participants have the tools, resources, and information to make the most informed decision regarding their choice of ICA. If a participant has no preference regarding the selection of their ICA, an ICA will be auto-assigned to the participant at the ADRC based on ICA availability in that region and capacity of the ICA (if applicable). When a participant selects an ICA, the ADRC will route the referral information accordingly.

ICAs are required to: 1) conduct annual level of care redetermination/evaluation activities using the State's automated long-term care functional screen; 2) develop individual support and service plans; 3) perform prior authorization of waiver services; 4) assure that approved plans and any modifications remain within a person's Individual budget; 5) recruit and train IRIS Consultants; 6) develop and implement QA/QI plans related to all of these functions; and 7) assist the participant in ensuring that employee/provider new-hire paperwork is completed correctly and will complete the criminal and caregiver background checks. These agencies assure that there are adequate, well-trained IRIS Consultants to facilitate participant self-direction within the Medicaid regulations. The extent of IRIS Consultant services may range from very limited, minimal assistance to ongoing support in plan development and implementation based upon the needs of the individual IRIS participant. The IRIS Consultants are also responsible to provide ongoing contacts to monitor implementation of the plan, to assure participant health and safety, to ensure that services are provided according to the approved plan and to review monthly expenditure reports to assure appropriate use of the authorized budget.

The participant will function as the common law employer, soliciting and hiring workers, training workers as necessary and making arrangements to purchase needed services and supports from vendors. The participant will review and approve timesheets and other documentation and submit them to their chosen Fiscal/Employer Agent for payment and record-keeping. The F/EA will assure that participant-employed caregivers meet appropriate requirements, report payroll claims to the TPA, provide required data to DHS, and provide monthly payroll expenditure reports to the participant's chosen ICA and the participant.

The ICA will be reimbursed a monthly rate of service for each participant that utilizes their agency for ICA services. This monthly rate of service was developed by the Department based on historical costs and enrollment in the IRIS program. The Department will track and monitor the number of participants being served by each individual ICA on a monthly basis and will provide the ICA with their reimbursement based on monthly enrollment. Because these services are required as a part the IRIS program model, these monthly rates will not be charged against the participant's budget.

☑ **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
Respite	☐
3-4 Bed Adult Family Home	☐
Supported Employment	☐
1-2 Bed Adult Family Home	☐

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Nursing Services	☐
Vocational Futures Planning	☐
Communication Aids Vendors/Interpreter Services	☐
Customized Goods and Services	☑
Home Delivered Meals	☐
Housing Counseling	☑
Home Modification	☐
IRIS Consultant Services	☐
Personal Emergency Response System	☐
Fiscal / Employer Agent Services	☐
Adult Day Care	☐
Specialized Medical Equipment and Supplies	☐
Specialized Transportation 2	☐
Relocation - Housing Start Up and Related Utility Costs	☐
Support Broker	☑
Supportive Home Care	☐
Consumer Education and Training	☐
Specialized Transportation	☐
Counseling and Therapeutic Services	☑
Adaptive Aids	☐
Daily Living Skills Training	☐
Day Services	☐
CBRF	☐
Prevocational Services	☐
Live-in Caregiver (42 CFR §441.303(f)(8))	☐
Residential Care Apartment Complex	☐

☐ **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:

Independent advocacy is available from Disability Rights Wisconsin, the state's protection and advocacy agency, the Board on Aging and Long Term Care and the Independent Living Centers in the state. Participants in IRIS are notified of these agencies by the ICA and the ADRC and provided information on how to contact the agencies and the services provided by each.

DHS confirms that these agencies are not service providers.

Participants are able to access these services by contacting the agencies directly as follows:
Board on Aging and Long Term Care
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
(800) 815-0015 Toll-free
(608) 246-7001 Fax
boaltc@ltc.state.wi.us

Disability Rights Wisconsin has offices in Madison, Milwaukee and Rice Lake.

Madison
131 W. Wilson St., Suite 700
Madison, WI 53703
608-267-0214
TTY: 888-758-6049
Fax: 608-267-0368
Toll Free: 800-928-8778*

Milwaukee
6737 W. Washington St., Suite 3230
Milwaukee, WI 53214
414-773-4646
TTY: 888-758-6049
Fax: 414-773-4647
Toll Free: 800-708-3034*

Rice Lake
217 W. Knapp St.
Rice Lake, WI 54868
715-736-1232
TTY: 888-758-6049
Fax: 715-736-1252
Toll Free: 877-338-3724

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:

Participants may voluntarily leave IRIS at any time and may choose to enroll in Family Care managed care or use the Medicaid State Plan Services. The IRIS Consultant Agencies refer people who indicate that this is their choice to the Aging and Disability Resource Centers (ADRCs). People may also access the ADRC on their own without notifying their chosen IRIS Consultant Agency. ADRCs assist these individuals to understand their long-term support program options. Services are continued for the participant until the transition date to the selected program is completed.

The disenrollment from IRIS and enrollment in Family Care may occur simultaneously. The participant is assisted with a smooth transition between the programs by the IRIS Consultant and the Managed Care Interdisciplinary Team. There is no established timeframe for the IRIS Consulting Agencies to complete a transition of enrollment to Family Care. This is to allow flexibility in developing a smooth transition for the participant.

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.

The criteria for involuntary disenrollment from the IRIS waiver include: 1) the participant's health and safety is jeopardized; 2) purchasing authority is mismanaged; or 3) the enrollee refuses to report information necessary to adequately monitor the supports and services per his or her ISSP. The decision to involuntary disenroll a participant from the IRIS waiver remains under the direct authority of the SMA and participants are properly notified of their Fair Hearing rights.

When action is taken to involuntarily terminate the participant from the IRIS waiver, the IRIS Consultant in collaboration with the ADRC, assists the participant in accessing needed and appropriate services through other Medicaid programs such as Family Care, Partnership, Medicaid ForwardHealth services, and other support options. The IRIS Consultant ensures, to the extent practicable, that there is no lapse in necessary funding and services for which the participant is eligible while the participant is being enrolled in another program.

The IRIS Consultant Agencies or the Fiscal/Employer Agents may make the recommendation to the DHS to terminate a participant's enrollment in the IRIS waiver, but the SMA makes the final decision. IRIS Consultant Agencies are expected to bring concerns to the SMA when they arise so that the SMA can assist with addressing issues before termination is considered. The DHS role includes a conversation with the participant and any legal representative for the person, as well as a review of the case file and all relevant documentation.

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		2548
Year 2		3135
Year 3		3505
Year 4		3864
Year 5		4224

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:

Under the Employer Authority, the participant is supported to recruit, hire, supervise and direct the workers who furnish supports. The participant functions as the co-employer of these workers. The selected agency functions as the common law employer. When the Employer Authority is utilized, the participant rather than a waiver provider agency carries out employer responsibilities for workers.

☑ **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)**

- [x] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [ ] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- [x] **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.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **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*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **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 LTCFS is used to identify the characteristics related to long-term support needs of an individual that are predictive of support and service costs. These results will be used to identify a comparison group of people with similar needs in Family Care and actuarially sound methodologies are utilized to establish an individual budget. The participant is notified of this individual budget and may use these fiscal resources for the purchase of waiver goods and services identified in the Individual Support and Service Plan (ISSP). If the actual support costs exceed the estimated budget, DHS has budget amendment and one-time expense processes to increase the budget upon approval. If the cost of meeting the participant's needs is less that the projected budget, the cost saving remain in the overall program budget for DHS management.

The comparison group consists of a total population of: 12,737.
The target group populations of the comparison group are:
Persons with Developmental Disabilities – 3,064
Persons defined as Frail Elders – 3,646
Persons with Physical Disabilities – 6,027

DHS has worked with actuarial services to evaluate the predictive nature of each element of the LTC FS and the ability of those characteristics to predict long-term support costs. DHS uses statistical models to set the budgets for IRIS participants. This is based upon the cost experience for people in Wisconsin's long-term support system. Regression analysis is used to determine if this is a reliable technique. DHS will use the budget produced from the regression model and apply the budget methodology with respect to each person enrolled in IRIS.

If a person's long-term support needs exceed the available individual budget either on a one-time basis or on an ongoing basis (budget amendment), then the IRIS Consultant assists the person in preparing a request per DHS procedures and submits the information to the DHS IRIS Section for review. The Bureau of Long Term Support has developed a review group of DHS employees from the IRIS section and the Legacy Waiver section to review both IRIS requests and requests from the COP/CIP Waivers. This was designed to ensure consistency in decision-making across programs. The review group analyzes the request and recommends one of the following: approval, partially approved, request for further information, or denial. In cases where the request was denied or only partially approved, the participant has the option to request an Independent review by DHS. This review is conducted by a committee convened by the IRIS Section Chief. No individual who was part of the initial decision may be part of the Independent Review committee. This committee then reviews the recommendation for final approval or denial. If the request is denied, or the participant chooses not to engage in an Independent Review, the IRIS participant is afforded Medicaid Fair Hearing rights.

Budget amendments and one-time expenses are contained on separate SharePoint lists within the same Budget Amendment SharePoint site. Each ICA has its own Budget Amendment SharePoint site. These sites each contain a library that consists of the Budget Amendment and One-Time Expense policies and work instructions that detail the process; applicable forms including instructions and examples; and the Budget Amendment and One-Time Expense SharePoint User's Manuals. Each time a new IRIS Consultant Agency is certified, the Department meets with the new agency and walks through the entire process from identification of the participant's need through the completion of the paperwork, through the use of the SharePoint sites, through the decision-making process, and finally through the Independent Review and appeals process. This policy can be found at http://www.dhs.wisconsin.gov/bdds/iris.

Each budget amendment or one-time request with the status, "Pending Review" indicates that it is ready for DHS review. Any request with the status of "Pending Review" on Thursday will be reviewed by the review committee on the following Tuesday – this would make the established timeframe for reviewing requests once they pass the pre-review process approximately four business days. Exceptions to this schedule may be made due to holidays, but these exceptions are communicated in advance to the ICAs and the review committee members.

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.

The LTCFS serves as the basis for the individual budget calculation in the IRIS Waiver. Once a person is determined to be functionally and financially eligible for long-term supports, the individual receives Options and Enrollment Counseling. The Family Care and IRIS Programs are explained to the individual. As the person is advised of his/her eligibility, he/she will also be advised of the individual budget amount determined by the LTC FS that is available should he or she select IRIS. This occurs at the Aging and Disability Resource Center (ADRC). Individuals will be aware of the amount of the budget before they make their selection of either IRIS or Family Care. The IRIS Consultant confirms this amount as part of the individual support and service plan development process.

The participant may request a one-time expense adjustment to their budget for one time purchases. This is a temporary adjustment specific to the needed item or service.

If a participant has additional needs that will require modification budget amendment, or if the individual budget does not appear adequate to meet the participant's assessed needs, the IRIS Consultant will work with the participant to submit a request for a budget amendment. A Budget Amendment, on a short-term basis, is also available when temporary residential care is needed or for ongoing residential care in certain situations.

The SMA retains authority over all Budget Amendment and One-Time Expense requests. The Bureau of Long Term Support has developed a review group of DHS employees from the IRIS section and the Legacy Waiver section to review both IRIS requests and requests from the COP/CIP Waivers. This was designed to ensure consistency in decision-making across programs. When the SMA (DHS) receives a request for budget amendment or funding for a one-time expense, a decision is made within 14 days of receipt of request. If the request is denied, the participant receives a letter explaining the decision and offering the option of an Independent Review. The participant is given ten days to request an Independent Review. If the participant requests an Independent Review and the request is again denied, a notice of action that includes information about the Fair Hearing process and how to file. The person is given 45 days in which to file a Fair Hearing Request and if the person files within ten days of the Notice of Action, any reduction to budget or services is pended until the outcome of the hearing is complete. If the participant does not respond to the offer of an Independent Review, a notice of action that includes information about the Fair Hearing process and how to file an appeal is mailed out after ten days.

Beginning March 1, 2014, each IRIS Consultant Agency began collecting data regarding budget amendments and one-time expenses.

The ADRC informs participants of their individual budgets amounts prior to referral and enrollment to the IRIS Program. Thereafter, budget information is conveyed by the ICAs, including any annual revisions. If the individual participant believes the budget is insufficient, the participant's selected ICA does not need to agree in order for the Budget Amendment request to be submitted to DHS, but does need to ensure that it meets the criteria. DHS typically reviews Budget Amendment requests within a two week timeframe. DHS is able to handle emergency budget amendment requests, including those for short-term residential services, on an immediate, "presumptive approval" process. If the increase is later determined unable to be approved, then the participant is afforded Fair Hearing Rights and the budget is reduced. All budget amendments are tracked in a DHS SharePoint site and reflected on the person's approved service plan. This information is communicated to the Fiscal/Employer Agent and/or Third Party Administrator via receipt of the updated plan or the centralized data system so that services are paid according to the updated plan.

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:

Any changes made to a participant's plan, the participant must notify their chosen IRIS Consultant Agency either through the IRIS Consultant or by contacting the IRIS Consultant Agency directly. Any changes require the participant's plan to be updated and entered into the centralized IT system so that the TPA and F/EAs can render payments accordingly.

IRIS waiver participants are permitted to modify individual support and service plans within their individual budgets without prior approval under certain conditions. The centralized IT system will have a participant-facing portal that will allow participants who choose to do so the ability to make these changes independently in the system. Parameters to ensure all services and supports on the plan remain within the approved budget amount will be built into the system through business rules during the configuration of the system. The centralized IT system will not allow a plan to be "approved" in the system when the total amount of the plan exceeds the approved budget amount. Conditions that do not need prior approval may include situations in which the person:
-identifies a need to increase or decrease the amount of services currently received on their plan without exceeding the budget;
-terminates a provider;
-adds a provider (individual or agency) that is currently established in the centralized IT system;

-removes a service currently being received; or
-shift resources between supports and services on the plan

Approval of the plan is required when the person wants to
--add a new service or,
--make a substantial change to services being received such as moving to a different residential setting
--adding a new provider that is not yet established in the centralized IT system, or
-make a one-time purchase that would exceed the allocation amount.

In these situations, the ICAs would conduct a review of changes similar to the initial plan review process. This is to ensure that changes are in accordance with service standards/requirements, within the person's budget, and assure that assessed needs are addressed and that health and safety assurances are maintained.

The participant will receive confirmation that requested plan amendments were either approved or denied. A written notice of action with Fair Hearing notification is sent to the participant in the event of a partial approval or denial of the requested support or service. Standard timelines for notification apply in this process; the ICAs must make a decision to approve or deny the participant's plan amendment within five business days of plan submission. A notice of action must be sent within 24 hours of decision.

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 IRIS Consultant Agencies track and monitor expenditures to ensure that IRIS waiver participants do not overspend or deplete their individually allocated budgets prematurely or under spend. A monthly report is produced that identifies individual IRIS participants who have gone over or under budget which is provided to the IRIS Consultant Agencies and the DHS IRIS staff for review each month. IRIS participants and/or their designated representative also receive a monthly report informing them of their previous month's expenditures and remaining budget for the year so they are aware of the status of their budget on a regular basis. A real-time view of service utilization and budget will be available to participants via the centralized IT system. If concerns or trends are identified by the ICAs or DHS IRIS staff, the IRIS consultant contacts the IRIS participant or designated representative to determine the reasons for the discrepancy and provide assistance as needed. In addition, cases with significant overspending issues are tracked in a SharePoint site and/or module in the centralized IT system.

If the IRIS participant experiences a change in needs (increase or decrease) the ICAs conduct a change in condition screen using the Long Term Care Functional Screen and notify the Department. The Department then determines, based on the individual's situation, if the individual budget would be affected. In addition, if the person requests an increase in their individual budget, the participant would follow the process for a budget amendment or one-time expense as described in Appendix E-2.b.iii. If changes are made to the individual budget, this would be reflected in an updated Individual Service and Support Plan.

The IRIS Consultant (IC) must contact the participant related to both significant under and overspending. Since some costs are incurred intermittently, it is possible that overspending is consistent with the participant's approved plan. However, the IC follows up to assure that overspending does not represent mismanagement of the participant's individual budget. The IC also follows up related to underspending to ensure participant health and safety and to determine if there are issues to be resolved to ensure receipt of waiver services.

Change in condition LTC FS are to be completed within 30 days of the identified change. A participant may also request this type of reevaluation at any time.

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.

At the time of orientation and on an annual basis, the participant receives information and education regarding the appeals and grievances processes using the document, "Participant Education: Appeals and Grievances". In addition, when a Notice of Action describing the action taken and providing an explanation, additional information is sent to the participant explaining their rights and the process with regard to filing an appeal, including their opportunity to indicate on the Request for a State Fair Hearing their desire to continue their services while their appeal is under consideration. When a participant elects to continue their services and the state receives the participant's request on or before the effective date of the intended action, the services are continued automatically. When the request is not received on or before the effective date of the intended action, the participant receives written notification that their services will not be continued.

Participants are informed of the right to request a fair hearing from multiple sources. The Aging and Disability Resource Center (ADRC) informs potential enrollees of their right to the fair hearing process prior to enrollment or if an enrolled IRIS participants contacts the ADRC regarding an applicable concern. ADRCs provide a brochure to all enrollees that contain this information. The county economic support unit determines financial eligibility for Medicaid and all managed long-term care programs and processes enrollments. These agencies use standardized eligibility notification forms that include information about the right to a fair hearing.

In the event a participant's request for services are denied, suspended, reduced, or terminated, the participant's IRIS Consultant Agency provides a written notice of action with an explanation of the reason for the denial. This notice is sent within 24 hours or next business day in which a decision is made. The notice of action also includes information about their right to request a Fair Hearing, how to appeal, and appeal timeframes. In this notice the person is informed that if want to keep services in place until a decision in rendered through the Fair Hearing process, they must file their appeal within 10 days of receipt of notice. Otherwise, the timeline is 45 days to file an appeal. The IRIS participant can obtain assistance with making the request from their chosen IRIS Consultant Agency, the ADRC, the Ombudsman Program, or other person that the participant chooses.

The participant is informed of this right, in writing, within the Medicaid Fair Hearing Notification. The ICAs send this notification per the policies and procedures established by DHS. The DHS receives a copy of the notice and both DHS and the ICA maintain a record of this correspondence.

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.

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 Department of Health Services is the State Agency responsible for the operation of the grievance or complaint system. Initial resolution is delegated to the IRIS Consultant Agencies and the Fiscal/Employer Agents. If these agencies are unable to resolve an issue, or the participant chooses to contact DHS directly, then DHS takes on management of the grievance or complaint through the use of a contracted agency (MetaStar).

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).

At the time of orientation and on an annual basis, the participant receives information and education regarding the appeals and grievances processes using the document, "Participant Education: Appeals and Grievances". These documents explain the complaint and grievance processes through the ICAs, F/EAs, and MetaStar. These documents also explain the state fair hearing process and ombudsman program options. The IRIS Consultants are required to meet face-to-face with the participants and explain the material in the education sheets. Additionally, these participant education sheets are available to the participants at any time on the IRIS website: http://www.dhs.wisconsin.gov/bdds/iris.

The IRIS Consultant Agencies (ICAs) have staff who are assigned to addressing IRIS participants' concerns and grievances. Participants are notified by their chosen IRIS Consultant Agencies of these options. The ICAs also receive, respond to and track grievances and complaints from participants and providers related to IRIS, and responds to the complaint or grievance within a reasonable time period. The tracking system includes the outcome or resolution that occurs. Data on complaints and grievances is reviewed as part of contract monitoring and oversight. The ICAs, F/EAs, and the agency contracted to resolve participant issues on DHS' behalf engage DHS IRIS program management and quality staff, if needed, to resolve an issue.

The Fiscal/Employer Agents (F/EAs) also has an established system for to receive, respond to and track grievances or complaints from participants and providers related to the role of the F/EAs, and responds to the complaint or grievance within a reasonable time period. This includes data on the outcome of the issue. Data on complaints or grievances is reviewed as part of contract monitoring and oversight. The F/EAs engage DHS IRIS program management and quality staff, if needed, to resolve an issue.

If a participant is not able to resolve their complaint/grievance through their ICA's or F/EA's complaint or grievance process, he or she may contact the State Medicaid Agency via a toll free hotline number and/or email address to seek resolution. Additionally, the participant may contact DHS IRIS program management and quality staff at any time to report concerns or issues. DHS staff and/or a contracted agency (MetaStar) work with the participant in an attempt to negotiate an informal resolution that is mutually agreeable to the participant and the ICA or F/EAs. However, the State Medicaid agency may take contract enforcement actions through performance adjustments based on facts discovered during the information gathering part of the process. This process builds on existing quality management processes already in place and functions that DHS staff already perform in investigating complaints and working to resolve issues at the participant and systemic levels.

Any of the grievance and appeal rights available to participants, including fair hearing, may be exercised at any time. While participants are encouraged to use informal procedures as a first attempt to resolve their concerns, the use of one procedure is not required, nor does it limit the opportunity to use any other procedure. In addition, participants may to choose more than one avenue to resolve their issue simultaneously.

The ICAs, F/EAs, MetaStar and DHS strive to respond to complaints within 48 hours of receiving a report. Formal grievances may take up to one month to ensure a thorough investigation and establish appropriate resolution. If health or safety is at risk, each agency takes immediate action.

The participant may also contact the Ombudsmen Program directly at any time.

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).

A critical incident is an event or situation that poses an immediate and/or serious risk to the physical or mental health, safety, or well-being of a waiver participant. A critical incident may also involve the misappropriation of a waiver participant's property or a violation of the person's rights. Critical incidents include such events or situations as:

- Any abuse (mental/emotional, physical, sexual, verbal) or neglect allegations and findings;
- An event or significant behavior that causes a serious injury or risk of harm;
- Death of the participant;
- Errors in medical or medication management that result in a significant adverse reaction that requires medical attention;
- Serious illness, hospitalization (emergency medical treatment, mental or behavioral health) injury, accident; suicide attempt;
- Investigation by law enforcement of an event or allegation of possible criminal activity or victim of crime;
- Damage to a participant's residence due to fire, natural disaster or other cause; or
- Misappropriation of a person's funds and/or property; loss in value of the personal or real property of a participant due to theft, damage or exploitation.

In addition, the unauthorized use of restraint or seclusion is a reportable event.

The ADRCs, IRIS Consultant Agencies, Fiscal/Employer Agents and providers must report Critical Incident Reports as part of their reporting to the Department of Health Services. Critical incidents alleging abuse, material abuse, neglect, or self-neglect are also referred to the county or tribal Adult Protective Services system for review and investigation when indicated as provided by Wisconsin's Adults at Risk statutes. Whenever an employee of an IRIS Consultant Agency, a Fiscal/Employer Agent, an ADRC or any of the employees or providers with whom the IRIS waiver participant contracts believes that abuse, material abuse, neglect or self-neglect of an adult age 18 - 64 years or an elder person 65 years of age or older has occurred, the employee or provider makes a report to the agency designated under s. 46.90 Wisconsin Statutes. Reports of a critical incident must be made to the State and an investigation initiated immediately by the appropriate agency. Contractor agencies (ADRC, ICAs, and F/EAs), employees, providers, legal representatives and others are required to report critical incidents to DHS using the Critical Incident Reporting (CIR) form. Participants may report a Critical Incident as well, either by use of this form or by calling their IRIS Consultant or their chosen IRIS Consultant Agency's 24/7 after hours number. The ICAs provide instruction and guidance to IRIS waiver participants and providers in recognizing and reporting critical events.

The IRIS Consultant Agencies, Fiscal/Employer Agents, ADRCs, and/or the contracted providers are subject to certification, licensing, contractual, statutory or regulatory requirements for reporting of critical incidents, including requirements to report and investigate deaths or abuse and neglect of residents of certain facilities (e.g., s.50.034 or s. 50.04 Wisconsin Statutes, or chapters HFS 12, 13, 83 and 88 Wisconsin Administrative Code). These agencies are required to report critical incidents to the DHS IRIS quality staff using the CIR form.

The participant's chosen ICA or other authorized entity conducts an immediate investigation to assess the health, safety and well-being of waiver participants who are the subject of critical incidents. If there is evidence of immediate risk to the health, safety or well-being of a waiver participant, the ICA, Adult Protective Services agency and law enforcement agency as applicable, or any other agency or provider must take all reasonable steps to protect the person.

A preliminary report with further details and disposition of the CIR is due within seven days to the DHS IRIS quality management staff. If all aspects of the report are not resolved by this point, a final report is due to the IRIS staff within 30 days. A SharePoint site is used to record this information including steps taken to ensure the immediate and ongoing health and welfare of the participant. In addition, aggregate data can be collected from this site to inform quality improvement projects that address system-level issues.

The Division of Quality Assurance in DHS is consulted as needed to determine if a regulated setting has cause for a violation citation to be issues, or to offer technical assistance as appropriate. Critical incidents may be events or situations that may need to be reported to the State DQA for investigation by the Caregiver Quality Unit and to DQA staff responsible for monitoring assisted living and other facilities/providers that it regulates.

Local law enforcement may also be involved with critical incidents in situations of a death or possible commission of a crime. When multiple agencies are responsible for investigating, coordination occurs among agencies with the lead agency, such as law enforcement agency if commission of a crime may be involved, taking the lead in the investigation.

In addition, any concerned individual can report suspected abuse or neglect directly to a local Adult Protective Services (APS) agency or law enforcement. Those individuals whose employment brings them into contact with vulnerable adults are mandated reporters and are required to report any suspected abuse or neglect or threatened abuse or neglect seen in the course of their professional duties.

DHS IRIS quality management staff review all critical incidents as part of the IRIS Waiver Quality Improvement Strategy. Reports are reviewed and tracked in a SharePoint site to assess for trends, identify potentially preventable incidents, and determine if system level improvements are required. This SharePoint site allows for the exchange of information when the Department feels that more action or information is required to ensure the immediate and/or ongoing welfare of the participant.

All waiver service providers, as well as the ICAs and Fiscal/Employer Agents are mandated reporters.

The ICAs are responsible for investigations. In the event a referral is made to APS by ICA staff, the ICA and APS staff will communicate findings to one another in order to fulfill respective reporting requirements and ensure that appropriate steps are taken to address the issue when warranted (i.e. alleged abuse/neglect/misappropriation of funds etc. is substantiated.) If a referral is made to APS by another individual (not an ICA staff person), then the APS staff person will contact the participant's chosen ICA to inform them of the referral, coordinate follow up action as needed and appropriate to the situation, and share results of investigations.

The completed incident report is submitted to DHS within 7 days of the incident being reported to the participant's chosen IRIS Consultant Agency. The IRIS Consultant Agencies are required to notify DHS of all high-profile incidents within 24 hours of receiving notification of the incident. DHS monitors all incidents with the ICAs and determines if adequate follow through has occurred based upon the nature of the incident. The unauthorized use of seclusion, restraint or restrictive procedures is all reportable incidents.

The ICAs and F/EAs are in contact with one another if an incident investigation involves both agencies.

The ICAs have sufficient authority to address participant health and safety. DHS is also immediately informed and assures that proper steps are taken to ensure health and safety.

DHS requires the use of the following incident reporting form: http://www.dhs.wisconsin.gov/forms1/F2/f22541.pdf

Detailed instructions and specifications related to this form are found at this link:
http://www.dhs.wisconsin.gov/forms1/F2/f22541i.pdf

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.

As part of the Department-approved training provided by the IRIS Consultant Agencies to the participant, information will be provided on protections from abuse, neglect and exploitation, and how to report incidents that may occur. Information is also provided and available through the ADRC. One condition of participation of each person in the SDS Waiver, and of provider agreements, will be the commitment to report each critical incident to their chosen IRIS Consultant Agency.

Participants are notified of their right to be free from abuse, neglect and exploitation through the participant rights and responsibilities document. This is provided upon enrollment and at least annually thereafter. DHS is also developing a brochure that provides this information in an additional and user friendly format.

PARTICIPANT RIGHTS AND RESPONSIBILITIES - Excerpt
D. Other rights
You have a number of rights specified in Wisconsin law. These rights include but are not limited to:
1. You have a right to be treated with dignity and respect. This includes the right to free association to see whom you want, when you want unless a court order states otherwise.
2. You have a right to control your life and the services you get as much as you are able. You have the right to choose where you live, if you live alone or with others and with whom you will live. You have the right to be told that if you choose to live in certain settings, you may lose your eligibility for funding under the Medicaid Waiver.
3. You have a right not to be hurt or threatened. You have the right to be free from abuse and neglect. You have a right to be free from restrictive measures and all unreasonable restraints. You have the right to refuse to take drugs you do not want to take unless ordered to do so by a court of law. You have the right to report any incident that violates this right.
4. You have the right to privacy. Your right to privacy includes having information that is said or written about you kept confidential, the right to receive and open your own mail, to make and receive private phone calls and to have visitors in your private areas including your bedroom and have the door closed.
5. You have a right to see your file, have it corrected, and to get copies of reports in it.
6. You have the right to direct you own services within the rules of the waiver in which you are enrolled. You have the right to have the self-directed service option explained to you and made available.
7. You have the right to know what other rights apply to you. You may have rights because of where you live (e.g. in a group home (CBRF)), because a court was involved in your services, or because of the nature of your disability. Your chosen IRIS Consultant Agency is responsible for telling you about these rights and for making sure you are adequately informed about them

Where you can get help:
1. Older adults or persons with physical disabilities may contact:
Board on Aging and Long Term Care (On line at: BOALTC@ltc.state.wi.us)
Ombudsman Program
1402 Pankratz Street, Suite 111
Madison, Wisconsin 53704-4001
1-800-815-0015
The Regional Ombudsman Locator is on line at:

http://longtermcare.state.wi.us/home/ombudsman%20county%20served.htm

2. Persons with developmental disabilities or mental illness may contact:
Disability Rights Wisconsin
Located on line at: www.disabilityrightswi.org

Madison Office
131 West Wilson St, Suite 700
Madison, WI 53703
Phone: (608) 267-0214
Fax: (608) 267-0368
TTY (888) 758-6049
Toll Free: (800) 928-8778

Milwaukee Office
6737 West Washington St. Suite 3230
Milwaukee, Wisconsin 53214
Phone: (414) 773-4646
Fax: (414) 773-4647
TTY: (888) 758-6049
Toll Free: (800) 708-3034

Rice Lake Office
217 W. Knapp St.
Rice Lake, WI 54868
Phone (715) 736-1232
Fax: (715) 736-1252
TTY: 888-758-6049
Toll Free: (877) 338-3724

_____ _____
Signature - Participant/guardian* Signature □ IRIS Consultant

Date _____ Date _____

* My signature indicates that I have been informed of and understand my rights and responsibilities under the Medicaid waiver programs. I have received this information verbally and in writing.

Participants are also given resources to call within the Participant Handbook: IRIS Participant Handbook - http://www.wisconsin-iris.com/docs/iris_handbook_F_0810.pdf was also added: Staying Healthy and Safe
You can keep some important phone numbers in the chart on page 2 of this handbook. If you have concerns about your safety or are not sure who to contact, call the IRIS Service Center at 1-888-515-4747.
If you or someone you know is being abused or neglected, call your local Law Enforcement or your County Adult Protective Services office to make a report.

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.

DHS, the ICAs and the F/EAs share the responsibility, through different roles, in reviewing critical incidents. The State provides statewide policy and oversight. The IRIS Consultant Agencies and Fiscal/Employer Agents have procedures to ensure compliance within their areas of responsibilities and the providers that the participant contracts with as part of the Individual Support and Service Plan. Local Adult Protective Services units play a role with their responsibilities under Adults-at-Risk statutory requirements.

Specifically, the IRIS Consultant Agencies:
□ Provide Department-approved training for staff on critical incidents and reporting but may request State assistance as needed. All new hires will be trained.
□ Provide training for waiver participants on recognizing and reporting critical incidents and secure participant agreement to report critical incidents.
□ Receive reports from the participant and his/her family members and also from service providers regarding critical incidents;
□ Assure that action is taken to protect the immediate and ongoing health, safety and well-being of the participant, following up as appropriate.
□ Document incidents in a DHS prescribed format (CIR) according to established timelines;
□ Inform DHS of the incident according to pre-established timelines;
□ Oversee the referral to appropriate entities (APS, Law Enforcement, DQA, Caregivers Registry, etc.);
□ Monitor to ensure that appropriate review/assessment and fact finding occurs; and
□ Ensure that effective remediation efforts occur including steps necessary to ensure that the incident will not recur.

Identify secondary discovery strategies to be employed;
□ Submit the Critical Incident Report (CIR) to the State summarizing the data about the incident, the findings of the review/assessment and the action taken.
□ Enter incident information into SharePoint/ISITS module
• Respond to requests from the Department for additional action/information to ensure the immediate and ongoing health and

welfare of the participant.

Participants and/or legal guardian/decision-maker are notified of the incident report within 3 days of report being made if they are not the ones to make report. The results of the incident review/assessment are shared with the participant and/or legal guardian/decision-maker upon completion of incident review/assessment. The incident review/assessment may not exceed 30 days from the date of notification of the IRIS Consultant that the incident has occurred. Investigative activities to be conducted by the participant's chosen ICA include fact-finding about the incident, ensuring the participant's immediate health and welfare, and ensuring the participant's ongoing health and welfare. For participants who are in the hospital or rehabilitation facility for a period of time anticipated to surpass thirty days, the ICA is required to document their plans of how they intend to ensure the participant's health and welfare upon discharge. Exclusions to the 30-day rule include obtaining information from outside agencies – i.e. coroner, APS, law enforcement, etc. – over which the ICA has no control. This information is required to be submitted to DHS immediately when it is received after the 30 day deadline.

ICA staff send the completed CIR form within seven days of the incident. Additional information, if necessary is due within 30 days. If ICA staff are unable to gain access to certain findings or records within the 30-day period due to concurrent incident reviews/assessments or other extenuating circumstances beyond their control, the ICA submits all available information with a notation that the report is not complete. ICA staff indicate the expected timeline for the remainder of the reportable information. The Department is responsible for"closing" all critical incident reports once there is sufficient documentation that the participant's immediate and ongoing health and welfare have been ensured. Closing means submitting a report and any necessary updates so that all pertinent information about the event and the response are included in the SharePoint record regarding the incident. Follow-up visits or future targeted reviews are usually not part of the report unless they occur within a short time frame though the expectation that if these activities are appropriate, they will be scheduled and this information will be included in the report to demonstrate intent. The Department implemented in April 2014 a secondary review process to examine a portion of the incident reports each month to ensure that planned follow up has occurred as reported in the initial incident report.

The Fiscal/Employer Agents also must receive notices of critical incidents and be responsible for assisting with the investigation and reporting of critical incidents in collaboration with the ICAs on incidents relating to the F/EAs functions. The F/EAs must meet all described requirements of the Critical Incident Reporting System noted above. The ICAs and F/EAs must complete all other required reporting procedures and meet the timelines of other required reports. These remain in force and are not replaced or superseded by this process.

The IRIS Consultant Agencies are responsible for the review and assessment of critical incidents. Incidents involving abuse or neglect are investigated by Adult Protective Services. Incidents in which the participant has been the victim or perpetrator of a crime are investigated by law enforcement. In all cases, the IRIS Consultant Agencies are responsible for ensuring the immediate and ongoing health and welfare of the participants. In all cases this is done through the review and assessment process following a reportable critical incident. Review and assessment activities include the following:

- Collecting pertinent information regarding the incident including what happened, when it happened, to whom it happened, how it happened, and why it happened.
- Reporting incidents that involve abuse, neglect, etc. to Adult Protective Services for investigation and following up with the APS agency to find out investigation results and next steps.
- Reporting incidents in which the participant was the victim or perpetrator in the commission of a crime to law enforcement for investigation and following up with the law enforcement agency to find out investigation results and next steps.
- Helping the participant and/or legal representative Identify and implement steps to ensure the participant's immediate and ongoing health and welfare.
- Submitting the incident report to DHS via the IRIS Consultant Agency's assigned Incident Reporting SharePoint site in accordance with DHS policy and work instructions.
- Reviewing the participant's plan with the participant and determining whether or not any changes are necessary to complete the activities identified to ensure the participant's immediate and ongoing health and welfare.
- Monitoring the participant to ensure that steps identified to mitigate risk to the participant's immediate and ongoing health and welfare are being carried out.

The IRIS Consultant Agencies have additional responsibilities with regard to Critical Incident Reporting and prevention including the following:

- Reviewing data generated by the ICA's assigned Critical Incident SharePoint site on a monthly, quarterly, and annual basis to identify prevention strategies.
- Participate in monthly Critical Incident Reporting / Mortality Review Committee meetings. Each meeting contains the following activities:
- Reviewing each participant death;
- Reviewing each case of abuse and neglect;
- Reviewing monthly critical incident SharePoint data;
- Discussing any questions or issues regarding the process or policy;
- Discussing opportunities for prevention strategies.

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 the Critical Incidents Response process. As indicated in Appendix H, oversight of critical incidents and events is part of the Quality Management Strategy. As with all components of the Quality Management Strategy, DHS identifies trends. Quality assurance and quality improvement action plans are developed as needed, based on prioritized trends. DHS is responsible for implementing and evaluating the effectiveness of quality assurance and quality improvement plans. Meetings about the Quality Management Strategy occur quarterly, or more often if necessary.

The State IRIS Quality Assurance staff review all Critical Incident Reports. This review is intended to determine:
 That the health, safety and well-being of the participant are adequately protected;
 That the response to the situation and events was reasonable and appropriate;
 That the participant's chosen ICA's and/or F/EA's procedures and system for responding to such incidents were adequate;
 That the service plan is adequate;
 That relevant steps to prevent similar incidents were developed;
 That all service providers or staff involved in the incident are adequately trained or that additional training as needed will be provided; and
 If a follow-up response is needed which may include informal follow-up, site visit, formal plan of correction or a licensing referral.

Adult Protective Services, including reporting, investigation and case management, are delivered in Wisconsin through a state-supervised, county administered system. Allegations are reported to local agencies in the state. Data regarding each report investigated is sent to and compiled by the Adults At Risk Reporting System to assist State policy makers, service providers and the public. The data compiled through the Adults at Risk Reporting system are aggregated statewide and includes information from all reports entered into the system; this report does not uniquely identify IRIS or other program participants or general public.

Adult Protective Services is responsible for responding to and investigating the abuse, neglect, and financial misappropriation of Elders at Risk and Adults at Risk. Adult at Risk, as defined in Wis. Stat. § 55.043(1e), means any adult who has a physical or mental condition that substantially impairs his or her ability to care for his or her needs and who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self-neglect, or financial exploitation. Elder Adult at Risk, as defined in Wis. Stat. § 46.90(br), means any person age 60 or older who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self-neglect, or financial exploitation.
The following publication was developed to assist IRIS Consultants navigate the Adult Protective Services system and processes: http://www.dhs.wisconsin.gov/publications/p0/p00328.pdf

Adult Protective Services is required to report to DHS the findings of the investigation and frequently the APS worker will collaborate with DHS and the participant's ICA to mutually establish steps to ensure the participant's immediate and ongoing health and welfare. In April 2014, a field was added to each Critical Incident SharePoint site that captures whether or not the incident was reported to APS. The DHS Quality Assurance Specialists follows up with APS at the county or state level to attempt to obtain the outcome. This information is also captured in that participant's ICA's Critical Incident SharePoint site. Data can be collected to reflect the APS investigation outcomes. In addition, based on the information received from APS, the DHS Quality Assurance Specialist can communicate the need for additional work to the participant's ICA to ensure the participant's immediate and ongoing health and welfare.

DHS reviews the results of the particpant's chosen IRIS Consultant Agency's incident review/assesment. DHS follows up with the participant's chosen IRIS Consultant Agency as necessary to ensure that participant health and safety is maintained. DHS has the authority to direct the contracted agencies to take further action and DHS has the ability to engage in direct incident review/assessment until a satisfactory outcome is achieved. Direction for additional information or action takes place through the use of SharePoint to adequately document the request and subsequent response. DHS also has the authority to require a corrective action plan related to contracted agencies performance or their duties related to critical incidents.

DHS has performance measures to demonstrate QA activities related to critical incidents.

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).

The Department of Health Services (DHS), which is the SMA, allows for the use of restraint, isolation and seclusion in very limited situations. Wisconsin Administrative Code HFS 94.10 states: "Isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s.51.61 (1) (i) 2, Stats. For a community placement, the use of isolation, seclusion or physical restraint shall be specifically approved by the Department on a case-by-case basis. In granting approval, a determination shall be made that use of restrictive measures is necessary for continued community placement of the individual and that supports and safeguards necessary for the individual's health, safety and welfare are in place. The Department is the entity responsible for informing providers about this process.

The use of restraint, isolation or seclusion is prohibited unless DHS has approved in advance in writing, except as an emergency response to a crisis situation. The use of such restrictive measures in a crisis situation must be reported to the participant's chosen ICA immediately by either the person/guardian or the involved provider. The participant's chosen IRIS Consultant Agency then files a report with DHS within 48 hours. The participant's chosen ICA is responsible to submit a written plan within seven days to avoid such crises and any emergency need for restrictive measures in the future.

Medications to manage behavior (chemical restraints) may be used only in licensed nursing facilities when required to treat the resident's medical symptoms. All such plans will be under the direct supervision of the attending physician. The Department's Division of Quality Assurance monitors use of such restraints in accordance with State statutes and rules governing those facilities.

For restraints to be used as part of a treatment plan that is non-emergency in nature, the participant or a provider must request DHS approval through the participant's chosen ICA. If the participant's chosen ICA agrees that there may be a need for the use of restraint, isolation or seclusion, the consultant must forward the request to the DHS. The Department will approve the use of restraint, isolation or seclusion only if sufficient behavioral supports to eliminate dangerous/challenging behaviors have been attempted. The request must be part of a written behavior intervention plan developed by a behavior specialist. Requests are reviewed by staff in the DHS Bureau of Long Term Support and will be denied if alternative measures appear to be available. Approvals are granted only for specific situations and for a minimal time period. The IRIS consultant is required to have regular in-person contact with the participant to monitor for health, safety and welfare on an ongoing basis.

DHS has established the following definitions for restraint, seclusion and isolation:
"Restraint" is any device, garment or physical hold that restricts the voluntary movement of a person's body or access to any part of the body and cannot be easily removed by the individual. Types of restraint include:
 Manual restraint
 Holding limbs or body contingent upon behavior
 Restricting or preventing movement
 Cannot exceed 15 continuous minutes
 Mechanical restraint
 A device applied to any part of a person's body
 Contingent upon behavior
 Restricts or prevents movement or normal use/functioning of the body part
 Cannot be easily removed by the individual

"Isolation and Seclusion" is any non-voluntary physical or social separation from others by actions of another.

The DHS requires that all applications be completed using the "Request for Use of Restraints, Isolation, or Protective Equipment as Part of a Behavior Support Plan". All application approvals are time limited and never exceed one year.
A Request for Use of Restraint, Isolation or Seclusion includes:
 The participant's name and living situation
 Personal summary of the participant (strengths and needs)
 Health considerations
 Prescribed medications
 Detailed description of the significant challenging behavior
 Previous intensive behavior supports tried, including outcomes
 Current positive behavior supports used (include behavioral support plan)
 A response to the question: why is restraint, isolation or seclusion needed?
 A detailed description of the restraint, isolation or seclusion approach being requested
 A plan for monitoring, documenting and review of the progress
 Plan for training parents/family/providers
 Names and relationship of the participant's community behavioral support team

- Physician signature
- Signatures of parent, or legal representative, and team members reviewing the plan

The DHS/Bureau of Long Term Support reviews each application to assure the least restrictive approach is being used for the participant. The goal of the behavioral support plan is to address significant challenging behaviors effectively by recommending positive practices and using a community behavioral support team to provide intensive behavioral supports to avoid the use of restraint, isolation or seclusion. The expectation is that the use of restraint, isolation or seclusion is reduced or eliminated by implementing more positive behavioral supports.

DHS will review the restrictive measures application and inform the participant and/or legal representative of the approval status within fifteen working days of the receipt of the application unless other arrangements are made. Complex cases may require additional time.

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:

The State Medicaid Agency is responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning the use of these measures are followed. The State considers the use of unauthorized or unapproved restraints or seclusion a reportable incident. In the event a report is made concerning the use of unauthorized or unapproved restraints or seclusion, the DHS IRIS Quality Staff will monitor these events for any trends through the critical incident reporting system. If trends are identified, the Department will take appropriate action.

When use of restrictive measures is approved by DHS, monthly submission by the provider of a report to the chosen IRIS Consultant Agency, evaluating the results of the use of the approved restrictive measure(s) and the status of the participant is required. The report must include results of the review and monitoring of:
• The specific use of the restraint, isolation or protective equipment and an assessment of the effectiveness of the item being used;
• The condition of any equipment to ensure the equipment is in good working order;
• The continued availability of trained staff to implement the behavior intervention plan;
• Information from direct support staff concerning the person's response to the behavior intervention plan;
• The need for modifications to the behavior intervention plan; and
• Progress on the plan to reduce/eliminate the use of restraint, isolation, or protective equipment.

There are two indicators on the Record Review that are pertinent in monitoring the authorized use of restrictive measures. One indicator monitors to ensure that the Wisconsin Restrictive Measures Protocol is followed. The second indicator measures whether or not all reportable incidents have been reported. Unauthorized use of restrictive measures is a reportable incident.

Record Reviews are completed through a manual review of the participants' electronic records identified in the random sample. The centralized IT system is the primary source of data for the record review information. The record reviews are completed by the DHS IRIS Quality Management Specialists on a quarterly basis. To communicate the findings to the ICAs, the reviewers enter the results into the Record Review SharePoint sites specific to the reviewed participants' chosen IRIS Consultant Agencies. In addition to the findings of the record review, these Record Review SharePoint sites communicate the reasons for negative findings as well as the required remediation activities to the ICAs. The sites also allow the DHS reviewer document confirmation of the remediation activities completed by the ICAs. The data reporting capabilities of these Record Review SharePoint sites allow for sophisticated individual and aggregate reporting on the findings of the record review, the reasons for any negative findings, and the prescription and completion of remediation activities by the ICAs. All negative findings are remediated by the participant's IRIS Consultant Agency.

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.

The Department of Health Services (DHS), which is the SMA, allows for the use of restraint, isolation and seclusion in very limited situations. Wisconsin Administrative Code HFS 94.10 states: "Isolation, seclusion or physical restraint may be used only in an emergency, when part of a treatment program or as provided in s.51.61 (1) (i) 2, Stats. For a community placement, the use of isolation, seclusion or physical restraint shall be specifically approved by the Department on a case-by-case basis. In granting approval, a determination shall be made that use of restrictive measures is necessary for continued community placement of the individual and that supports and safeguards necessary for the individual's health, safety and welfare are in place. The Department is the entity responsible for informing providers about this process.

The use of restraint, isolation or seclusion is prohibited unless DHS has approved in advance in writing, except as an emergency response to a crisis situation. The use of such restrictive measures in a crisis situation must be reported to the participant's chosen ICA immediately by either the person/guardian or the involved provider. The participant's chosen IRIS Consultant Agency then files a report with DHS within 48 hours. The participant's chosen ICA is responsible to submit a written plan within seven days to avoid such crises and any emergency need for restrictive measures in the future.

Medications to manage behavior (chemical restraints) may be used only in licensed nursing facilities when required to treat the resident's medical symptoms. All such plans will be under the direct supervision of the attending physician. The Department's Division of Quality Assurance monitors use of such restraints in accordance with State statutes and rules governing those facilities.

For restraints to be used as part of a treatment plan that is non-emergency in nature, the participant or a provider must request DHS approval through the participant's chosen ICA. If the participant's chosen ICA agrees that there may be a need for the use of restraint, isolation or seclusion, the consultant must forward the request to the DHS. The Department will approve the use of restraint, isolation or seclusion only if sufficient behavioral supports to eliminate dangerous/challenging behaviors have been attempted. The request must be part of a written behavior intervention plan developed by a behavior specialist. Requests are reviewed by staff in the DHS Bureau of Long Term Support and will be denied if alternative measures appear to be available. Approvals are granted only for specific situations and for a minimal time period. The IRIS consultant is required to have regular in-person contact with the participant to monitor for health, safety and welfare on an ongoing basis.

DHS has established the following definitions for restraint, seclusion and isolation:
"Restraint" is any device, garment or physical hold that restricts the voluntary movement of a person's body or access to any part of the body and cannot be easily removed by the individual. Types of restraint include:
- Manual restraint
- Holding limbs or body contingent upon behavior
- Restricting or preventing movement
- Cannot exceed 15 continuous minutes
- Mechanical restraint
- A device applied to any part of a person's body
- Contingent upon behavior
- Restricts or prevents movement or normal use/functioning of the body part
- Cannot be easily removed by the individual

"Isolation and Seclusion" is any non-voluntary physical or social separation from others by actions of another.

The DHS requires that all applications be completed using the "Request for Use of Restraints, Isolation, or Protective Equipment as Part of a Behavior Support Plan". All application approvals are time limited and never exceed one year.
A Request for Use of Restraint, Isolation or Seclusion includes:
- The participant's name and living situation
- Personal summary of the participant (strengths and needs)
- Health considerations
- Prescribed medications
- Detailed description of the significant challenging behavior
- Previous intensive behavior supports tried, including outcomes
- Current positive behavior supports used (include behavioral support plan)
- A response to the question: why is restraint, isolation or seclusion needed?
- A detailed description of the restraint, isolation or seclusion approach being requested
- A plan for monitoring, documenting and review of the progress
- Plan for training parents/family/providers

- Names and relationship of the participant's community behavioral support team
- Physician signature
- Signatures of parent, or legal representative, and team members reviewing the plan

The DHS/Bureau of Long Term Support reviews each application to assure the least restrictive approach is being used for the participant. The goal of the behavioral support plan is to address significant challenging behaviors effectively by recommending positive practices and using a community behavioral support team to provide intensive behavioral supports to avoid the use of restraint, isolation or seclusion. The expectation is that the use of restraint, isolation or seclusion is reduced or eliminated by implementing more positive behavioral supports.

DHS will review the restrictive measures application and inform the participant and/or legal representative of the approval status within fifteen working days of the receipt of the application unless other arrangements are made. Complex cases may require additional time.

The State considers the use of unauthorized or unapproved restraints or seclusion a reportable incident. In the event a report is made concerning the use of unauthorized or unapproved restraints or seclusion, the DHS IRIS Quality Staff will monitor these events for any trends through the SharePoint Site and/or incident reporting module in the centralized IT system. If trends are identified, the Department will take appropriate action.

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:

The State Medicaid Agency is responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning the use of these measures are followed. The State considers the use of unauthorized or unapproved restraints or seclusion a reportable incident. In the event a report is made concerning the use of unauthorized or unapproved restraints or seclusion, the DHS IRIS Quality Staff will monitor these events for any trends through the critical incident reporting system. If trends are identified, the Department will take appropriate action.

When use of restrictive measures is approved by DHS, monthly submission by the provider of a report to the chosen IRIS Consultant Agency, evaluating the results of the use of the approved restrictive measure(s) and the status of the participant is required. The report must include results of the review and monitoring of:
• The specific use of the restraint, isolation or protective equipment and an assessment of the effectiveness of the item being used;
• The condition of any equipment to ensure the equipment is in good working order;
• The continued availability of trained staff to implement the behavior intervention plan;
• Information from direct support staff concerning the person's response to the behavior intervention plan;
• The need for modifications to the behavior intervention plan; and
• Progress on the plan to reduce/eliminate the use of restraint, isolation, or protective equipment.

There are two indicators on the Record Review that are pertinent in monitoring the authorized use of restrictive measures. One indicator monitors to ensure that the Wisconsin Restrictive Measures Protocol is followed. The second indicator measures whether or not all reportable incidents have been reported. Unauthorized use of restrictive measures is a reportable incident.

Record Reviews are completed through a manual review of the participants' electronic records identified in the random sample. The centralized IT system is the primary source of data for the record review information. The record reviews are completed by the DHS IRIS Quality Management Specialists on a quarterly basis. To communicate the findings to the ICAs, the reviewers enter the results into the Record Review SharePoint sites specific to the reviewed participants' chosen IRIS Consultant Agencies. In addition to the findings of the record review, these Record Review SharePoint sites communicate the reasons for negative findings as well as the required remediation activities to the ICAs. The sites also allow the DHS reviewer document confirmation of the remediation activities completed by the ICAs. The data reporting capabilities of these Record Review SharePoint sites allow for sophisticated individual and aggregate reporting on the findings of the record review, the reasons for any negative findings, and the prescription and completion of remediation activities by the ICAs. All negative findings are remediated by the participant's IRIS Consultant Agency.

The State considers the use of unauthorized or unapproved restraints or seclusion a reportable incident. In the event a report is made concerning the use of unauthorized or unapproved restraints or seclusion, the DHS IRIS Quality Staff will monitor these events for any trends through the critical incident reporting system. If trends are identified, the Department will take appropriate action.

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).

”Isolation and Seclusion” is any non-voluntary physical or social separation from others by actions of another.

The DHS requires that all applications be completed using the ”Request for Use of Restraints, Isolation, or Protective Equipment as Part of a Behavior Support Plan”. All application approvals are time limited and never exceed one year. A Request for Use of Restraint, Isolation or Seclusion includes:
- The participant’s name and living situation
- Personal summary of the participant (strengths and needs)
- Health considerations
- Prescribed medications
- Detailed description of the significant challenging behavior
- Previous intensive behavior supports tried, including outcomes
- Current positive behavior supports used (include behavioral support plan)
- A response to the question: why is restraint, isolation or seclusion needed?
- A detailed description of the restraint, isolation or seclusion approach being requested
- A plan for monitoring, documenting and review of the progress
- Plan for training parents/family/providers
- Names and relationship of the participant’s community behavioral support team
- Physician signature
- Signatures of parent, or legal representative, and team members reviewing the plan

The DHS/Bureau of Long Term Support reviews each application to assure the least restrictive approach is being used for the participant. The goal of the behavioral support plan is to address significant challenging behaviors effectively by recommending positive practices and using a community behavioral support team to provide intensive behavioral supports to avoid the use of restraint, isolation or seclusion. The expectation is that the use of restraint, isolation or seclusion is reduced or eliminated by implementing more positive behavioral supports.

The State considers the use of unauthorized or unapproved restraints or seclusion a reportable incident. In the event a report is made concerning the use of unauthorized or unapproved restraints or seclusion, the DHS IRIS Quality Staff will monitor these events for any trends through the critical incident reporting system. If trends are identified, the Department will take appropriate action.

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:

The State Medicaid Agency is responsible for overseeing the use of seclusion and ensuring that State safeguards concerning the use of these measures are followed. The State considers the use of unauthorized or unapproved seclusion a reportable incident. In the event a report is made concerning the use of unauthorized or unapproved seclusion, the DHS IRIS Quality Staff will monitor these events for any trends through the Critical Incident Reporting SharePoint site assigned to each agency. If trends are identified, the Department will take appropriate action.

When use of seclusion is approved by DHS, monthly submission by the provider of a report to the participant’s chosen IRIS Consultant Agency, evaluating the results of the use of the approved restrictive measure(s) and the status of the participant is required. The report must include results of the review and monitoring of:
- The continued availability of trained staff to implement the behavior intervention plan;
- Information from direct support staff concerning the person’s response to the behavior intervention plan;
- The need for modifications to the behavior intervention plan; and
- Progress on the plan to reduce/eliminate the use of seclusion.

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.

IRIS participants who are served in licensed or certified living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents such as an adult family home, residential care apartment complex, or community based residential facility, the on-going medication management and follow-up are provided through the provider under the supervision of an appropriately licensed health care professional. The Division of Quality Assurance is the State agency has statutory responsibility to monitor the performance of medication administration and management for licensed/certified facilities. IRIS Consultants are required to report medication errors in compliance with the IRIS program's Critical Incident process to include the use of the agency's assigned Critical Incident SharePoint site. As part of the critical incident reporting process, the IRIS Consultant Agencies are required to submit information describing how the participant's immediate and ongoing health and welfare have been ensured. Using the Critical Incident SharePoint sites assigned to each IRIS Consultant Agency, the Department reviews every reported critical incident. In cases where the information provided does not adequately describe activities that ensure that participant's immediate and ongoing health and welfare, the Department and the ICAs communicate back and forth through the agency's assigned Critical Incident SharePoint site until the negative finding has been remediated. In addition, ten percent of the incident reports are undergo an additional review on a monthly basis to ensure that the case notes reflect that the actions described in the incident report took place as reported. The DQA and IRIS Quality Staff will coordinate efforts or information as needed to resolve or address medication error issues.

Wisconsin's Nurse Practice Act regulates the roles and responsibilities of a nurse in delegating tasks to unlicensed assistive personnel. For participants who are not self-directing their medication management and a nurse is involved, Wisconsin's Nurse Practice Act allows non-nursing staff to administer medications only under the supervision of a registered nurse. Staff administering medications must receive training specific to the participant related to administration of the medication. This training may be provided by a registered nurse employed by the provider. The nurse is responsible to assure that the staff who will be providing the dispensing services are appropriately and specifically trained in dispensing each specific medication to each participant. Each medication administered is documented at the time of dispensing with any errors documented. Supervision of delegated nursing services such as medication administration and medication management is provided consistent with the standards contained in the Wisconsin Nurse Practice Act.

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.

IRIS participants who are served in licensed or certified living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents such as an adult family home, residential care apartment complex, or community based residential facility, the on-going medication management and follow-up are provided through the provider under the supervision of an appropriately licensed health care professional. The Division of Quality Assurance is the State agency has statutory responsibility to monitor the performance of medication administration and management for licensed/certified facilities. IRIS Consultants are required to report medication errors in compliance with the IRIS program's Critical Incident process to include the use of the agency's assigned Critical Incident SharePoint site. As part of the critical incident reporting process, the IRIS Consultant Agencies are required to submit information describing how the participant's immediate and ongoing health and welfare have been ensured. Using the Critical Incident SharePoint sites assigned to each IRIS Consultant Agency, the Department reviews every reported critical incident. In cases where the information provided does not adequately describe activities that ensure that participant's immediate and ongoing health and welfare, the Department and the ICAs communicate back and forth through the agency's assigned Critical Incident SharePoint site until the negative finding has been remediated. In addition, ten percent of the incident reports are undergo an additional review on a monthly basis to ensure that the case notes reflect that the actions described in the incident report took place as reported. The DQA and IRIS Quality Staff will coordinate efforts or information as needed to resolve or address medication error issues.

Wisconsin's Nurse Practice Act regulates the roles and responsibilities of a nurse in delegating tasks to unlicensed assistive personnel. For participants who are not self-directing their medication management and a nurse is involved, Wisconsin's Nurse Practice Act allows non-nursing staff to administer medications only under the supervision of a registered nurse. Staff administering medications must receive training specific to the participant related to administration of the medication. This

training may be provided by a registered nurse employed by the provider. The nurse is responsible to assure that the staff who will be providing the dispensing services are appropriately and specifically trained in dispensing each specific medication to each participant. Each medication administered is documented at the time of dispensing with any errors documented. Supervision of delegated nursing services such as medication administration and medication management is provided consistent with the standards contained in the Wisconsin Nurse Practice Act.

As part of the record review, the DHS reviewers are examining the case notes to ensure that all reportable incidents, including medication errors. As part of the critical incident reporting process, the IRIS Consultant Agencies are required to submit information describing how the participant's immediate and ongoing health and welfare have been ensured. Using the Critical Incident SharePoint sites assigned to each IRIS Consultant Agency, the Department reviews every reported critical incident. In cases where the information provided does not adequately describe activities that ensure that participant's immediate and ongoing health and welfare, the Department and the ICAs communicate back and forth through the agency's assigned Critical Incident SharePoint site until the negative finding has been remediated. In addition, ten percent of the incident reports are undergo an additional review on a monthly basis to ensure that the case notes reflect that the actions described in the incident report took place as reported.

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).

If an IRIS participant is self-administering medications, the IRIS consultant will follow up as needed with the participant to assess and address any potential risks with this arrangement.

When a participant is self-directing medication administration and management tasks, they are delegating the waiver service provider to perform these tasks and the participant or designated representative assumes responsibility for monitoring how it is performed and the frequency. When a waiver service provider is responsible for the administration of medications to a participant, there must be a written order from a physician and a properly labeled prescription, including dosage. If the medication prescribed is given on an as-needed basis, then a clear definition of the circumstances under which the medication is to be administered must be provided as well. In these circumstances, the IRIS consultant will follow up with the participant as needed to ensure the waiver service provider is meeting participant expectations for this task.

Wisconsin''s Nurse Practice Act regulates the roles and responsibilities of a nurse in delegating tasks to unlicensed assistive personnel. For participants who are not self-directing their medication management and a nurse is involved, Wisconsin''s Nurse Practice Act allows non-nursing staff to administer medications only under the supervision of a registered nurse. Staff administering medications must receive training specific to the participant related to administration of the medication. This training may be provided by a registered nurse employed by the provider. The nurse is responsible to assure that the staff who will be providing the dispensing services are appropriately and specifically trained in dispensing each specific medication to each participant. Each medication administered is documented at the time of dispensing with any errors documented. Supervision of delegated nursing services such as medication administration and medication management is provided consistent with the standards contained in the Wisconsin Nurse Practice Act.

For participants who choose to reside in a regulated Assisted Living Facility (such as an adult family home, or residential care apartment complex), on-going medication management and follow-up are provided through the Assisted Living provider under the supervision of an appropriately licensed health care professional. The Division of Quality Assurance is the State agency involved in monitoring the performance of medication administration and management for licensed/certified facilities.

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 errors such as a missed dose or wrong medication must be documented. If an error results in an adverse event, a Critical Incident Report must be submitted to the participant's chosen ICA, and handled through the critical incident management process. All providers and contractors are required to report critical incidents including those relating to medication errors that result in an adverse event so that effective and timely remediation occurs and steps are taken to ensure that the incident will not recur. The ICAs will instruct participants and their designated representative on critical incidents and reporting including reporting those relating to medication management errors resulting in an adverse event and secure participant agreement to report critical incidents.

For IRIS waiver participants residing in assisted living type facilities regulated by DHS, the Division of Quality Assurance provides ongoing oversight of these practices and intervenes if a pattern of error is discovered in residential facilities that it licenses, certifies and regulates.

Medication errors are required to be reported through the state's Critical Incident Reporting process including any errors in medical or medication management by waiver providers that result in a significant adverse reaction requiring medical attention in an emergency room, urgent care center, or hospital.

(b) Specify the types of medication errors that providers are required to *record:*

Medication errors such as a missed dose or wrong medication must be documented. If an error results in an adverse event, a Critical Incident Report must be submitted to the participant's chosen ICA, and handled through the critical incident management process. All providers and contractors are required to report critical incidents including those relating to medication errors that result in an adverse event so that effective and timely remediation occurs and steps are taken to ensure that the incident will not recur. The ICAs will instruct participants and their designated representative on critical incidents and reporting including reporting those relating to medication management errors resulting in an adverse event and secure participant agreement to report critical incidents.

For IRIS waiver participants residing in assisted living type facilities regulated by DHS, the Division of Quality Assurance provides ongoing oversight of these practices and intervenes if a pattern of error is discovered in residential facilities that it licenses, certifies and regulates.

Medication errors are required to be reported through the state's Critical Incident Reporting process including any errors in medical or medication management by waiver providers that result in a significant adverse reaction requiring medical attention in an emergency room, urgent care center, or hospital.

(c) Specify the types of medication errors that providers must *report* to the State:

Medication errors such as a missed dose or wrong medication must be documented. If an error results in an adverse event, a Critical Incident Report must be submitted to the participant's chosen ICA, and handled through the critical incident management process. All providers and contractors are required to report critical incidents including those relating to medication errors that result in an adverse event so that effective and timely remediation occurs and steps are taken to ensure that the incident will not recur. The ICAs will instruct participants and their designated representative on critical incidents and reporting including reporting those relating to medication management errors resulting in an adverse event and secure participant agreement to report critical incidents.

For IRIS waiver participants residing in assisted living type facilities regulated by DHS, the Division of Quality Assurance provides ongoing oversight of these practices and intervenes if a pattern of error is discovered in residential facilities that it licenses, certifies and regulates.

Medication errors are required to be reported through the state's Critical Incident Reporting process including any errors in medical or medication management by waiver providers that result in a significant adverse reaction requiring medical attention in an emergency room, urgent care center, or hospital.

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.

When an IRIS participant resides in a regulated residential facility such as Residential Care Apartment Complexes (RCAC), or a 3-4 bed Adult Family Homes (AFH) the Department's Division of Quality Assurance (DQA) monitors performance of these providers in the administration of medications. The rules and regulations enforced by DQA governing the operation

of these facilities are based in state statute and also administrative rule. These include provisions related to medication administration, including self-administration or assistance with administering medication, and medication management which includes medication storage, record keeping, and other specified management activities. Before a licensee or service provider dispenses or administers a prescription medication to a resident, the licensee must obtain a written order from the physician who prescribed the medication specifying who by name or position is permitted to administer the medication, under what circumstances and in what dosage the medication is to be administered. DQA regulation of licensed and certified residential facilities includes regular on-site monitoring and investigation of complaints and incidents within these facilities. Any findings related to health and safety, including medication errors that are found in a facility that includes an IRIS waiver participant will be reported to the participant's chosen IRIS Consultant Agency and appropriate DHS IRIS staff as part of the Critical Incident Management System protocol.

If the IRIS participant resides in their own home, the IRIS consultant will monitor the performance of waiver providers who administer medications to the participant during regular contacts with participant but may occur more often if needed. DHS incorporates the participant safeguard assurance relating to medication management and administration as part of its Quality Improvement Strategy through IRIS participant record reviews, review of the ICAs' and F/EAs' quality assurance activities and contracts as applicable, the Critical Incident Management System, complaints, Division of Quality Assurance monitoring findings, and other discovery methods that may occur.

DQA findings are disseminated internally within DHS through the DLTC Administrator's Office. These findings are then sent from the administrator's office to all programs impacted by the findings. The IRIS Section then notifies the ICA in writing of the finding and requires the ICA to confirm the information has been disseminated throughout the ICA.

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.
(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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:
Number and percent of participant records reviewed where the participant or legal representative received information/education about how to report abuse, neglect, exploitation and other critical incidents. Numerator/Denominator: Number of records where the legal representative received information about critical incidents over the number of 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:	☐ **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 critical incidents reports that indicated that the incident was addressed in a manner that ensures the health and safety of the participant.
Numerator/Denominator: Number of critical incidents reported in which the incident was addressed over the number of incidents reported during the time period.

Data Source (Select one):
Critical events and incident reports
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:	☐ **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 participant deaths reviewed by the mortality review committee. Numerator/Denominator: Number of participant deaths reviewed by the mortality review committee over the number of deaths occuring during the designated time period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Mortality review committee reports and critical incident reports

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:
Number and percent of restrictive measures that were applied for and reviewed according to the restrictive measures application application protocol. Numerator/Denominator: Number of restrictive measures reviewed according to protocol over the number of restrictive measures applications submitted during time period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Restricitve measures data

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:
Number and percent of participant records reviewed that indicate an incident report was completed and submitted for each reportable incident. Numerator/Denominator: Number of participant records reviewed for which an incident report was completed and submitted for each incident over the number of participant records reviewed for which there was at least one incident discovered.

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:	☐ **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 restrictive measures as identified in the participant record review that followed the WI Restrictive Measures protocol. Numerator/Denominator: Number of restrictive measures in place as identified in the participant record review that followed the restrictive measures protocol over the number of restrictive measures identified in the participant record review.

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:	☐ **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.

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.

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.

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.
Strategies for discovering issues pertaining to the health, safety, and welfare of IRIS waiver participants include the IRIS participant record review, complaints, critical incident reporting, critical incident and mortality review committee, and restrictive measures application. Critical incidents, including those that involve the death of a participant, are initially reported to the ICA and then submitted to the SMA/DHS for aggregation and review. All deaths are reported to the participant's chosen ICA and subsequently submitted to the Department. This information can be confirmed by the DHS from disenrollment data. Wisconsin has a statewide policy on restrictive measures and uses a centralized process for reviewing and approving restrictive measures applications. Any medication errors reported through the incident reporting process will be monitored and trended during review of reports and analysis of data. The IRIS quality management team reviews critical incidents and deaths on an on-going basis.

As of October 1, 2013, all critical incident data is stored in a DHS-owned SharePoint site. Each ICA will have its own SharePoint specific to Critical Incident Reporting to ensure HIPAA compliance. The ICAs are responsible for entering the description of the report, the steps taken to ensure immediate health and welfare, and the steps taken to ensure ongoing health and welfare. The Department reviews these steps to ensure compliance with the performance measures and either closes the incident report or returns the incident report for additional work to ensure that the participant's immediate and ongoing health and welfare has been safeguarded. The fields within these SharePoint sites clearly record both whether or not the ICA had adequately ensured the participant's health and welfare at the time of report submission and if remediation was required, whether or not the ICA had adequately ensured the participant's health and welfare at the time of closure.

Death information is exported to an Excel document from each ICA's Critical Incident SharePoint site for discussion and the discussions are captured in the meeting minutes for the Mortality Review Committee. These minutes are stored in the library within the Critical Incident SharePoint site for each ICA.

Record Reviews are completed through a manual review of the participants' electronic records identified in the random sample. The centralized IT system will be the primary source of data for the record review information. The record review tool containing a combination of indicators that measure data for performance measure reporting as well as elements of best practice was established in 2011. Each year revisions are completed to either clarify the data being collected and/or to add more indicators to measure aspects of best practice and contract compliance. The record reviews are completed by the DHS IRIS Quality Management Specialists on a quarterly basis. To communicate the findings to the ICAs, the reviewers enter the results into the Record Review SharePoint sites specific to the reviewed participants' chosen IRIS Consultant Agencies. In addition to the findings of the record review, these Record Review SharePoint sites communicate the reasons for negative findings as well as the required remediation activities to the ICAs. The sites also allow the DHS reviewer document confirmation of the remediation activities completed by the ICAs. The data reporting capabilities of these Record Review SharePoint sites allow for sophisticated individual and aggregate reporting on the findings of the record review, the reasons for any negative findings, and the prescription and completion of remediation activities by the ICAs.

Restrictive Measures data for the Developmentally Disabled target group is collected, maintained, and reported by the Bureau of Long Term Supports Restrictive Measures Lead. In addition to notification of the participant, the BLTS RM Lead provides email notification of the decision to the DHS IRIS Quality Team Lead and the participant's chosen ICA. In addition, upon request, the BLTS RM Lead will provide a compilation report of all of the outcomes of the reviews of RM applications.

Restrictive Measures data for the Physically Disabled and Frail Elder target groups is collected and reported by the IRIS Consultant Agencies.

The implementation of the Restrictive Measures/ Behavior SharePoint sites for the IRIS Consultant Agencies in 2014 will allow for more extensive monitoring and oversight of the Restrictive Measures process for the Developmentally Disabled and Physically Disabled / Frail Elder waiver groups. These Behavior / Restrictive Measures SharePoint sites will also increase the Department's ability to isolate data elements and/or compare and contrast data elements for a more complex analysis.

The Department extracts all data from each of these SharePoint sites to ensure that the data is collected the same way between sites and between IRIS Consultant Agencies. Each IRIS Consultant Agency is required to have its own set of SharePoint sites to ensure HIPAA compliance. Replications of the Behavior/Restrictive Measures, Critical Incident

Reporting, and Record Review SharePoint sites are prepared in advance of onboarding a new IRIS Consultant Agency and the Department provides intensive training on how to use these sites in conjunction with the IRIS Policy Manual Work Instructions and each site's SharePoint User's Manual.

All SharePoint sites (Record Review, Budget Amendment, One-Time Expense, Critical Incident Reporting, Program Integrity, Behavior/Restrictive Measures, etc.) are designed with the intention of serving as the foundations for the modules in the centralized IT system.

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. In addition, provide information on the methods used by the State to document these items.

The IRIS Consultant Agencies are responsible for addressing individual issues related to the health, safety, and welfare of participant, however there may be occasions when the financial services office is involved. The DHS IRIS quality specialist works with these agencies, and other officials such as adult protective services and law enforcement, to ensure appropriate and timely remediation occurs and provide follow-up as needed. Critical incidents are tracked in a SharePoint Site and/or centralized data system incident reporting module that includes results of investigation and remediation that occurred. The critical incident and mortality review committee reviews reporting related to IRIS participant incidents deaths and will conduct investigations as needed. Critical incidents and deaths are aggregated and analyzed monthly and quarterly which the QM team uses to monitor for any trends that might indicate a systems level issue. If a systemic issue is identified, then appropriate systems level improvements will be made. Issues or concerns related to restrictive measures may be discovered through various means and will be documented accordingly. The QM team will compile all issues related to restrictive measures to monitor for trends.

Record Reviews are sampled on a quarterly basis and completed on an ongoing basis throughout the quarter; however data, findings, and remediation activities are only calculated and communicated on a quarterly basis.

Critical Incidents are reviewed at minimum on a weekly basis, though the DHS IRIS Quality Specialist tends to review on a more frequent basis due to the volume of reports received during a week. In addition, the secondary monitoring process was established in 2014 in which the DHS reviewer goes into the participant's case record and reviews a sample of the incident reports to ensure that the steps taken to ensure the participants' immediate and ongoing health and welfare the IRIS Consultant Agency reported actually occurred as reported. This process is known as the Remediation Approval Process (RAP).

Data is not aggregated and analyzed for these performance measures on a daily basis. However, in several respects, the collection of the information is a continuous and ongoing process. The incident reports are reported to the Department on a daily basis through their entry into SharePoint. Restrictive measures data is collected with each application reviewed. Record reviews are completed on a continuous and ongoing basis. The data aggregation and analysis takes place according to the schedules identified in the aggregation/analysis tables, typically on a monthly or quarterly basis, with additional annual reporting.

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.

An enhanced SharePoint site was implemented October 1, 2013. Additionally, a refined process including a project charter, work instructions, and review process were implemented as well.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §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 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;
- 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, 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 Quality Improvement Strategy 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 Quality Improvement Strategy. 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 2)

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 Quality Improvement System for IRIS is designed to ensure the quality and integrity in the implementation of waiver program policies, processes, resource allocation and utilization of waiver services, and most importantly that program participants are meeting their needs and desired outcomes through this self-directed services model. The scope of the QIS encompasses the statewide implementation of the IRIS program (both the 484 and 485 waiver programs) by the Department's contracted agencies, the IRIS Consultant Agencies (ICAs), Fiscal/Employer Agents (F/EAs), and Third Party Administrator (TPA). It also includes the Department functions and oversight of other program related functions such as 1.) The statewide implementation of the web-based Long-Term Care Functional Screen (LTC FS) that is used by multiple waiver programs to determine Level of Care (LOC), 2.)Aging and Disability Resource Centers (ADRCs) that conduct options and enrollment counseling to potential enrollees, conduct initial LOC determinations using the LTC FS, and refer potential enrollees to the IRIS, Family Care, or other institutional programs depending on the option the enrollee chooses, and 3.) Encounter data and claims reporting for waiver services provided.

The DHS/BLTS utilizes a variety of methods and processes for trending, prioritizing, and implementing system improvements. Trends are identified over time through consistent data collection, monitoring activities, and program evaluation. In general, systems issues that concern the health, safety, and welfare of IRIS waiver program participants and financial accountability of the program are given highest priority. Priorities for system improvements are determined by input from various stakeholders described below and the process is continuous. The Bureau of Long Term Support (BLTS) within the Department provides the administrative oversight for the IRIS program. The BLTS Quality Management (QM) team is responsible for the implementation of the QIS. The QM team consists of a quality team lead, data analyst, quality specialists, and includes participation of the IRIS Section Chief, BLTS Director, and other staff within BLTS as needed. The quality team lead manages the overall implementation of the QIS at the direction of the IRIS Section Chief. This includes development and implementation of an annual quality work plan that outlines the quality improvement activities being implemented and identifies priorities, provides oversight and leadership to quality assurance and improvement activities, ensures appropriate analysis of data and reporting, and presents systems improvement recommendations for decision-making. The data analyst is responsible for the development, coordination, and implementation of the various reporting mechanisms to obtain data related to performance measures and other monitoring activities. The data analyst aggregates data and conducts analysis of data. Quality specialists are responsible for the implementation of the participant record review, reviewing incident reporting activities, reviewing fraud investigation and prevention activities, aggregating and analyzing data, working with and providing oversight to contracted agencies in addressing individual participant issues that are discovered, providing follow-up to ensure that appropriate remediation occurs, and participating in the implementation of quality improvement activities as needed.
QIS Implementation:
Record reviews for both the 484 and 485 waivers are determined based on a random sample with a 95 percent level of confidence. The total number that should be sampled is divided among the four quarters in the calendar year. The quarterly sample will be pulled at the beginning of each year based on the number of participants enrolled at that point in time. Participants must be enrolled for at least 12 months in each waiver program to be included in the sample. The sample will include a list of alternates in the event that participant disenrolls from the program prior to the record the review being conducted. The record reviews will be conducted using a tool that incorporates criteria related to the performance measures defined in this application and will occur on a quarterly basis. The review will look at participant records on a "rolling quarter" basis. For example, records reviewed during the first quarter of the year will examine January-December of the previous year. Records reviewed during the second quarter will examine April-March. Individual participant results of the record review will be entered into a database and will include documentation of remediation provided to address individual issues. In addition, the record review results will be aggregated on a quarterly basis to monitor for any trends that might indicate a system level issue. The record review process has been in place since March 2011.

Data collection and reporting mechanisms related to performance measures are used to monitor and ensure compliance with waiver policies, processes, and requirements within the six assurance areas defined by CMS. Most of the performance measures in five of the assurance areas defined in this application also serve to ensure that the program operations implemented by contracted agencies (ICAs, F/EAs, TPA, and ADRCs) are meeting the Department's expectations and therefore also assure administrative oversight. These performance measures and reporting mechanisms were established and operational beginning the first quarter of 2011. Additionally, other reporting mechanisms will be used for quality monitoring such as utilization data to identify over and underutilization of waiver services, LTC FS data, disenrollment data, critical incident reporting, and appeals and grievances.
A SharePoint site designed to track policy and program operations-related issues that are discovered through various means including issues identified by contracted agencies or other sections within the Department in implementing of program operations, performance measures, and individual participant complaints or issues that warrant system level changes was implemented in January 2013. This database will also document decision-making and remediation for tracking and trending purposes.

Data and results of quality management/oversight efforts conducted by other sections within the department related to waiver program implementation such as the LTC FS, referral/enrollment process by ADRC, or Encounter reporting is shared with the BLTS Director, IRIS Section Chief, and Quality Team Lead to be incorporated as necessary within the QIS.

A critical incident and mortality review committee was established to conduct analysis of data from these reporting systems and results of any remediation to identify trends. Utilizing a SharePoint site to compile this data is improving the ability to generate valuable data and meaningful analysis.

The QM team meets monthly to coordinate implementation of QIS and update annual quality work plan. When trends are identified that indicate a quality concern, further analysis may be conducted depending on the scope of the concern to more clearly define the issue or cause and identify the system improvements needed. Methods for further analysis may include conducting targeted reviews, root-cause analysis, cause and effect diagramming, process mapping or flow-charting, and failure mode and effects analysis. This analysis is typically performed by the QM team or in partnership with the ICAs or F/EAs or other sections within the DHS. Results of analysis and recommendations for improvement are communicated as appropriate to various stakeholders described below to establish priorities for systems improvement. Implementation of systems improvement may be done directly by the BLTS QM team, delegated to contractor agencies with oversight by BLTS QM team, or in collaboration with other departments and offices within DHS. The results of systemic changes will be evaluated based on the quantitative data available that can demonstrate the effectiveness of change and may also include qualitative information provided by participants.

Methods for establishing priorities and communication:
In addition, internal staff meetings within the DHS/ BLTS occur regularly to establish priorities and monitor progress related to overall systems and processes of the IRIS program and those conducted by ICAs and F/EAs. Information and reports regularly reviewed within BLTS includes: quality dashboard/performance measures; critical incident reporting and mortality review; restrictive measures; IRIS Participant Record Review process, implementation, and findings; individual budget amendments; participant identified quality issues; provider quality and capacity; service utilization data; appeals/grievances; contractor reports from ICAs and F/EAs and results of any corrective actions in place; participant statistics including enrollment and disenrollment data; Policies and procedures; and IRIS Advisory Committee recommendations.
The following stakeholders are involved to varying degrees in the decision-making process for establishing QIS priorities; a description of each stakeholder group and the how they contribute to the process, and communication is described below.

Leadership across the DHS sections that are involved in the oversight and implementation of centralized processes/systems meet weekly to collaborate and address system issues that affect multiple waiver programs including IRIS. White papers or issue papers, reports, or other documentation is shared to communicate issues. These centralized systems include: LOC determinations and LTC FS quality; options counseling and enrollment processes through the ADRCs; statewide data reporting systems; Ombudsmen programs; information technology; and financial management and oversight. Division level administration determines priorities that are communicated at these leadership meetings.

The DHS/BLTS and its contractor agencies (ICAs and F/EAs) meet monthly to evaluate, determine, and/or communicate priorities. These meetings consist of review of contractor reporting and analysis, implementation of data collection and reporting systems, participant issues and results of remediation efforts, infrastructure of program operations, results of quality assurance/improvement activities, and when applicable progress made on any corrective actions in place. Meeting agendas and minutes record results of these meetings. In addition, the access database for policy/process related issues will document decisions or remediation that occurs as a result of these meetings.

The IRIS Advisory Committee is an external stakeholder group whose membership consists of members of advocacy organizations, agency providers, IRIS program participants, and open to public participation is another venue for establishing priorities. The full committee and its sub-committees meet every other month to provide input, feedback, and recommendations to the DHS/BLTS. Information shared with committee members include the on-going reporting and analysis conducted by the ICAs or F/EAs, and progress updates on implementation and analysis of improvement activities. The recommendations and feedback provided during these sessions are then used in the decision-making process at DHS/BLTS for priority setting related to overall system improvements. Meeting agenda and minutes are recorded and distributed to committee members including any additional documents such as ICA and F/EA reports, issue papers and draft policies and other documents relative to discussions/recommendations.
Other advisory groups that include consumers and advocates which also provide input into the priority-setting include the Wisconsin Board for People with Developmental Disabilities and the Council on Long-term Care (continued below).

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 F/EAs	☐ **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.

(Continued from above H.a. i)
In addition, priorities are set within the broader context based on CMS expectations, priorities set forth by Wisconsin policy-makers such as the Governor and Legislature, and the State Medicaid Agency.
IRIS Participants/Families are informed about relevant quality improvement activities that may directly impact processes they use through a quarterly newsletter. An annual report is also generated for Wisconsin Legislature and the public that describes how these programs are providing long-term care options and services to Wisconsin's frail elders and individuals with developmental or physical disabilities. The report will present data on all of the Long Term Care programs, to the extent possible.

Priorities for systems level improvements are determined based on multiple factors. Factoring in input from the stakeholder described above, the SMA, DHS and BLTS ultimately determine the priorities for systems improvements. Member health, safety, and welfare is a critical area and given high priority based on the extent that significant improvement can be achieved and sustained over time. Ensuring enrollees have the information they need to make informed choices and having access to the supports and services they need for self-direction, and maintaining cost-neutrality with self-directed supports and services are other priority areas for the IRIS program. Long-term care reform in Wisconsin, initiated in 2007, continues to impact priority setting in responding to rapid geographic expansion of the IRIS program and the increase in the numbers of enrollees choosing the IRIS waiver program until expansion of Family Care statewide is complete. For example, building resource capacity for IRIS Consultants that work directly with waiver participants, addressing the training needs of IRIS Consultants, and improving information management systems are systems issues that remain a priority during this waiver renewal timeframe.

System design improvement:
System design improvements specific to the IRIS program are accomplished using the Plan Do Study Act (PDSA) methodology to structure the implementation (strategize), monitor progress, evaluate effectiveness of change, and determine if any additional changes or modification is needed. The IRIS QM team manages/coordinates the implementation of systems improvements or provides oversight to the delegated contractor agencies conducting improvement activities. Depending on the nature of the systems issue(s), improvement processes may include: process or performance improvement projects; development and implementation of training/education and technical assistance; development and implementation of additional resources for IRIS waiver participants and families to support self-determination; corrective action plans that require larger system changes (i.e., agency infrastructure, roles/responsibilities of staff resources, significant process changes); modification of existing data collection and reporting mechanisms or development of new mechanisms; or modification of existing policies and procedures or development of new ones to address additional program needs.

System Design Changes- Start of H.b.i

The IRIS QM team is responsible for evaluating the impact and effectiveness of system design changes. Whenever feasible, indicators for improvement will be defined with corresponding measures and incorporated into the PDSA methodology so that the evaluation is built into the process up front. If the systems change relates to one of the six quality assurance areas and related performance measures, then performance measure will be trended over time to demonstrate if change resulted in improvement. Other methods may be used depending on the improvement activity. For example, if training and technical assistance (TA) is the improvement activity, then a process will be developed to measure the impact of training or TA such as a pre-test/post-test.

The quality team lead will document any system change activities in a report or summary format that can be shared and distributed as appropriate within the DHS, to the IRIS Advisory Committee, the ICAs and F/EAs, IRIS participants, and other stakeholders as needed or required depending on the nature of the change. This document will include a description of the issue, the desired change to be made, what steps or activities were implemented to achieve desired change, any indicators and measures related to activity, a summary of findings and conclusions drawn as a result.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The QIS is designed building on current processes implemented during the initial waiver application and includes modifications to data collection and reporting mechanisms, incorporation of performance measures for each of the six assurance areas, and implementing strategies for more structured quality assurance and improvement activities. The QM team plans to conduct an annual evaluation to assess the current structure and processes in place for efficacy, and make modifications as needed. After three years of implementation, the QM team will conduct a more thorough evaluation of its QIS and summarize achievement of quality improvement efforts to demonstrate the strengths of the current system, identify challenges and barriers, and determine what additional changes need to be made to improve its effectiveness. The QM team is considering the use of a logic-model design to document and structure the QIS which can then be used to evaluate the program.

The addition of multiple ICAs and F/EAs, the addition of a Third Party Administrator (TPA), the implementation of a centralized data system, and the transition of ICA and F/EA services from administrative services to benefits are a system design changes implemented through this amendment for which the state will monitor for program and financial integrity. The following activities will take place to ensure that these system design changes have improved program efficiency and are meeting the needs of the participants. All activities below will be added to the 2014 IRIS Quality Management Work Plan for tracking purposes.

• Continue meeting with the IRIS Advisory Committee to hear feedback from stakeholders;

• Implement participant satisfaction surveys conducted both through the centralized data system and other means to collect direct information from participants regarding what is working and what is not working well with the implemented changes;

• Conduct focus groups with participants, providers, and other stakeholders to hear what is working well and what is not working well with the implemented changes;

• Collect data through the complaints and grievances tracking systems relative to these system design changes;

• Evaluate all available performance measure data on a regular basis and compare to pre-implementation baseline data to try to identify any positive or negative change;

• Identify and implement indicators to measure select contract performance standards for all IRIS Consultant Agencies, Fiscal/Employer Agents, and the Third Party Administrator listed in Appendix A to ensure that each agency is meeting the state's standards.

Should negative trends emerge suggesting that the system design changes implemented through this amendment are not effective or beneficial to the participants; the following activities will take place. All activities related to quality improvement will be added to the 2014 IRIS Quality Management Work Plan.

• If the issue is specific to the performance of one IRIS Consultant Agency or Fiscal/Employer Agent, the state will mandate that the agency comply with a Quality Improvement Project following the state's policy.

• If the issue is specific to the effectiveness of the system design change itself, the state will systematically begin exploring ways to improve the effectiveness of the system design change using the Plan-Do-Study-Act methodology.

• If the issue is specific to the participants' satisfaction regarding the system design change, the state will expand its data collection to collect more detailed information from participants regarding the issue. The state will then use the Plan-Do-Study-Act methodology to devise ways to improve the system design change to better meet participants' expectations.

Should positive trends emerge regarding the implemented system design changes, the state will follow the aforementioned strategies to build upon and further enhance the implemented system design changes to support program efficiency and participant satisfaction.

Performance measure data will be one way that the state collects information to inform not only the state and key stakeholders of the success of the system design changes, but also the Centers for Medicare and Medicaid Services. In addition to replacing the words, "FSA" with "F/EA", the following updates to performance measures are required and are also captured in the appropriate appendices throughout the amendment:

Administrative Authority (Appendix A)

• Add performance measure: Number and percent of required TPA reports that were submitted to the SMA per contract requirements. Numerator/Denominator: Number of TPA report submitted per contract requirements over the number of required reports.

• Revise performance measure: Number and percent of new participant-hired workers for which the F/EA ensured that the provider had a signed Medicaid Provider agreement prior to furnishing services. Numerator/Denominator: Number of new participant-hired workers on the F/EA provider registry that have signed Medicaid provider agreements over the number of new participant-hired workers on the F/EA registry. Changed FSA to F/EA and limited "providers" to participant-hired workers. Clarified denominator to be total number of "new" providers to align with numerator.

• Add performance measure: Number and percent of new providers for which the TPA ensured that the provider had a signed Medicaid Provider agreement prior to furnishing services. Numerator/Denominator: Number of new providers on the TPA provider registry that have signed Medicaid provider agreements over the number of new providers on the TPA registry.

Participant Services (Appendix C)

• Revise performance measure: Number and percent of licensed/certified providers employed directly by the participant with current completed criminal background and caregiver registry checks. Numerator/Denominator: The number of licensed/certified providers employed directly by the participant for whom the F/EA has completed current criminal background and caregiver registry checks over the number of licensed/certified providers employed directly by the participant. Changed terminology from FSA to F/EA.

• Revise performance measure: Number and percent of non-licensed/non-certified participant-hired workers with current criminal background and caregiver registry checks. Numerator/Denominator: The number of non-licensed/non-certified participant-hired workers for whom the F/EA has completed criminal background and caregiver registry checks over the number of providers. Changed terminology from FSA to F/EA. Changed "providers employed directly by the participant" to "participant-hired workers".

• Revise performance measure: Number and percent new providers that meet required licensure or certification standards prior to furnishing waiver services, as verified by the TPA. Numerator/Denominator: The number of new licensed/certified providers that hold required licensure/certification for the services being provided over the total number of new licensed/certified providers. Changed responsibility from FSA to TPA. Clarified denominator to be total number of "new" providers to better align with numerator.

• Revise performance measure: Number and percent of providers who continue to meet required licensure or certification standards as confirmed by the TPA every four years. Numerator/Denominator: The number providers with

licensure/certification confirmed over the number of providers requiring their licensure/certification to be confirmed. Changed responsibility from FSA to TPA.
•
Participant-Centered Planning and Service Delivery (Appendix D)
• Clarification to performance measure: Number and percent of participants who received services within the approved individual budget. Numerator/Denominator: Number of participants reviewed who reported claims paid were under the current approved individual budget during the designated time period over the total number of participants reviewed. Removed word "allocation" and changed denominator to reflect the number of participants reviewed in the record review rather than all participants for whom a claim was paid.
Participant Safeguards (Appendix G)
• Clarification to performance measure: Number and percent of restrictive measures as identified in the participant record review that followed the WI Restrictive Measures protocol. Numerator/Denominator: Number of restrictive measures in place as identified in the participant record review that followed the restrictive measures protocol over the number of restrictive measures identified in the participant record review. Changed to measure compliance in order to be consistent with the wording of the other PMs. Previous wording measured the non-compliant restrictive measures.
Financial Accountability (Appendix I)
• Revision of performance measure: The number and percent of TPA monthly encounter data submissions that were accepted and certified timely. Numerator/Denominator: Number of TPA monthly submissions accepted and certified timely over the total number of submissions. Responsibility was previously that of the F/EA.

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).

The Department of Health Services ensures the financial integrity of payments that have been made for waiver services. The Bureau of Long-Term Support (BLTS), and Bureau of Fiscal Services (BFS), and DLTC Bureau of Financial Management Services (BFM) including the BFM Audit Section each have responsibilities in monitoring key aspects of financial accountability. These functions are described below.

The Bureau of Financial Management Services (BFM) within the DLTC provides oversight of the service utilization data reported to DHS by the Third Party Claims Administrator (TPA). Service utilization data is submitted to the Department through the encounter data reporting system. The TPA is the exclusive submitter of data in this system. The encounter system collects data submitted electronically through a standard .xml file format. The encounter reporting system has edits in place to detect errors in reporting which reject errors and flag potential errors. The TPA is notified of these error flags. The TPA corrects and resubmits data until it is accepted by the system. The accepted data is then certified by executive staff at the TPA.

In addition to system edits, encounter Data Integrity Audits will be conducted by BFM. These audits will be conducted by the Data Validity Workgroup. This workgroup will systematically identify incorrectly reported encounter data. If reporting anomalies are detected during these data evaluations, the BFM and BLTS follow through with the TPA to correct these in a timely manner.

The state contracts directly with two types of service providers, IRIS Consultant Agencies and IRIS Fiscal Employer Agents (Reference Appendix C for service definitions). The DHS contract with the ICAs and F/EAs require each agency to have an annual independent third party audit for contract and expenditure compliance by a certified public accounting (CPA). The IRIS Section Chief in collaboration with BFM audit personnel who are also CPAs reviews the results of these audits. Any findings resulting from the independent third party must be remediated by the contracted agencies. The IRIS Section Chief takes advisement from the BFM audit personnel to implement corrective action with the contract agencies, including but not limited to updated policy and procedures and/or additional internal controls. These corrective actions are implemented and monitored through the contract quality assurance protocols established within the IRIS Section.

The BFM audit section will conduct data integrity audits on a three-year cycle, document the findings in a best practice industry standard auditing format, and submit the finding report to the IRIS Section. As part of the provider's contractual obligations, providers are required to comply with any Corrective Actions required by the state including those required from audit findings. The State will also conduct annual audits of the policy and procedure manuals of each provider, this review will include all internal audit controls used during for claims processing. Providers are required to have their policy and procedure manual be 100% certified to comply with the States claim processing requirements, including put not limited to validation of participant enrollment, service date, service unit, service amount and qualified provider as reflected on the participant's plan.

The IRIS section requires an annual review of the policy and procedure manual of each certified provider. Providers are required to have their policy and procedure manual be 100% certified to comply with the States claim processing requirements, including put not limited to validation of participant enrollment, service date, service unit, service amount and qualified provider as reflected on the

participant's plan.

The BFM audit section will conduct data integrity audits on a three-year cycle. This data integrity audit will include but is not limited to a financial data to encounter data, encounter data to plan data (source), provider claim submission to financial data, provider claim submission to encounter data, provider claim to plan data (source). All of the above audits will include the validation of services authorized for an enrolled participant, service date, service unit, service amount and qualified provider as reflected on the participant's plan.

All audit finding will be submitted to the IRIS Section in best practice industry standard auditing format.

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
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

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:
Number and percent of waiver service claims paid that were authorized in the participant's service plan. Numerator/Denominator: Number of claims submitted that are on the service plan over the total number of claims submitted during the designated period.

Data Source (Select one):
Financial records (including expenditures)
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: TPA	☐ **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: TPA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of waiver service claims paid that were coded correctly.
Numerator/Denominator: Number of claims coded correctly over the number of claims processed during the review period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Data integrity audit

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 = 99%
☐ **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:
Number and percent of claims held that were resolved prior to payment.
Numerator/Denominator: Number of claims pended that were resolved prior to payment over the total number of claims pended during the period.

Data Source (Select one):
Financial records (including expenditures)
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: TPA	☐ **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: TPA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
The number and percent of TPA monthly encounter data submissions that were accepted and certified timely. Numerator/Denominator: Number of TPA monthly submissions accepted and certified timely over the total number of submissions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter reporting program database

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: TPA	☐ **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: TPA	☐ **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.

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 TPA processes all claims related for the IRIS Waivers. The TPA is required to maintain an electronic payment system that tracks and monitors all paid claims. Claims submitted must meet prior authorization criteria in order to be paid. The TPAs review claims internally against the prior authorizations prior to claims payment. The TPA submits paid claims to the SMA through the encounter reporting system. This system contains internal edit checks that review submitted claims completeness and feasibility. The State's encounter reporting system has edits in place to detect errors in reporting which rejects and flags potential encounter claims reporting. No claims submitted to the TPA with an error status such as; no prior authorization, claim exceeds prior authorization, no provider record, provider license or certification not validated, will be paid unless the error is resolved.

In addition, the State will conduct a data integrity audit to certify the TPA's encounter reporting as it does with all encounter reporting entities. The Department's encounter data integrity program is intended to both prevent and discover errors in the encounter data. This oversight results in corrective actions to be taken against the causes of the errors. Once a sample size is determined, random records are selected from the repository for review. These records are reviewed for completeness and consistency to assure an accurate reflection of the data sampled. These same records are compared with the TPA's systems to verify the data transmission. In some cases, these records will be traced back to the originating provider to ensure the integrity of the data transferred between providers and the TPA.

The ongoing monitoring of claims coding and data reporting will be monitored by the State's Data Validity Workgroup as noted in section 1.a of Appendix I

In addition to the above, the Department conducts record reviews of the participant's ISSP to ensure on that the services included on the ISSP are allowable waiver services and that the goods and services are classified under the appropriate allowable waiver service for submission to the TPA. Any errors discovered as part of the record review process require 100% remediation of the participant's ISSP and may also require corrective action with the ICA that validated the ISSP including changes to policy and procedure and/or additional internal controls.

The IRIS section requires an annual review of the policy and procedure manual of each certified provider. Providers are

required to have their policy and procedure manual be 100% certified to comply with the States claim processing requirements, including put not limited to validation of participant enrollment, service date, service unit, service amount and qualified provider as reflected on the participant's plan.

The BFM audit section will conduct data integrity audits on a three-year cycle. This data integrity audit will include but is not limited to a financial data to encounter data, encounter data to plan data (source), provider claim submission to financial data, provider claim submission to encounter data, provider claim to plan data (source). All of the above audits will include the validation of services authorized for an enrolled participant, service date, service unit, service amount and qualified provider as reflected on the participant's plan.

All audit finding will be submitted to the IRIS Section in best practice industry standard auditing format.

The centralized system will house the prior authorization data and plan data (source) for the claims adjudication process however, the encounter data will be submitted by the TPA to the Departments centralized encounter universe.

Data is not aggregated and analyzed for these performance measures on a daily basis. However, in several respects, the collection of the information is a continuous and ongoing process. The data aggregation and analysis takes place according to the schedules identified in the aggregation/analysis tables, typically on quarterly basis, with additional annual reporting.

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. In addition, provide information on the methods used by the State to document these items.
There are multiple approaches the state uses to address individual problems with financial integrity. For those issues that involve remediation of the claims submitted by providers to the TPA, the contract the state holds with the TPA requires them to work directly with the provider to remediate problems discovered such as; claim file format errors, incorrect coding, non-validation of licensure or certification, unauthorized or non-allowable services. These contract requirements also include up front training from the TPA to the providers to help ensure accurate submission of claims.

The Fiscal / Employer Agencies are responsible for tracking and reporting issues with claims (timesheets) submitted to the F/EA from participant hired workers. This tracking and reporting of timesheet error submissions includes such things as non-authorized hours, non-authorized services and incorrect coding of services. The F/EAs work with the ICAs as necessary to contact the participant and the participant's employees to resolve the outstanding issue. In addition, when the ICA discovers trending of these issues specific to certain participant's or participant employee's they are required to complete additional training with the participant and the participant's employee(s) to ensure proper understanding of timesheet submission protocols.

Issues with individual claims submissions to the encounter system must be corrected through a reversal process. This process involves the TPA submitting documentation to reverse the incorrect claim and correct it using new information.

The state also requires training of both the TPA and the F/EAs to recognize fraudulent submission of claims and timesheets. If any contracted entity suspects fraudulent activity is occurring, they are required to report that activity to the state. In turn, the state will use the fraud monitoring protocols to investigate the activity and take action the Department's Office of Inspector General when applicable.

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: F/EAs & TPA	☐ **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 rates ranges established for the IRIS program will be done by the IRIS Section in collaboration with the Bureau of Financial Management. The rate ranges established for the IRIS waiver services will be based on actual historical costs based on geographic region. The methods used to establish these rates will be identical in all jurisdictions where the IRIS program is furnished. The methods and standards used to establish the rates will be equivalent and any variation in rates would only be due to geographical complexities such as qualified provider availability. Providers will be able to comment on rate setting methodology and standards.

The state establishes guidelines for a suggested payment range based on market and geographic complexities of providers and analysis of historical costs per unit and trending program expenditures. These guidelines are shared with the ICAs who in turn educate participant's on these historical costs and trending to ensure Participants have the tools resources and information to negotiate the most cost effective rate with their providers including those providers employed directly by the participant. Participants may exceed these parameters in their rate agreements with service providers, but the total of all service expenses may not exceed the total the individual budget amount. If the participant's individual budget is not sufficient to meet the needs of the participant, budget amendment or one-time expense request can be made to the DHS. A committee within the DHS reviews these request using a standard set of criteria to determine if the request will be approved, partially approved, or denied. Additionally, documentation must be part of the participant's record when pay ranges exceed the expected range.

The state contracts directly with two types of service providers, IRIS Consultant Agencies and IRIS Fiscal / Employer Agents (Reference Appendix C for service definitions). The state has established monthly rate for service for these services based on historical costs of services and participant enrollment in the program. As the state continues to promote and introduce competition through choice of provider of these services, the state will require implementation of best service delivery models from these providers in order to realize the most cost effective methods of delivering these services. The intention of the state is to implement the best practice methods and standards identified through competition of providers to ensure the most cost effective method of service delivery. Once the state has identified the best practice it will modify the certification criteria so all other providers adhere to the same best practice. If this best practice results in a rate driver reduction, the State would also reduce the rate of the provider based on the statewide implementation of the best practice. The addition of competition to the market of ICA and F/EA providers will also help inform the state's rate setting methods for these services.

The state does not have established mandated rates for those services provided by participant hired workers. If the state established and mandated such rates the state would be viewed as the employer of the participant hired worker instead of the participant. The state has established the rates for two waiver services IRIS Consultant Agencies Services and IRIS Fiscal / Employer Agent Services. The methodology used to establish these rates included a review of historical costs associated with these services relevant to enrollment at the time the services were provided. The state does have a guideline called the Supportive Home Care wage tool to help inform participants of the range of rate paid historically for supportive home care services. The state will include a copy of the supportive home care wage tool with the supplemental documentation submitted to CMS.

The rate for ICA and F/EA services will be uniform across all counties in 2014 and 2015. The state may wish to adjust rates in future years based on ICA or F/EA performance, regional variation, etc. If the state does implement a rate change, it will included in the certification criteria. The rates and/or methodology is included in the certification criteria which was publicly released in 2014.

The centralized IT system will house the rate ranges for all services by region. Once the provider and participant have negotiated and agreed on a rate and the participant's plan has been approved, the F/EAs will receive a prior authorization for each service generated by the centralized IT system. The ICAs and the participants will have access to these rate averages via the centralized IT system. The state will also provide ICAs a reference tool that has the rate averages for waiver services per region to help inform the participants and the ICAs of the average cost of services. This reference tool will also be available on the IRIS website in 2015.

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 Department will use a Third Party Administrator (TPA) for claims adjudication and processing. The TPA has been selected through a contract amendment to one of four existing contracts with TPAs providing claim services to other programs within the Department of Health Services. There are two types of claims which are submitted for reimbursement within the IRIS waiver program, traditional provider claims, and participant-hired payroll claims.
Traditional Provider claims are submitted from provider agencies that provide services to participants in which the participant is not the employer. Examples of these services include Adult Family Home Services, Adult Day Care Services, and Supportive Home Care Services provided through a Supportive Home Care Agency. These types of claims will be submitted directly to the TPA using industry standard best practice data required for claims adjudication, including but not limited to participant ID, provider ID, service type, service code, unit, rate, and date of service. The TPA will receive the claim from the provider and adjudicate that claim based on the participant's approved Individualized Service and Support Plan (ISSP) and corresponding prior authorization received by the TPA from the IRIS centralized IT system. Through the adjudication process the TPA will determine if the claim is authorized. If the claim is authorized, the TPA will submit the claim to the Department for funding. The state will then fund a zero balance state-held bank account. The provider will then receive reimbursement for the claim through electronic funds transfer. If the claim exceeds the authorization on the ISSP, the amount that exceeds the authorization will be pended until the TPA has been able to resolve the authorization issue, or if the claim was submitted inaccurately or not authorized, the claim will be denied. In either case, the provider will be notified of the pended or denied claim. If the TPA receives a claim that is not on the participant's ISSP, the claim will be denied and the provider will be notified of the denied claim.

Participant-hired worker payroll claims will be submitted to the TPA by the participant's F/EA. Prior to claim submittal to the TPA, the F/EA will receive the participant-hired worker timesheet, authorizing that services were received via the participant's signature and enter the timesheet into the payroll timesheet system. The payroll timesheet system will perform a validation against the participant's ISSP and notify the F/EA of any errors, unauthorized services, or services exceeding the authorization amount for the participant-hired worker. After completion of the timesheet validation process, the F/EA will conduct their payroll processing procedures to reimburse the participant-hired worker for services provided. The F/EA will also submit a line item claim to the TPA that includes the industry standard best practice data required for claims adjudication, including but not limited to participant ID, provider ID, service type, service code, unit, rate, and date of service. The TPA will receive this claim from the F/EA and perform the same adjudication of this claim as required for those claims submitted by traditional providers described above. Payroll claims that are paid to the participant-hired worker in error (keying error from validation to check write) are the responsibility of the F/EA to recoup, their reimbursement from the TPA will be only in the amount authorized on the ISSP.
The Department will receive claim data from the TPA for the claims submitted and reimbursed through the TPA for the IRIS program. The utilization of a TPA will allow the Department to receive more accurate and timely service utilization data. This timely and accurate data will allow the Department to more efficiently and economically analyze service utilization trends by specific service group, target group, and geographical location, as well as other unique elements detected through receiving encounter data in a consistent and standardized method. This will also allow the Department to update the budgeted service utilization of the participant's ISSP in a more precise and timely manner.

BFM staff prepares the documentation required for Federal Financial Participation and complete and certify the CMS-64. Additionally, claims paid are reviewed and analyzed by BFM staff through encounter reporting and IRIS quality assurance staff and through the participant record review process.

Additionally, the State utilizes the encounter data reporting system that was established and tested for Family Care for the SDS encounter reporting. The TPA is the exclusive submitter of SDS reporting in this system. As with Family Care, there are specifications in place to ensure proper encounter reporting, including a data certification.

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:

Providers, Participants and Participant hired workers are all instructed on claims submission and participant hired worker timesheet submission through different training mechanisms. The providers receive instruction on proper claim submission protocols from the TPA as part of the TPA's contractual obligations. Participants receive instruction on timesheet (claim) authorization and submission upon enrollment into the IRIS program from the ICA, as part of the ICA's contractual obligations. Participant hired workers receive instruction from the participant and the ICA on proper timesheet (claim) submission at the time they identified as a qualified participant hired worker.

Provider claims are validated by the TPA through the prior authorization the TPA received from the IRIS centralized IT system. This prior authorization includes, but is not limited to, the participant ID (ensuring waiver program eligibility), provider ID (ensuring validation of applicable provider licenses or certification), service type (ensuring allowable waiver services), service code, unit, rate, and date of service. The TPA is responsible to assure that payment is only made when the participant was eligible for Medicaid waiver service payment on the dates of service and that the service was included in the participant's approved Individual Support and Service Plan and is within the allowable budget amount.

Participant-hired worker payroll claims are also submitted to the TPA; however these claims are submitted by the participant's F/EA provider. Prior to claim submittal to the TPA, the F/EA will receive the participant-hired worker timesheet, authorizing that services were received via the participant's signature and enter the timesheet into the payroll timesheet system. The payroll timesheet system will perform a validation against the participant's ISSP and notify the F/EA of any errors, unauthorized services, or services exceeding the authorization amount for the participant-hired worker. After completion of the timesheet validation process, the F/EA will conduct their payroll processing procedures to reimburse the participant-hired worker for services provided. The F/EA will also submit a line item claim to the TPA that includes the industry standard best practice data required for claims adjudication, including but not limited to participant ID, provider ID, service type, service code, unit, rate, and date of service. The TPA will receive this claim from the F/EA and perform the same adjudication of this claim as required for those claims submitted by traditional providers described above. The participant's signature on the provider timesheet or claim authorizes payment for those service and validates that service was provided on the dates identifies and the rates identified on the claim. The TPA is responsible to assure that payment is only made when the participant was eligible for Medicaid waiver service payment on the dates of service and that the service was included in the participant's approved Individual Support and Service Plan and is within the allowable budget amount. Payroll claims that are paid to the participant-hired worker in error (keying error from validation to check write) are the responsibility of the F/EA to recoup, their reimbursement from the TPA will be only in the amount authorized on the ISSP.

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:

a) DHS makes payments directly from a State-held bank account upon receipt of an appropriate payment file from the Third Party Claims Administrator (TPA) based on paid claims reported by the TPA on the DHS Encounter reporting system.
b) Payments are processed through the TPA claims adjudication system. The TPA claims adjudication system receives a prior authorization from the State's centralized IT system. The TPA assures that payments to providers are in accordance with prior authorization generated from the participant's ISSP. Services that are not part of the ISSP or that exceed the approved use of the individual budget are denied.
c) The TPA submits paid claims through the DHS encounter reporting system and certifies that the submitted claims are true and accurate. To ensure financial integrity and accountability, DHS performs audits of the TPA to check its certified paid claims against participants authorized individualized budgets, and to determine if there is documentation that the services for paid claims were included in the ISSP and individual budget and were rendered. Where deficiencies are identified, corrective action will be required, according to the terms of the contract.
d) The draw of federal funds and claiming occurs based upon the information entered in the DHS encounter reporting system.

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 state use a Third Party Administrator as the limited fiscal agent. The TPA makes payments for all of the waiver services identified in Appendix C of this waiver.

Traditional Provider (whose employees are not directly employed by the participant) claims are validated by the TPA through the prior authorization the TPA received from the IRIS centralized IT system. This prior authorization includes, but is not limited to, the participant ID (ensuring waiver program eligibility), provider ID (ensuring validation of applicable provider licenses or certification), service type (ensuring allowable waiver services), service code, unit, rate, and date of service. The TPA is responsible to assure that payment is only made when the participant was eligible for Medicaid waiver service payment on the dates of service and that the service was included in the participant's approved Individual Support and Service Plan and is within the allowable budget amount.

Participant-hired worker payroll claims are also submitted to the TPA however, these claims are submitted by the participant's F/EA provider. Prior to claim submittal to the TPA, the F/EA will receive the participant-hired worker timesheet, authorizing that services were received via the participant's signature and enter the timesheet into the payroll timesheet system. The payroll timesheet system will perform a validation against the participant's ISSP and notify the F/EA of any errors, unauthorized services, or services exceeding the authorization amount for the participant-hired worker. After completion of the timesheet validation process, the F/EA will conduct their payroll processing procedures to reimburse the participant-hired worker for

services provided. The F/EA will also submit a line item claim to the TPA that includes the industry standard best practice data required for claims adjudication, including but not limited to participant ID, provider ID, service type, service code, unit, rate, and date of service. The TPA will receive this claim from the F/EA and perform the same adjudication of this claim as required for those claims submitted by traditional providers described above. The participant's signature on the provider timesheet or claim authorizes payment for those service and validates that service was provided on the dates identifies and the rates identified on the claim. The TPA is responsible to assure that payment is only made when the participant was eligible for Medicaid waiver service payment on the dates of service and that the service was included in the participant's approved Individual Support and Service Plan and is within the allowable budget amount. Payroll claims that are paid to the participant-hired worker in error (keying error from validation to check write) are the responsibility of the F/EA to recoup, their reimbursement from the TPA will be only in the amount authorized on the ISSP. To ensure financial integrity and accountability, DHS perform audits and other quality checks related to the TPA Encounter reporting and certified paid claims against participants authorized individualized budgets, and to determine if there is documentation that the services for paid claims were included in the ISSP and individual budget and were rendered. Where deficiencies are identified, corrective action will be required, according to the terms of the contract. In addition, the F/EAs are required through the provider certification and contract requirements to conduct their own internal quality check after each payroll period to ensure that payments were correctly made and payments were made are within participant's budget. This is another method used to ensure financial accountability.

Under no circumstances can a waiver service be directly billed to Medicaid. Waiver services are not included in the MA State plan, and would therefore be rejected.

In addition to the above, the Department conducts record reviews of the participant's ISSP to ensure on that the services included on the ISSP are allowable waiver services and that the goods and services are classified under the appropriate allowable waiver service for submission to the TPA. Any errors discovered as part of the record review process require 100% remediation of the participant's ISSP and may also require corrective action with the ICA that validated the ISSP including changes to policy and procedure and/or additional internal controls.

The state does plan to have a centralized timesheet reporting system as part of future enhancements to the centralized IT system. Until that functionality is available the centralized IT system will submit a prior authorization file to the F/EAs for each participant hired worker. This file will include the participant, the participant-hired worker, service, unit of measure, amount authorized, and cost of service. The F/EAs will enter timesheets into their payroll processing system and the data elements will then be adjudicated against the file submitted from the State to the F/EAs. Any data entry errors or unauthorized amounts will result in the overage amount of the claim being pended until the resolution to the overage is complete. In addition, once the F/EAs send the participant hired worker payroll claim to the TPA the TPA will also adjudicate the F/EAs claim against the prior authorization received from the State. Similarly, the unauthorized amounts will result in the overage amount of the claim being pended for reimbursement until the reason for the overage is resolved.

☐ **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 TPA as authorized by the participant. These services could include:
Adult Family Home
Supportive Home Care
Day Services
Pre-vocational Services
Supported Employment
Specialized 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:*

- **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. *Select one:*

- **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 §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 §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 §1915(b)/§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 §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

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 cost of room and board from the cost of allowable waiver services using the following guidelines prescribed by the State Medicaid Agency. In most instances the participant uses her or his own resources to pay for the cost of room and board.

A. The following are room and board costs for which FFP is unavailable. These costs may be included in its room and board rate as long as the facility can demonstrate that the costs are actually attributable to room and board. To calculate its room and board rate, a facility is to separate these costs actually attributable to room and board from other facility costs and divide this total by the number of residents licensed for the living arrangement. This room and board rate is paid for out of the waiver participant's personal maintenance allowance. Room and board costs must be facility specific. Items related to room and board NOT ALLOWABLE waiver costs
 Rent, mortgage payments, title insurance, mortgage insurance.
 Property and casualty insurance
 Building and/or grounds maintenance costs
 Resident's food
 Household supplies and equipment necessary for the room and board of the individual
 Furnishings used by the individual (does not include office furnishings)
 Utilities, resident phones, cable TV, etc.
 Property taxes
 Specific individual special dietary needs

B. The following are allowable elements in residential provider rates for which FFP can be claimed. Items related to personal care and supervision ALLOWABLE waiver costs
 Staff costs
* Salaries*
* FICA
* Staff health insurance costs (benefits)
* Worker's compensation
* Unemployment compensation
* Staff travel
* Staff liability insurance
* Staff development/education
 Resident travel (includes depreciation on vehicle)
 Administrative overhead-contractor's costs to do business, including
* Office Supplies and Furnishings
* Percentage of administrative staff salaries
* Office telephone
* Recruitment
* Audit fees
* Operating fees/permits/licenses
* Percentage of office space costs
* Data processing fees
* Legal fees
* Agency liability insurance
* In certain circumstances a staff person's wages and benefits may need to be apportioned between room and board costs and support and supervision. For example, a live-in manager of a facility, depending on her/his duties, may have time apportioned for supervision and support as well as building and ground maintenance.

Room and board costs are negotiated between the provider and the participant or legal decision-maker; the participant uses their own funds to cover these costs.

Currently the SMA gives providers the option to use Appendix J of Wisconsin Medicaid Waivers Manual that is used in other waiver programs (referenced in the web link - http://www.dhs.wisconsin.gov/bdds/waivermanual/app_j1.pdf) as a tool to distinguish room and board costs from service costs OR the residential provider can provide their own documentation of this breakdown. During the individual plan development process with participants, both the room and board costs and support/services costs are individual line items included on the plan. The TPA can only pay for services billed under the service/supports line, and not room and board.

In instances where the State or ICAs have questions as to whether the amount of the service includes room and board, the State requests a detailed breakdown of service costs from the provider. These requests also include the tool referenced in the above link distinguishing room and board costs.

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:

The rent and food expenses of an unrelated live-in caregiver, who does not hold the lease or own the residence, will be determined by dividing total household rent and food expenses by the number of residents in the home, including the caregiver. In other words, the caregiver is considered a resident in the home, and food and rent expenses are apportioned equally among all persons residing in the home. It is the responsibility of the ICA to document and report any waiver funds used to pay rent and food expenses of an unrelated live-in caregiver. These costs are authorized on the participants Individual Support and Service Plan and billed on an invoice that is submitted to the TPA. These costs are calculated on an estimated basis. The ICA reviews the calculations to ensure that only allowable items are calculated.

Participants are not reimbursed for these costs. Rather a direct payment is made to the live-in care provider. These costs are calculated on an estimated basis.

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

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	13340.06	10832.53	24172.59	30817.47	1265.80	32083.27	7910.68
2	11652.53		32567.56			38487.90	5920.34

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)
		20915.03		37046.03	1441.87		
3	13510.85	23926.94	37437.79	42667.51	1637.06	44304.57	6866.78
4	13974.71	24502.57	38477.28	44246.90	1673.52	45920.42	7443.14
5	18263.71	26266.60	44530.31	48035.87	1790.99	49826.86	5296.55

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:
		Nursing Facility
Year 1	2548	2548
Year 2	5146	5146
Year 3	7397	7397
Year 4	7118	7118
Year 5	7688	7688

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 enrollment days for the year by the number of 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. Monthly projected enrollment is generally based on historical SDS waiver enrollment experience. However, in counties that have people participating in legacy HCBS waivers or on a waitlist, projected enrollment is based on the number of people in the legacy waivers or on a waitlist multiplied by the statewide proportion of eligible individuals that enrolled in the SDS waiver.

The number of unduplicated participants served during the year is calculated by adding the number of members expected to disenroll during the year to the projected participant count at the end of the year. A churn factor based on the waiver's historical monthly disenrollment rate is applied to the projected monthly member count to calculate the number of members projected to disenroll each month. The sum of the monthly disenrollments is then added to the projected member count at year end to arrive at the total number of unduplicated participants served during the year.

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 for these estimates is as follows:

Factor D is based on actual SDS waiver service costs from CY2009. Service cost for the "Vocational and Futures Planning" benefit was projected by applying the assumed proportion of member utilization to the estimated service cost. Beginning in CY2014, a CBRF will no longer be an allowable living arrangement. The service cost structure of a comparable population not residing in a CBRF was used to estimate the cost structure of the program once the participants in CBRFs are transitioned into a new setting. The cost structure change is assumed to be cost neutral overall; however, there is a shift between waiver and non-waiver services. The transition is assumed to occur consistently throughout CY2014 and be completed by year end. Costs for IRIS Consultant Services and Fiscal/Employer Agent Services added as benefits in

CY2015 are based on current contracted rates. These services are assumed to be utilized by all members. All service costs are trended forward using the actuarially determined target group specific trend factor used to set capitation rates for the Family Care program, approximately 5.2% for calendar year 2010 and 5.5% for all subsequent years. Enrollment projections are based on program experience, approved transition plans, or members currently on a HCBS waiver or waitlist.

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 service costs paid by the State Medicaid plan for IRIS members while they were enrolled in the program. CY2009 costs are used as the base for Waiver Year 1 (CY2011) and CY2010 costs are used as the base for Waiver Years 2 through 5 (CY2012 - CY2015). In CY2014 and CY2015, there is a shift between waiver and non-waiver costs due to transitioning participants residing in CBRFs to different settings as described in the Factor D derivation above. Costs are trended forward using the Consumer Price Index for medical services, approximately 4.0%. Enrollment projections are based on IRIS experience, approved transition plans, or members currently on a HCBS waiver or waitlist.

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 Medicaid institutional costs for individuals residing in nursing homes. CY2008 costs are used as the base for Waiver Year 1 (CY2011) and CY2010 costs are used as the base for Waiver Years 2 through 5 (CY2012 - CY2015). Costs are trended forward using the actuarially determined target group specific trend factor used to set capitation rates for the Family Care program, approximately 5.2% for calendar years 2009 and 2010 and 5.5% for all subsequent years. The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay between the nursing home population versus the SDS waiver population.

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 Medicaid non-institutional costs for individuals residing in nursing homes. CY2008 costs are used as the base for Waiver Year 1 (CY2011) and CY2010 costs are used as the base for Waiver Years 2 through 5 (CY2012 - CY2015). Costs are trended forward using the Consumer Price Index for medical services, approximately 4.0%. The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay between the nursing home population versus the SDS waiver population.

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	
Daily Living Skills Training	
IRIS Consultant Services	
Live-in Caregiver (42 CFR §441.303(f)(8))	
Prevocational Services	
Respite	
Supported Employment	
Nursing Services	
Fiscal / Employer Agent Services	
1-2 Bed Adult Family Home	
3-4 Bed Adult Family Home	
Adaptive Aids	
CBRF	
Communication Aids Vendors/Interpreter Services	
Consumer Education and Training	
Counseling and Therapeutic Services	
Customized Goods and Services	
Day Services	
Home Delivered Meals	
Home Modification	
Housing Counseling	
Personal Emergency Response System	

Waiver Services	
Relocation - Housing Start Up and Related Utility Costs	
Residential Care Apartment Complex	
Specialized Medical Equipment and Supplies	
Specialized Transportation 2	
Specialized Transportation	
Support Broker	
Supportive Home Care	
Vocational Futures Planning	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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:							**283453.29**
Adult Day Care	☐	hours	42	223.03	30.26	**283453.29**	
Daily Living Skills Training Total:							**70227.74**
Daily Living Skills Training	☐	hours	8	287.63	30.52	**70227.74**	
IRIS Consultant Services Total:							**0.00**
IRIS Consultant Services	☐	months	0	0.00	0.01	**0.00**	
Live-in Caregiver (42 CFR §441.303 (f)(8)) Total:							**74576.80**
Live-in Caregiver (42 CFR §441.303 (f)(8))	☐	days	4	365.00	51.08	**74576.80**	
Prevocational Services Total:							**22895.50**
Prevocational Services	☐	hours	8	181.25	15.79	**22895.50**	
Respite Total:							**517269.19**
Respite	☐	hours	114	308.67	14.70	**517269.19**	
Supported Employment Total:							**2789.28**
Supported Employment	☐	hours	8	38.74	9.00	**2789.28**	
Nursing Services Total:							

GRAND TOTAL:	**33990472.66**
Total: Services included in capitation:	
Total: Services not included in capitation:	33990472.66
Total Estimated Unduplicated Participants:	**2548**
Factor D (Divide total by number of participants):	**13340.06**
Services included in capitation:	
Services not included in capitation:	13340.06
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
							497596.68
Nursing Services	☐	hours	80	1641.15	3.79	**497596.68**	
Fiscal / Employer Agent Services Total:							**0.00**
Fiscal / Employer Agent Services	☐	months	0	0.00	0.01	**0.00**	
1-2 Bed Adult Family Home Total:							**28418.00**
1-2 Bed Adult Family Home	☐	days	4	73.79	96.28	**28418.00**	
3-4 Bed Adult Family Home Total:							**100364.50**
3-4 Bed Adult Family Home	☐	days	8	161.42	77.72	**100364.50**	
Adaptive Aids Total:							**1168998.10**
Adaptive Aids	☐	items	248	5.88	801.65	**1168998.10**	
CBRF Total:							**695683.30**
CBRF	☐	days	25	59.80	465.34	**695683.30**	
Communication Aids Vendors/Interpreter Services Total:							**124560.37**
Communication Aids Vendors/Interpreter Services	☐	items	97	13.07	98.25	**124560.37**	
Consumer Education and Training Total:							**9730.05**
Consumer Education and Training	☐	hours	17	3.23	177.20	**9730.05**	
Counseling and Therapeutic Services Total:							**369885.57**
Counseling and Therapeutic Services	☐	hours	118	46.05	68.07	**369885.57**	
Customized Goods and Services Total:							**2393651.27**
Customized Goods and Services	☐	none	804	61.78	48.19	**2393651.27**	
Day Services Total:							**267140.08**
Day Services	☐	hours	38	370.39	18.98	**267140.08**	
Home Delivered Meals Total:							**158406.25**
Home Delivered Meals	☐	meals	131	105.70	11.44	**158406.25**	
Home Modification Total:							**604402.01**
Home Modification	☐	project	76	4.20	1893.49	**604402.01**	
Housing Counseling Total:							**95629.11**

GRAND TOTAL:	**33990472.66**
Total: Services included in capitation:	
Total: Services not included in capitation:	33990472.66
Total Estimated Unduplicated Participants:	**2548**
Factor D (Divide total by number of participants):	**13340.06**
Services included in capitation:	
Services not included in capitation:	13340.06
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
Housing Counseling	☐	none	17	16.60	338.87	95629.11	
Personal Emergency Response System Total:							113579.84
Personal Emergency Response System	☐	rent/month	227	23.37	21.41	113579.84	
Relocation - Housing Start Up and Related Utility Costs Total:							47067.55
Relocation - Housing Start Up and Related Utility Costs	☐	none	17	10.61	260.95	47067.55	
Residential Care Apartment Complex Total:							267701.40
Residential Care Apartment Complex	☐	days	21	178.94	71.24	267701.40	
Specialized Medical Equipment and Supplies Total:							73672.87
Specialized Medical Equipment and Supplies	☐	items	80	19.11	48.19	73672.87	
Specialized Transportation 2 Total:							212318.54
Specialized Transportation 2	☐	trips	206	221.65	4.65	212318.54	
Specialized Transportation Total:							673309.73
Specialized Transportation	☐	miles	598	1876.56	0.60	673309.73	
Support Broker Total:							150937.23
Support Broker	☐	hours	13	237.97	48.79	150937.23	
Supportive Home Care Total:							24952550.99
Supportive Home Care	☐	hours	2283	2899.13	3.77	24952550.99	
Vocational Futures Planning Total:							13657.43
Vocational Futures Planning	☐	hours	19	18.45	38.96	13657.43	
					GRAND TOTAL:		3990472.66
					Total: Services included in capitation:		
					Total: Services not included in capitation:		33990472.66
					Total Estimated Unduplicated Participants:		2548
					Factor D (Divide total by number of participants):		13340.06
					Services included in capitation:		
					Services not included in capitation:		13340.06
					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 §1915(b)/§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 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**499961.36**
Adult Day Care	☐	hours	85	184.27	31.92	**499961.36**	
Daily Living Skills Training Total:							**130084.14**
Daily Living Skills Training	☐	hours	17	237.64	32.20	**130084.14**	
IRIS Consultant Services Total:							**0.00**
IRIS Consultant Services	☐	months	0	0.00	0.01	**0.00**	
Live-in Caregiver (42 CFR §441.303 (f)(8)) Total:							**177028.65**
Live-in Caregiver (42 CFR §441.303 (f)(8))	☐	days	9	365.00	53.89	**177028.65**	
Prevocational Services Total:							**42409.36**
Prevocational Services	☐	hours	17	149.74	16.66	**42409.36**	
Respite Total:							**909732.85**
Respite	☐	hours	230	255.02	15.51	**909732.85**	
Supported Employment Total:							**5169.61**
Supported Employment	☐	hours	17	32.01	9.50	**5169.62**	
Nursing Services Total:							**878623.20**
Nursing Services	☐	hours	162	1355.90	4.00	**878623.20**	
Fiscal / Employer Agent Services Total:							**0.00**
Fiscal / Employer Agent Services	☐	months	0	0.00	0.01	**0.00**	
1-2 Bed Adult Family Home Total:							**55725.36**
1-2 Bed Adult Family Home	☐	days	9	60.96	101.57	**55725.36**	
3-4 Bed Adult Family Home Total:							**185903.84**
3-4 Bed Adult Family Home	☐	days	17	133.36	82.00	**185903.84**	
Adaptive Aids Total:							**2063368.79**
Adaptive Aids	☐	items	502	4.86	845.74	**2063368.79**	
CBRF Total:							**1237099.42**
CBRF	☐	days	51	49.41	490.93	**1237099.42**	
Communication Aids Vendors/Interpreter Services Total:							**219406.32**

GRAND TOTAL:	**59963902.40**
Total: Services included in capitation:	
Total: Services not included in capitation:	59963902.40
Total Estimated Unduplicated Participants:	**5146**
Factor D (Divide total by number of participants):	**11652.53**
Services included in capitation:	
Services not included in capitation:	11652.53
Average Length of Stay on the Waiver:	261

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Communication Aids Vendors/Interpreter Services	☐	items	196	10.80	103.65	219406.32	
Consumer Education and Training Total:							16971.32
Consumer Education and Training	☐	hours	34	2.67	186.95	16971.32	
Counseling and Therapeutic Services Total:							650394.74
Counseling and Therapeutic Services	☐	hours	238	38.05	71.82	650394.74	
Customized Goods and Services Total:							4216669.60
Customized Goods and Services	☐	none	1625	51.04	50.84	4216669.60	
Day Services Total:							471962.28
Day Services	☐	hours	77	306.01	20.03	471962.28	
Home Delivered Meals Total:							278275.30
Home Delivered Meals	☐	meals	264	87.33	12.07	278275.30	
Home Modification Total:							1060561.74
Home Modification	☐	project	153	3.47	1997.63	1060561.74	
Housing Counseling Total:							166766.60
Housing Counseling	☐	none	34	13.72	357.50	166766.60	
Personal Emergency Response System Total:							200221.72
Personal Emergency Response System	☐	rent/month	459	19.31	22.59	200221.72	
Relocation - Housing Start Up and Related Utility Costs Total:							81995.35
Relocation - Housing Start Up and Related Utility Costs	☐	none	34	8.76	275.30	81995.35	
Residential Care Apartment Complex Total:							477737.57
Residential Care Apartment Complex	☐	days	43	147.84	75.15	477737.57	
Specialized Medical Equipment and Supplies Total:							130047.70
Specialized Medical Equipment and Supplies	☐	items	162	15.79	50.84	130047.70	
Specialized Transportation 2 Total:							374169.10
Specialized Transportation 2	☐	trips	417	183.12	4.90	374169.10	
Specialized Transportation Total:							1198645.25
Specialized Transportation	☐	miles	1208	1550.40	0.64	1198645.25	

GRAND TOTAL:		**59963902.40**
Total: Services included in capitation:		
Total: Services not included in capitation:		59963902.40
Total Estimated Unduplicated Participants:		**5146**
Factor D (Divide total by number of participants):		**11652.53**
Services included in capitation:		
Services not included in capitation:		11652.53
Average Length of Stay on the Waiver:		261

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Support Broker Total:							**263158.55**
Support Broker	☐	hours	26	196.61	51.48	**263158.55**	
Supportive Home Care Total:							**43947384.47**
Supportive Home Care	☐	hours	4610	2395.24	3.98	**43947384.47**	
Vocational Futures Planning Total:							**24428.20**
Vocational Futures Planning	☐	hours	39	15.24	41.10	**24428.20**	
					GRAND TOTAL:		**59963902.40**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		59963902.40
					Total Estimated Unduplicated Participants:		**5146**
					Factor D (Divide total by number of participants):		**11652.53**
					Services included in capitation:		
					Services not included in capitation:		11652.53
					Average Length of Stay on the Waiver:		261

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**832845.10**
Adult Day Care	☐	hours	122	202.69	33.68	**832845.10**	
Daily Living Skills Training Total:							**213122.34**
Daily Living Skills Training	☐	hours	24	261.41	33.97	**213122.34**	
IRIS Consultant Services Total:							**0.00**
IRIS Consultant Services	☐	months	0	0.00	0.01	**0.00**	
Live-in Caregiver (42 CFR §441.303 (f)(8)) Total:							**249003.00**
Live-in Caregiver (42 CFR §441.303 (f)(8))	☐	days	12	365.00	56.85	**249003.00**	
Prevocational Services Total:							**69498.66**
Prevocational Services						**69498.66**	
					GRAND TOTAL:		**99939758.84**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		99939758.84
					Total Estimated Unduplicated Participants:		**7397**
					Factor D (Divide total by number of participants):		**13510.85**
					Services included in capitation:		
					Services not included in capitation:		13510.85
					Average Length of Stay on the Waiver:		285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	☐	hours	24	164.72	17.58		
Respite Total:							**1515451.11**
Respite	☐	hours	330	280.53	16.37	**1515451.11**	
Supported Employment Total:							**8467.30**
Supported Employment	☐	hours	24	35.21	10.02	**8467.30**	
Nursing Services Total:							**1460238.16**
Nursing Services	☐	hours	232	1491.50	4.22	**1460238.16**	
Fiscal / Employer Agent Services Total:							**0.00**
Fiscal / Employer Agent Services	☐	months	0	0.00	0.01	**0.00**	
1-2 Bed Adult Family Home Total:							**86233.80**
1-2 Bed Adult Family Home	☐	days	12	67.06	107.16	**86233.80**	
3-4 Bed Adult Family Home Total:							**304584.41**
3-4 Bed Adult Family Home	☐	days	24	146.70	86.51	**304584.41**	
Adaptive Aids Total:							**3441759.11**
Adaptive Aids	☐	items	721	5.35	892.26	**3441759.11**	
CBRF Total:							**2054913.17**
CBRF	☐	days	73	54.35	517.93	**2054913.17**	
Communication Aids Vendors/Interpreter Services Total:							**366340.00**
Communication Aids Vendors/Interpreter Services	☐	items	282	11.88	109.35	**366340.00**	
Consumer Education and Training Total:							**28316.31**
Consumer Education and Training	☐	hours	49	2.93	197.23	**28316.31**	
Counseling and Therapeutic Services Total:							**1087644.25**
Counseling and Therapeutic Services	☐	hours	343	41.85	75.77	**1087644.25**	
Customized Goods and Services Total:							**7032753.81**
Customized Goods and Services	☐	none	2335	56.15	53.64	**7032753.81**	
Day Services Total:							**782382.62**
Day Services	☐	hours	110	336.61	21.13	**782382.62**	

GRAND TOTAL:	**99939758.84**
Total: Services included in capitation:	
Total: Services not included in capitation:	99939758.84
Total Estimated Unduplicated Participants:	**7397**
Factor D (Divide total by number of participants):	**13510.85**
Services included in capitation:	
Services not included in capitation:	13510.85
Average Length of Stay on the Waiver:	285

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meals Total:							**463457.80**
Home Delivered Meals	☐	meals	379	96.06	12.73	**463457.80**	
Home Modification Total:							**1771143.00**
Home Modification	☐	project	220	3.82	2107.50	**1771143.00**	
Housing Counseling Total:							**278883.27**
Housing Counseling	☐	none	49	15.09	377.17	**278883.27**	
Personal Emergency Response System Total:							**334058.47**
Personal Emergency Response System	☐	rent/month	660	21.24	23.83	**334058.47**	
Relocation - Housing Start Up and Related Utility Costs Total:							**137192.24**
Relocation - Housing Start Up and Related Utility Costs	☐	none	49	9.64	290.44	**137192.24**	
Residential Care Apartment Complex Total:							**786542.53**
Residential Care Apartment Complex	☐	days	61	162.62	79.29	**786542.53**	
Specialized Medical Equipment and Supplies Total:							**218024.07**
Specialized Medical Equipment and Supplies	☐	items	234	17.37	53.64	**218024.07**	
Specialized Transportation 2 Total:							**623794.47**
Specialized Transportation 2	☐	trips	599	201.43	5.17	**623794.47**	
Specialized Transportation Total:							**1983643.00**
Specialized Transportation	☐	miles	1736	1705.45	0.67	**1983643.00**	
Support Broker Total:							**434588.08**
Support Broker	☐	hours	37	216.27	54.31	**434588.08**	
Supportive Home Care Total:							**73334885.65**
Supportive Home Care	☐	hours	6627	2634.78	4.20	**73334885.65**	
Vocational Futures Planning Total:							**39993.10**
Vocational Futures Planning	☐	hours	55	16.77	43.36	**39993.10**	
					GRAND TOTAL:		**99939758.84**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		99939758.84
					Total Estimated Unduplicated Participants:		**7397**
					Factor D (Divide total by number of participants):		**13510.85**
					Services included in capitation:		
					Services not included in capitation:		13510.85
					Average Length of Stay on the Waiver:		285

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**835279.74**
Adult Day Care	☐	hours	118	199.23	35.53	**835279.74**	
Daily Living Skills Training Total:							**223011.65**
Daily Living Skills Training	☐	hours	24	259.34	35.83	**223011.65**	
IRIS Consultant Services Total:							**0.00**
IRIS Consultant Services	☐	months	0	0.00	0.01	**0.00**	
Live-in Caregiver (42 CFR §441.303 (f)(8)) Total:							**262712.40**
Live-in Caregiver (42 CFR §441.303 (f)(8))	☐	days	12	365.00	59.98	**262712.40**	
Prevocational Services Total:							**72394.99**
Prevocational Services	☐	hours	24	162.70	18.54	**72394.99**	
Respite Total:							**1522673.10**
Respite	☐	hours	318	277.26	17.27	**1522673.10**	
Supported Employment Total:							**8828.06**
Supported Employment	☐	hours	24	34.80	10.57	**8828.06**	
Nursing Services Total:							**1469402.82**
Nursing Services	☐	hours	224	1474.12	4.45	**1469402.82**	
Fiscal / Employer Agent Services Total:							**0.00**
Fiscal / Employer Agent Services	☐	months	0	0.00	0.01	**0.00**	
1-2 Bed Adult Family Home Total:							**89915.45**
1-2 Bed Adult Family Home	☐	days	12	66.28	113.05	**89915.45**	
3-4 Bed Adult Family Home Total:							**317562.90**
3-4 Bed Adult Family Home	☐	days	24	144.99	91.26	**317562.90**	
Adaptive Aids Total:							**3455867.18**

GRAND TOTAL:		**99472016.08**
Total: Services included in capitation:		
Total: Services not included in capitation:		99472016.08
Total Estimated Unduplicated Participants:		**7118**
Factor D (Divide total by number of participants):		**13974.71**
Services included in capitation:		
Services not included in capitation:		13974.71
Average Length of Stay on the Waiver:	280	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adaptive Aids	☐	items	694	5.29	941.33	3455867.18	
CBRF Total:							972611.21
CBRF	☐	days	71	25.07	546.42	972611.21	
Communication Aids Vendors/Interpreter Services Total:							367022.45
Communication Aids Vendors/Interpreter Services	☐	items	271	11.74	115.36	367022.45	
Consumer Education and Training Total:							28361.30
Consumer Education and Training	☐	hours	47	2.90	208.08	28361.30	
Counseling and Therapeutic Services Total:							1081857.35
Counseling and Therapeutic Services	☐	hours	329	41.14	79.93	1081857.35	
Customized Goods and Services Total:							7017835.12
Customized Goods and Services	☐	none	2247	55.19	56.59	7017835.12	
Day Services Total:							786059.97
Day Services	☐	hours	106	332.69	22.29	786059.97	
Home Delivered Meals Total:							467155.84
Home Delivered Meals	☐	meals	365	95.30	13.43	467155.84	
Home Modification Total:							1777038.21
Home Modification	☐	project	212	3.77	2223.41	1777038.21	
Housing Counseling Total:							277347.25
Housing Counseling	☐	none	47	14.83	397.91	277347.25	
Personal Emergency Response System Total:							333166.59
Personal Emergency Response System	☐	rent/month	635	20.87	25.14	333166.59	
Relocation - Housing Start Up and Related Utility Costs Total:							136528.50
Relocation - Housing Start Up and Related Utility Costs	☐	none	47	9.48	306.42	136528.50	
Residential Care Apartment Complex Total:							795825.19
Residential Care Apartment Complex	☐	days	59	161.25	83.65	795825.19	
Specialized Medical Equipment and Supplies Total:							217348.04
Specialized Medical Equipment and Supplies	☐	items	225	17.07	56.59	217348.04	

GRAND TOTAL:	**99472016.08**
Total: Services included in capitation:	
Total: Services not included in capitation:	99472016.08
Total Estimated Unduplicated Participants:	**7118**
Factor D (Divide total by number of participants):	**13974.71**
Services included in capitation:	
Services not included in capitation:	13974.71
Average Length of Stay on the Waiver:	280

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Transportation 2 Total:							**626130.09**
Specialized Transportation 2	☐	trips	576	199.09	5.46	**626130.09**	
Specialized Transportation Total:							**1999788.97**
Specialized Transportation	☐	miles	1671	1685.58	0.71	**1999788.97**	
Support Broker Total:							**426254.79**
Support Broker	☐	hours	35	212.58	57.29	**426254.79**	
Supportive Home Care Total:							**73863867.61**
Supportive Home Care	☐	hours	6377	653.66	17.72	**73863867.61**	
Vocational Futures Planning Total:							**40169.33**
Vocational Futures Planning	☐	hours	53	16.57	45.74	**40169.33**	
					GRAND TOTAL:		**99472016.08**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		99472016.08
					Total Estimated Unduplicated Participants:		**7118**
					Factor D (Divide total by number of participants):		**13974.71**
					Services included in capitation:		
					Services not included in capitation:		13974.71
					Average Length of Stay on the Waiver:		280

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**976077.40**
Adult Day Care	☐	hours	127	205.06	37.48	**976077.40**	
Daily Living Skills Training Total:							**254129.40**
Daily Living Skills Training	☐	hours	25	268.92	37.80	**254129.40**	
IRIS Consultant Services Total:							**18909404.80**
IRIS Consultant Services						**18909404.80**	
					GRAND TOTAL:		**140411418.14**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		140411418.14
					Total Estimated Unduplicated Participants:		**7688**
					Factor D (Divide total by number of participants):		**18263.71**
					Services included in capitation:		
					Services not included in capitation:		18263.71
					Average Length of Stay on the Waiver:		288

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	☐	months	7688	9.46	260.00		
Live-in Caregiver (42 CFR §441.303 (f)(8)) Total:							**300263.60**
Live-in Caregiver (42 CFR §441.303 (f)(8))	☐	days	13	365.00	63.28	**300263.60**	
Prevocational Services Total:							**82210.68**
Prevocational Services	☐	hours	25	168.12	19.56	**82210.68**	
Respite Total:							**1883149.78**
Respite	☐	hours	343	301.33	18.22	**1883149.78**	
Supported Employment Total:							**10026.64**
Supported Employment	☐	hours	25	35.97	11.15	**10026.64**	
Nursing Services Total:							**1726212.15**
Nursing Services	☐	hours	241	1523.98	4.70	**1726212.15**	
Fiscal / Employer Agent Services Total:							**5163722.08**
Fiscal / Employer Agent Services	☐	months	7688	9.46	71.00	**5163722.08**	
1-2 Bed Adult Family Home Total:							**106240.95**
1-2 Bed Adult Family Home	☐	days	13	68.52	119.27	**106240.95**	
3-4 Bed Adult Family Home Total:							**360785.23**
3-4 Bed Adult Family Home	☐	days	25	149.89	96.28	**360785.23**	
Adaptive Aids Total:							**4066785.45**
Adaptive Aids	☐	items	750	5.46	993.11	**4066785.45**	
CBRF Total:							**0.00**
CBRF	☐	days	0	0.00	0.01	**0.00**	
Communication Aids Vendors/Interpreter Services Total:							**431447.34**
Communication Aids Vendors/Interpreter Services	☐	items	292	12.14	121.71	**431447.34**	
Consumer Education and Training Total:							**33586.56**
Consumer Education and Training	☐	hours	51	3.00	219.52	**33586.56**	
Counseling and Therapeutic Services Total:							**1271109.46**
Counseling and Therapeutic Services	☐	hours	356	42.34	84.33	**1271109.46**	

GRAND TOTAL:	**140411418.14**
Total: Services included in capitation:	
Total: Services not included in capitation:	140411418.14
Total Estimated Unduplicated Participants:	**7688**
Factor D (Divide total by number of participants):	**18263.71**
Services included in capitation:	
Services not included in capitation:	18263.71
Average Length of Stay on the Waiver:	288

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Customized Goods and Services Total:							**8229859.92**
Customized Goods and Services	☐	none	2427	56.80	59.70	**8229859.92**	
Day Services Total:							**922199.44**
Day Services	☐	hours	114	343.94	23.52	**922199.44**	
Home Delivered Meals Total:							**551710.08**
Home Delivered Meals	☐	meals	394	98.82	14.17	**551710.08**	
Home Modification Total:							**2094944.67**
Home Modification	☐	project	229	3.90	2345.70	**2094944.67**	
Housing Counseling Total:							**326713.55**
Housing Counseling	☐	none	51	15.26	419.80	**326713.55**	
Personal Emergency Response System Total:							**390779.63**
Personal Emergency Response System	☐	rent/month	686	21.48	26.52	**390779.63**	
Relocation - Housing Start Up and Related Utility Costs Total:							**160746.01**
Relocation - Housing Start Up and Related Utility Costs	☐	none	51	9.75	323.27	**160746.01**	
Residential Care Apartment Complex Total:							**944006.72**
Residential Care Apartment Complex	☐	days	64	167.14	88.25	**944006.72**	
Specialized Medical Equipment and Supplies Total:							**254889.75**
Specialized Medical Equipment and Supplies	☐	items	243	17.57	59.70	**254889.75**	
Specialized Transportation 2 Total:							**738580.95**
Specialized Transportation 2	☐	trips	623	205.82	5.76	**738580.95**	
Specialized Transportation Total:							**2357710.74**
Specialized Transportation	☐	miles	1804	1742.58	0.75	**2357710.74**	
Support Broker Total:							**502522.34**
Support Broker	☐	hours	38	218.80	60.44	**502522.34**	
Supportive Home Care Total:							**87313654.59**
Supportive Home Care	☐	hours	6887	677.97	18.70	**87313654.59**	
Vocational Futures Planning Total:							**47948.24**

GRAND TOTAL:		**140411418.14**
Total: Services included in capitation:		
Total: Services not included in capitation:		140411418.14
Total Estimated Unduplicated Participants:		**7688**
Factor D (Divide total by number of participants):		**18263.71**
Services included in capitation:		
Services not included in capitation:		18263.71
Average Length of Stay on the Waiver:	288	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vocational Futures Planning	☐	hours	58	17.13	48.26	**47948.24**	
					GRAND TOTAL:		**140411418.14**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		140411418.14
					Total Estimated Unduplicated Participants:		**7688**
					Factor D (Divide total by number of participants):		**18263.71**
					Services included in capitation:		
					Services not included in capitation:		18263.71
					Average Length of Stay on the Waiver:		288