



Wisconsin Department of Health Services

IRIS Policy Manual

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1.0 Introduction to Include, Respect, I Self-Direct (IRIS)

IRIS is an authorized program under the Medicaid Home and Community-Based Services (HCBS) waiver section 1915(c) of the federal Social Security Act. Program manuals, including information and policies regarding rules and regulations governing eligibility, need and amount of assistance, participant's rights and responsibilities and the services that are covered must be made public per DHS 104.01(9)(9)(a).

1.1 Background, Purpose and Philosophy

This section provides an overview of the IRIS Self-Directed Supports (SDS) program in the context of Wisconsin's long-term care system and long-term care reform implementation. This section discusses the purpose and goals of IRIS, its basis in the principles of self-determination, and a comparison to managed long-term care. This section also describes the overall structure of IRIS, the role and responsibilities of the IRIS participant and the organizational components of the program, including those entities that support participants to successfully self-direct their services.

1.1A Background

IRIS is a community-based long-term support program that began in Wisconsin on July 1, 2008. Oversight for IRIS is in the Wisconsin Department of Health Services (DHS), Division of Long Term Care (DLTC) under the authorization of the Centers for Medicaid and Medicare Services (CMS). DHS seeks input from participants and other stakeholders through a variety of advisory boards, focus groups, and tribal consultations.

DLTC oversees the provision of several long-term support options for frail elders and people with disabilities, as well as other programs for elders and persons with disabilities. The Office of Resource Center Development (ORCD) within DLTC manages the Aging and Disability Resource Centers (ADRCs) which are the unbiased source of options counseling for people eligible for long-term care.

IRIS is available to Wisconsin residents who are Medicaid eligible, eligible for publicly funded long-term support services and who live in a county where Family Care, managed long-term care, is available. People are offered the choice of IRIS or managed long-term care when they enter the state publicly funded long-term care system through the local ADRC.

IRIS was created in response to consumer demand and a directive from the federal Centers for Medicare and Medicaid Services (CMS) that individuals who are eligible for managed long-term care in Wisconsin have the opportunity to have choice relative to long-term care program enrollment. Managed long-term care includes Family Care and, where available, Family Care Partnership and Program for All-Inclusive Care for the Elderly (PACE). IRIS was designed and began to operate in July 2008 as Wisconsin's SDS Medicaid HCBS waiver program. Since November 2009, IRIS participants eligible for personal care services are also provided the option to self-direct their personal care services under Section 1915(j) of the Social Security Act through a Medicaid state plan amendment or to receive these services from an agency through their Medicaid ForwardHealth card.

People who choose to participate in IRIS have choice, control, and freedom to design their support and service plans in order to meet their functional, vocational, medical, and social needs. These rights are structured within program policies and procedures to ensure compliance with the federal 1915(c) HCBS Waiver application and subsequent renewal requests filed by DHS with CMS. These HCBS waivers define the types of services and goods that are included in the IRIS program. Persons enrolled in IRIS self-manage their goods and services and may use IRIS-funded supports and services to remain in their community and avoid moving into a nursing home or other institution. Frail elders and adults with physical or intellectual or developmental disabilities have control over the type of services they receive in allowable home and community settings through the IRIS program.



Since 2008, Wisconsin has undergone a major transformation in the way MA HCBS long-term care services are delivered statewide, moving from a system in which 72 counties managed and implemented adult HCBS waiver services to a system that provides statewide access to managed long term-care services and self-directed supports.

The state's vision for long term-care reform includes the following goals:

- Access – improve people's access to services.
- Choice – give people better choices about the goods, supports, and services to meet their needs.
- Cost Effectiveness – create a cost effective long-term care system for the future.
- Quality – improve the quality of the long-term care system by focusing on achieving people's health and long-term care outcomes.

This statewide reform effort included the establishment of Aging and Disability Resource Centers (ADRCs) to provide options and enrollment counseling to people with long-term care needs so that they can make informed choices about their long-term care services. People who are eligible have a choice among traditional nursing home or institutional care, managed long term-care and IRIS in Wisconsin.

1.1B Purpose

The purpose of IRIS is to help participants design and implement plans for HCBS services and supports as an alternative to institutional care. IRIS facilitates participant choice, direction, and control over services and supports that are purchased in accordance with a support and service plan, an individual budget range and natural supports. The goals of IRIS, as embodied in its name, refer to the following:

Include – Wisconsin frail elders, adults with physical disabilities and adults with developmental disabilities with long-term care needs who are Medicaid eligible are included in communities across Wisconsin. IRIS services help to meet a person's long-term support needs are designed by the participant or the participant's guardian to meet these needs in community settings.

Respect – Participants choose their living setting, their relationships, their work, and their participation in the community.

I Self-Direct – IRIS is a self-directed long-term care option in which the participant manages supports and services using natural supports and an individual budget range to purchase supports and services to meet their long-term care needs and outcomes within the guidelines of allowable supports and services. The participant has the flexibility to design a cost-effective and personal plan to meet long-term care needs and outcomes.

1.1C Philosophy

Self-direction means people have more choice, control, flexibility, freedom, and responsibility. Within the context of IRIS, self-direction means participants decide upon the following:

- The goods, supports, and services needed to help live the life he or she wants while meeting his or her long-term care outcomes.
- The amount and location goods, supports, and services are provided, as well as decisions on the provider of these services.
- The use of the individual IRIS budget to meet his or her needs responsibly and cost-effectively.
- To determine the needed assistance to plan for needed goods, supports and services.



Self-direction is a tool that leads to self-determination through which participants take control of their long-term care outcomes and have more freedom to lead a meaningful life at home, at work and in their communities.

1.1D Guiding Principles

The vision for IRIS is to support participants to lead self-determined lives. Accordingly, the IRIS self-directed supports program is based on the five core principles of self-determination:

- Freedom to decide how an individual wants to live their life.
- Authority over an individual budget.
- Support to organize resources and direct services in ways that are life enhancing and meaningful to the person and that recognize the contribution that people with disabilities can make in their communities.
- Responsibility for the wise use of public dollars.
- Confirmation of the important role that people with disabilities have in being self-advocates and affecting change.

Further information about self-determination can be found at the Center for Self-Determination website at <http://www.dhs.wisconsin.gov/sds/index.htm>

1.2 Structure, Roles and Responsibilities

Several organizational components are in place to support the IRIS participant to successfully self-direct goods, supports and services. As Wisconsin's designated Medicaid agency, DHS retains authority for overall administration, oversight, and coordination of the IRIS program. The Department contracts with agencies to assist and facilitate IRIS participants in self-direction. These agencies also provide important protections and safeguards for participants who self-direct. The contracted agency types include:

- Aging and Disability Resource Centers (ADRCs);
- IRIS consultant agencies (ICA); and
- IRIS fiscal employer agents (FEA)

1.2A Participant

The essential leadership role of participants in planning and purchasing goods, supports, and services is recognized within the IRIS program structures. The participant is the eligible individual who chooses IRIS as the program for needed publicly funded long-term care supports and services. In this manual, "participant" means:

- The participant acting independently on their own, or with the assistance of a person designated by the participant; or
- A legal representative when the representative has authority to make pertinent decisions on behalf of the participant (e.g., guardian).

The IRIS participant has three key roles in self-directing their goods, supports, and services in IRIS, as well as responsibilities related to those roles.

1.2A.1 Decision-Making

Participants in the IRIS program have made a choice to self-direct all of their long-term care services and supports. This provides participants a high degree of choice and control over services and supports delivered. Participants develop their support and service plans, within their individual budget range, and direct the services and supports identified on their

plans. Participants are responsible to work with their IRIS Consultant, the IRIS consultant agency and the IRIS fiscal employer agent to implement their plans.

1.2A.2 Participant Budget Authority

Participants manage and direct an individual service budget. The person's plan defines the goods and services that will be paid to meet their long-term care needs consistent with their approved support and service plan. Participants do not set the level of funds they have available; however, they do exercise choice over how those funds are spent. Participants are accountable for the use of IRIS funds consistent with their long-term care support and service plan, established policies and procedures, and the federal waiver authority for IRIS. Payment for authorized services and supports is made through the FEA. Participants do not receive the funds in their budget; rather payment is made through these third parties for authorized expenditures.

1.2A.3 Participant Employer Authority

Participants may hire, manage and direct their paid workers or care providers. There are two ways in which IRIS participants can carry out their employer role. One is as a common law employer, and the other is as a co-employer with an agency. A common law employer role occurs when a participant serves as the employer of record and engages in all typical employer responsibilities. These responsibilities include recruiting and hiring workers; training, scheduling and directing workers; and reviewing and approving timesheets and other documentation. If the participant chooses to be a co-employer then the responsibility of the employer tasks is shared with a qualified agency, and that agency serves as the employer of record.

1.2B Wisconsin Department of Health Services

The Wisconsin Department of Health Services is the State Medicaid Agency, and, accordingly, is responsible for providing oversight of Medicaid HCBS waiver programs in Wisconsin. The Department assures authority and responsibility for these programs, including IRIS, through administrative oversight and the issuance of policies, rules, and regulations. DHS establishes policies and procedures to assure compliance with federal and state regulations governing the program. While agencies with which DHS contracts, such as the IRIS consultant agencies and fiscal employer agencies perform key functions and activities in IRIS, each contracted agency directs policy issues and decisions to DHS. In addition, DHS ensures that Medicaid provider agreements are in place with each paid provider of self-directed services before service claims are paid.

The Department provides state oversight of ADRCs, including the quality and administrative oversight of the Long-Term Care Functional Screen which determines an individual's level of care and functional eligibility for IRIS and other adult long-term care programs.

The Department is responsible for Wisconsin's Medicaid HCBS waiver application for IRIS, as approved by CMS. Therefore DHS is required to demonstrate that the CMS assurance requirements in the HCBS waivers for IRIS are being met. The CMS assurances under the Medicaid waivers, including IRIS, are identified below, along with a description of the State Medicaid agency's demonstration of compliance with each assurance.

1.2B.1 Administrative Authority

The Department must demonstrate that it retains ultimate administrative authority and responsibility for the operation of the HCBS waiver program and provides administration of the HCBS waiver program consistent with its approved federal 1915(c) application, including oversight of the performance of waiver functions by other state, regional, local, and contracted entities.



1.2B.2 Level of Care

The Department must demonstrate that it implements the processes and instrument(s) specified in its approved waiver for evaluating and reevaluating a participant's level-of-care consistent with the care provided in a nursing home or Intermediate Care Facility for people with intellectual or developmental disabilities (ICF-IDD).

1.2B.3 Qualified Providers

The Department must demonstrate that waiver services are provided by qualified providers who meet required licensure and/or certification standards and adhere to other specified standards prior to providing waiver services.

1.2B.4 Service Plan

The Department must demonstrate that:

- Participants are afforded choice between waiver services and institutional care and among waiver services and providers;
- Service plans address participant's assessed needs and long-term care outcomes;
- Service plan development is monitored;
- Service plans are updated/revised at least annually and when warranted by changes in the participant's needs; and
- Services are delivered in accordance with the service plan.

1.2B.5 Health and Welfare

The Department must demonstrate that it identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

1.2B.6 Financial Accountability

The Department must demonstrate that it has a system in place for assuring financial accountability in the approved HCBS waiver.

1.2C Aging and Disability Resource Centers (ADRCs)

ADRCs are public entities that are responsible for providing accurate, unbiased information on all aspects of life related to aging or living with a disability. ADRCs are designed to be friendly, welcoming places where anyone – individuals with disabilities, concerned families or friends, or professionals working with issues related to aging or disabilities – can go for information and assistance related to long-term care.

ADRCs provide a central source of reliable and objective information about a broad range of programs and services and help individuals understand and evaluate the various options available to them. By enabling people to find resources in their communities and make informed decisions about long-term care, ADRCs can help people conserve their personal resources, maintain self-sufficiency and delay or prevent the need for potentially expensive long-term care. ADRCs serve as the single-access-point for publicly funded long-term care, including IRIS and Family Care, managed long-term care.

ADRCs perform the following key roles in Wisconsin's long-term care system:

1.2C.1 Information and Assistance

ADRCs provide information about local services and resources and assist people to find services to match their needs. ADRCs can also connect people to wellness and preventative-focused programs to help keep them healthy and independent.

1.2C.2 Benefit Counseling

ADRCs provide information about publicly funded benefits that a person may be eligible to receive, such as Medicare, Medicaid, Social Security, disability supports, and low-income housing, as well as other benefits. Additionally, benefit specialists advocate for people when they have issues with these benefit programs.

1.2C.3 Long-Term Care Options Counseling

ADRCs provide information about the choices that people with long-term care needs have about where to live, what kind of help they need, where to receive that care and help, and how to pay for it. In addition, ADRCs provide one-on-one consultation to help people think through the benefits and limitations of the various options given their particular situation, values, resources, and preferences.

1.2C.4 Enrollment/Disenrollment Counseling

ADRCs explain the publically funded program choices that people have for long-term care, including the option of participating in IRIS, so that people have an informed decision about the program they choose. In addition to IRIS, these program choices include Family Care, and in some areas, Family Care Partnership and PACE (Program of All-Inclusive Care for the Elderly).

1.2C.5 Access to Funding for Long-Term Care

ADRCs are the entryway to the publicly funded long-term care system. They administer the automated Long-Term Care Functional Screen to determine if people with long-term care needs are functionally eligible for public funding of long-term care. ADRCs also coordinate with Income Maintenance agencies to assist participants with the Medicaid financial eligibility process.

Further information about ADRCs, their role and responsibilities can be found at the DHS website:

<https://www.dhs.wisconsin.gov/adrc/index.htm>

A directory of ADRCs can be found at:

<https://www.dhs.wisconsin.gov/adrc/consumer/index.htm>

1.2D Income Maintenance (IM)

Income Maintenance, formerly known as Economic Support, is a regional consortium of counties, a subunit of a tribal government, or a state-operated entity, responsible for determining financial eligibility for publicly funded programs, including IRIS, and other public benefits. Income Maintenance staff determine financial eligibility using the state's Client Assistance for Reemployment and Economic Support (CARES) system. All Medicaid cost share calculations are made by the IM Office.

A directory of IM agencies can be found at:

<http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm>

1.2E IRIS Consultant Agencies (ICA)

The federal Medicaid waiver authority for IRIS requires that information and assistance be made available to facilitate self-direction. The ICAs, under contract with DHS, provide flexible and specialized supports that are responsive to a participant's needs and preferences. Individuals select their ICA based on information provided through ADRC enrollment counseling.

The IRIS consultant agencies' roles and responsibilities focus on several key areas to support the IRIS participant in self-direction as follows:

1.2E.1 Enrollment in IRIS and Continued Eligibility

The ICAs:

- Provide initial orientation for a person who has chosen IRIS for long-term care, including assisting the person in selecting a consultant who will work in partnership with the participant.
- Provide comprehensive and detailed IRIS program orientation and skills training to participants related to self-direction, support and service plan development and individual budget management.
- Provide information and training to participants regarding individual budget management and the participant's obligations for financial accountability and eligibility in the program.
- Provide information and training to participants regarding the roles and responsibilities of being an employer.
- Establish a participant's IRIS start date and coordinates and communicates this start date with the ADRC and IM.
- Provide information to participants on the participant's responsibilities related to cost share obligations as calculated by IM.
- Conduct functional screens for IRIS participants annually to ensure that continued functional eligibility is maintained, and when a change in participant condition warrants a new functional screen.
- Interact with the fiscal employer agencies, the ADRCs and DHS as needed surrounding IRIS continuing eligibility issues.
- Review budget status and expenditure reports with the participant.

1.2E.2 IRIS Consultant Network

- Develops and maintains a network of consultants.
- Provides general and specialized support and information to IRIS consultants regarding such matters as housing, employment, youth transition planning, behavioral management, and relocation assistance.
- IRIS consultants are trained and responsible to:
 - Assist participants in understanding IRIS.
 - Serve as an ongoing source of collaboration and support to participants in self-direction.
 - Provide a level and frequency of consultant support that is responsive to a participant's changing strengths, needs, and preferences.
 - Assist a participant in the development and ongoing implementation of their support and service plan and use of the budget, including the identification of informal or natural supports.
 - Assist participants, as needed, in the identification of qualified service providers and helps to ensure that service providers receive adequate training.
 - Develop and submit requests for additional funding to meet exceptional, changing, and/or one-time needs to DHS.
 - Administer the review and approval process for support and service plans for IRIS participants, including changes or additions to plans as appropriate.
 - Review budget updates and exceptional expense requests and submits completed documentation to DHS for review and approval.
 - Help assure program quality through various quality management activities that are carried out in partnership with the participant and DHS. These activities involve, but are not limited to: personal experience outcomes, provider qualifications, participant emergency and back-up plans, critical incident reporting, and service plan and budget monitoring.
 - Act as the primary contact for program participants.
 - Assist participants to coordinate their IRIS-Self Directed Personal Care services.

1.2F IRIS Fiscal Employer Agent (FEA)

The federal Medicaid waiver authority for IRIS does not permit payments for services to be made directly to IRIS participants. Instead, participants have individual budget authority to decide upon the funded supports and services. The payments are made through the IRIS FEA. The FEA, under contract with DHS, performs IRIS related financial transactions on the participant's behalf, such as paying for goods and services, processing payroll for the participant's hired workers and processing agency provider invoices. Individuals select an FEA from among those certified by DHS to operate in their area.

The FEA supports the IRIS participant in carrying out their budget and purchasing role and employer role as follows:

1.2F.1 Support for Participant Budget and Purchasing

- Conduct criminal and caregiver background checks for selected workers initially and at least every four years thereafter and interacts with the participant, the ICA and DHS on these results as needed.
- Assure completion of required documentation for newly hired workers, such as verifying workers' citizenship or legal alien status and completing required forms.
- Verify that workers and other providers selected by the participant meet the provider qualifications for the services that they claim for payment.

- Ensure that MA provider agreements are signed and maintained on behalf of DHS consistent with federal Medicaid HCBS waiver requirements.
- Receive and process participant authorized worker timesheets consistent with the participant's support and service plan.
- Secure coverage and pays workers' compensation insurance premiums and employee benefits for participant hired workers as requested by the participant.
- Operate a payroll service that completes bi-monthly payroll for the participant-hired workers, including the withholding of federal and state taxes from wages, and the filing and payment of federal and state employment taxes and insurance premiums.
- Process any garnishments or levies on employee wages as ordered by a court.
- Deposit electronically, or mail, worker payroll checks to the participant to give to their workers or provide checks directly to the participant's workers based on the preference and direction of the participant, or deposits paychecks onto a prepaid debit card.
- Receive and account for all required IRIS participant Medicaid cost share payments, when applicable, to maintain an individual's Medicaid and IRIS eligibility.
- Process and pay participant authorized vendor invoices for goods and services submitted by the participant and consistent with the participant's support and service plan.

1.2G IRIS Self-Directed Personal Care Agency (IRIS SDPC)

Participants who are eligible for personal care may obtain their personal care assistance from either a certified Medicaid Personal Care Agency (MAPC), or through the IRIS-SDPC option. The Department contracts with an agency to administer the program. Agency nurses perform clinical assessments and obtain the needed authorizations that enable the participant to employ his or her own workers. The wages of participant employed, personal care workers are paid through the IRIS fiscal employer agent.

2.0 Eligibility

Per 42 CFR 442.302(b-c), all participants must meet and continue to maintain functional, financial and nonfinancial eligibility requirements.

Eligibility requirements are based on several factors. To be eligible, the IRIS applicant must meet the following criteria:

1. Must be at least 18 years of age;
2. Meet applicable requirements for Wisconsin residency and live in a county where the IRIS and Family Care programs are available;
3. Meet the definition of an eligible population (i.e., target group);
4. Meet functional eligibility including NH or ICF-IDD level of care assignment;
5. Meet the financial eligibility criteria for Medicaid;
6. Meet the non-financial eligibility criteria for Medicaid;
7. Reside in a program-eligible setting or living arrangement, and
8. Have a need for long-term care supports and services.

2.1 Functional Eligibility

This section describes the functional eligibility requirements for the IRIS HCBS Waiver Program. IRIS is a federally approved HCBS waiver. Participants must meet the definition of an eligible target population and also have a level of care assignment that would allow admission to an NH or an ICF-IDD. The long-term care eligibility condition must be expected to last more than 12 months. Eligible target populations include adults with a developmental disability (DD), adults with a physical disability (PD) and frail elders (FE). All participants must also have a Nursing Home level of care assignment.

2.1A Wisconsin Adult Long-term care Functional Screen (LTC FS)

Functional eligibility for the IRIS program is established when the applicant meets an eligible level of care. To determine the level of care, a qualified screener with the ADRC conducts a face-to-face interview with the applicant and completes the Wisconsin LTC FS. The functional screen process gathers relevant information from the person, their family, formal and informal caregivers, health care professionals and other relevant sources, as necessary. Upon completion of the screening process, the collected information is entered into the LTC FS, the Department's automated eligibility determination system, and the functional screen logic determines whether the person's needs meet a level of care.

2.1A.1 Developmental Disability (DD)

Under federal rules (Public Law 106-402) a developmental disability (DD) means a severe and chronic disability of an individual which:

- a. Is attributable to a mental or physical impairment or a combination of mental and physical impairments;
- b. Is manifested before age 22;
- c. Is likely to continue indefinitely;
- d. Results in a substantial functional limitation in **three or more** of the following areas of major life activity:
 - i. Self-Care;
 - ii. Receptive or expressive language;
 - iii. Learning;
 - iv. Mobility;
 - v. Self-direction;
 - vi. Capacity for independent living;
 - vii. Economic self-sufficiency; **and**

- e. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of a lifelong or extended duration and are individually planned and coordinated.

The Wisconsin definition of DD is broader than the federal definition. However if a person meets only the state's definition of DD, the person will not meet the federal DD definition.

2.1A.2 Physical Disability (PD)

Wisconsin statutes (s. 15.197 (4)(a)2), define physical disability as a physical condition, including an anatomical loss or musculoskeletal, neurological, respiratory or cardiovascular impairment, which results from injury, disease or congenital disorder and which significantly impairs at least one major life activity.

Major life activity means any of the following:

- a. Self-care;
- b. Performance of manual tasks unrelated to gainful employment;
- c. Walking;
- d. Receptive and expressive language;
- e. Breathing;
- f. Working;
- g. Participating in educational programs;
- h. Mobility, other than walking; and
- i. Capacity for independent living.

2.1A.3 Frail Elder (FE)

Wisconsin Administrative Code (DHS 10.13 (25m), defines the term frail elder as an individual aged 65 years or older who has a physical disability, or an irreversible dementia, that restricts the individual's ability to perform normal daily tasks or that threatens the capacity of the individual to live independently.

A qualifying functional screen result means that the person has a need for services and supports that is equivalent to the threshold level of care necessary for nursing home or ICF-IDD admission. Identified issues may include a need for assistance with activities of daily living (e.g., bathing, dressing, eating, and mobility) and/or instrumental activities of daily living (e.g., meal preparation, medication, and money management). Screen findings may also indicate a need for assistance with health related services that can include: nursing assessment, interventions related to behaviors and skilled therapies.

Medical diagnoses are not considered individually in determining functional eligibility. Rather, the LTC FS assesses the impact of the medical diagnosis on the participant's ability to complete both the activities of daily living (ADLs) and instrumental activities of daily living (IADLS). For example, a participant's LTC FS would not be affected due to the documentation of seizures in the diagnoses table. However, the participant's seizures may affect his or her ability to complete ADLs and IADLS and this would be represented in these needs in the LTC FS. Therefore, the impact of the seizure diagnosis is addressed in determining long-term care needs.

2.1B Level of Care

In addition to having long-term care needs documented in the LTC FS, all people enrolled in the IRIS Program are required to have one of two levels of care. For elders and persons with a PD this is a Nursing Home Level of Care. For individuals with a DD the level of care assignment must be ICF-IDD. In each of these situations the level of care verifies that the person meets the functional eligibility requirements to live in either a Nursing Home or an ICF-IDD.

2.2 Financial Eligibility

This section describes the financial eligibility requirements for the IRIS Medicaid HCBS Waiver Program. Applicants must meet financial eligibility requirements for Medicaid to participate in the program. In IRIS, as in Wisconsin's other MA HCBS waiver programs, the Medicaid eligibility limits are somewhat broader than those in the traditional Medicaid fee-for-service programs. This is because eligibility for the waiver programs is similar to eligibility for institutional Medicaid. If Medicaid financial eligibility is not present at application, then the individual is not eligible for the IRIS program. For current limits and restrictions, please reference the Medicaid Eligibility Handbook <http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm>. Financial eligibility is determined by the local IM Agency.

2.2A Assets

Asset eligibility for the IRIS program is comparable to the Wisconsin Elderly Blind and Disabled (EBD) Medicaid program. Asset eligibility determinations for SSI, SSI-E, 1619(a), and 1619(b) program participants are made by the Social Security Administration. The IM Agency determines asset eligibility for most other applicants. Generally, IRIS program applicants who are single may have no more than \$2,000 in countable assets. Exceptions to the \$2,000 limit include those persons enrolled in the Medicaid Purchase Plan (MAPP) or those participating in the BadgerCare Plus program.

Examples of countable assets may include: cash on hand, money in savings and checking accounts and other "liquid" assets. Other countable assets may include non-home property, stocks and bonds and the 'cash value' of certain life insurance policies.

Some assets are exempt; these may include the home of the participant, a vehicle owned and used by the participant and burial or funeral trusts up to a certain value. There are several categories of exempt, unavailable, and countable assets in Medicaid, and the eligibility rules are complex. For questions as to which resources may be counted and which may be exempt, IRIS applicants should consult with an ADRC benefit specialist or the IM agency, or reference Section 16 of the [Medicaid Eligibility Handbook](#).

For applicants who are married, spousal impoverishment asset protections available to the community spouse of an institutionalized person also apply to IRIS applicants/participants. Spousal impoverishment is addressed in more detail in Section 2.2C below. See also Section 18 of the [Medicaid Eligibility Handbook](#).

2.2B Income

Income eligibility for IRIS program participation is based on state and federal Medicaid criteria and Wisconsin's federally approved Medicaid HCBS waivers. These rules are comparable to institutional Medicaid; therefore income eligibility limits for all Medicaid HCBS waiver programs are broader than other types of Medicaid. As a result, many people residing in the community who would be otherwise ineligible for Medicaid may become financially eligible via Medicaid HCBS waiver programs. Financial eligibility may occur in one of three income-based categories referred to as Group A, Group B and Group B+. Financial eligibility criteria specific to each of these groups is described below.

Participants meeting the eligibility requirements who are employed, or seeking employment, are eligible for the IRIS program if their earnings are within the Medicaid allowable monthly earnings limits (see section 15.5 of the [Medicaid Eligibility Handbook](#)). If an employment outcome is established in a person's plan, then the participant can request Work Incentive Benefits Counseling as a waiver allowable service. The benefits specialist will assist the participant in determining the impact of work and earnings on the participant's financial eligibility.

2.2B.1 Group A

Financial eligibility Group A includes those persons who are Medicaid or Badger Care eligible at the time of application in a full benefit program. Group A also includes:

- Supplemental Security Income (SSI) and Supplemental Security Income Exceptional Expense (SSI-E) recipients,
- 1619 (a or b) SSI work incentive program recipients,
- 503 recipients,
- Widow/widowers,
- Disabled Adult Children (DAC),
- Medicaid – Medically Needy recipients with a met deductible,
- Katie Beckett Medicaid participants,
- BadgerCare Plus – Standard Plan participants (Income at or below 200% of the Federal Poverty Level (FPL)),
- Wisconsin Medicaid Purchase Plan (MAPP) enrollees,
- Foster Care Medicaid participants, and
- Special Needs/Subsidized Adoption Medicaid participants.

Persons eligible as Group A have no cost share obligation, although MAPP and BadgerCare Plus participants may pay a premium for those programs based on income. Other persons who may be eligible in Group A include low income persons receiving Elderly, Blind or Disabled (EBD) Medicaid who are age 65 years or older.

Not included in Group A are persons who are enrolled in the Wisconsin SeniorCare program and other partial benefit Medicaid programs including the BadgerCare Plus – Benchmark Plan. Other partial benefit programs not included in Group A include Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB) and SLMB+, Qualified Disabled and Working Individuals (QDWI); Tuberculosis-related Medicaid, Presumptive Eligible Pregnant women and those receiving emergency services for non-qualifying aliens. While not financially eligible in Group A, some partial benefit Medicaid recipients may be financially eligible in Group B or B+. Please consult with the IM Agency or the [Medicaid Eligibility Handbook](#) (Section 25, 32 and 33) for more information about partial benefit Medicaid programs.

For all Group A financially eligible persons choosing to participate in IRIS, the ADRC verifies Medicaid eligibility and initiates a referral to the ICA to complete the IRIS enrollment and service planning process.

2.2B.2 Group B

Financial eligibility Group B includes those persons whose countable monthly income is equal to or less than 300% of the SSI Federal Benefit rate. This amount is adjusted annually and can be obtained from Section 39 of the Medicaid Eligibility Handbook. All Group B Medicaid financial eligibility determinations are processed by the IM agency using the state's computerized CARES system.

IRIS applicants in financial eligibility Group B are allowed certain deductions from their income in the eligibility and post-eligibility determination processes. When applicable, married Group B applicants may also have spousal impoverishment protections applied.

At the initial application stage, the ADRC staff assists the Group B applicant to gather supporting documentation to verify countable deductions and exemptions from income. Examples of these include monthly medical and remedial expenses, special exempt income, applicable housing costs, and other deductible expenses. ADRC staff then provides these figures to the IM agency and assist the applicant to set up an appointment with IM staff to complete the Medicaid application.

At the time of application, the IM staff verifies the information provided and enters the income, allowable expenses, applicable disregards, and allowances into the CARES system for the Group B financial eligibility and cost sharing determination. Please consult with the IM Agency or the [Medicaid Eligibility Handbook](#) for more information about Group B financial eligibility.

2.2B.2.1 Medical/Remedial Expenses

Medical/remedial expenses for Group B are those recurring, monthly costs that directly relate to the person's care needs and/or costs incurred while treating or preventing or minimizing the effects of illness, injury or other impairments to the individual's physical or mental health. Allowable medical/remedial expenses include items and services that are purchased by the applicant and that are not covered by the Medicaid state plan, by Medicare, or by a private health plan and are not paid for by IRIS or by another funding source. Items or services that can be purchased under the IRIS program should not be counted as a medical or remedial expense.

a. Medical Expenses

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

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

Note: Certain medical bills cannot be counted as medical or remedial expenses. These include:

- Medical bills which remain unpaid, but were used previously to meet a Medicaid deductible;
- Bills which were incurred for institutional care provided during a previous Medicaid divestment penalty period;
- Bills that represent a patient liability amount/cost share incurred during some previous period of institutionalization or an unpaid Medicaid HCBS Waiver cost share obligation;
- Medical bills which will be paid by a legally liable third party (e.g. private health insurance, Medicare or Medicaid); and
- Bills which were previously allowed as a medical/remedial expense and counted to reduce a waiver cost share or used to reduce a nursing home patient liability obligation.

b. Remedial Expenses

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

Note: Room and board costs may not be counted as a medical or remedial expense.

When determining the person's monthly total amount of medical/remedial expenses for Group B financial eligibility, only those allowable expenses that are both incurred and paid by the applicant can be counted. Items or services that were bought for someone else (a spouse, child, etc.) or paid for by another person, or by the IRIS program, the Medicaid card, a private health plan or any other program are not counted. This differs from expenses allowed for Group B+ financial

eligibility calculations which are discussed below. For additional information and a listing of examples of common medical and remedial expenses, see the [Medicaid Eligibility Handbook](#), Section 15.7.3.

2.2B.2.2 Medicaid Cost Sharing

After the allowances and expenses described above are deducted, if there is any remaining income available, then the applicant will have a cost share obligation. The cost share is the amount of the participant's income that must be paid each month toward the cost of planned supports and services. Cost share payments are collected monthly and monitored by the IRIS fiscal employer agent (FEA). The payment of the cost share is required for continued program eligibility. Failure to meet the cost share obligation may result in disenrollment from the IRIS Program (see 2.0, Enrollment) and a referral to the Department of Revenue for collection of delinquent cost share. No cost share payment is required when an admission to a hospital, nursing home, or ICF-IDD results in a stay long enough for the participant to incur a patient liability cost.

When the application is processed, and a cost share obligation is determined, the IM staff "pends" the application in CARES and provides the IRIS applicant and the ADRC with the cost share information. Using the information provided by IM, the ADRC staff and the IRIS applicant discuss eligibility and cost sharing requirements. If the applicant decides to proceed with enrollment, then the ADRC staff notifies IM of the decision and makes the referral to the ICA to begin the IRIS program enrollment and service planning process.

2.2B.2.2.1 IRIS Consultant Agency and IRIS Consultant Role in Cost Shares

The ICA documents the participants cost share obligation as determined by IM at the time of referral. If medical/remedial expenses have been identified to offset the cost share obligation, then the IRIS consultant monitors that the participant continues to incur these expenses on an ongoing basis. The ICA reports any changes to medical or remedial expense payments to the IM. The ICA is informed of the monthly status of cost share payment and the IRIS consultants discuss any concerns with the participant at the next consultant visit with the participant. Based on cost share history reports from the FEA, if a participant fails to pay more than two monthly cost share payments when due, then the ICA offers the participant the chance to repay the arrears through a repayment plan that can last no longer than 12 months. If repayment plan proves unsuccessful, then DHS provides the ICA approval to initiate a program disenrollment for failure to pay the required cost share. Once approved by DHS, the ICA refers the person to IM to initiate the Medicaid disenrollment process. The IM office sends a formal disenrollment notice including the last date of Medicaid eligibility to the participant and informs the participant of his or her right to appeal. When the process is completed, the participant's Medicaid eligibility is ended. The ICA may rescind a request for disenrollment only when the individual pays all cost share arrears owed ahead of their Medicaid Fair Hearing date.

2.2B.2.2.2 Fiscal Employer Agent (FEA) Role in Cost Shares

The FEA receives the participant's cost share payments and documents the payment. Information on cost share payment history is sent monthly to the participant. The FEA forwards a record of payment history to the ICA monthly. The FEA deposits all cost share funds received and this income offsets IRIS program funded service costs.

2.2B.3 Group B+

Group B+ financial eligibility includes persons whose gross monthly income exceeds 300% of the current federal SSI benefit rate. This amount is adjusted annually. For current income levels, refer to Section 39.4 of the [Medicaid Eligibility Handbook](#).

The IRIS applicant/participant meets Group B+ financial eligibility when his or her net monthly income, after deducting an amount equal to the cost on institutional care, is equal to or less than the Medicaid Medically Needy income standard.

Persons eligible under this group have a cost share calculated based on their income and allowable deductions in the same way as do those in Group B. Any cost share amount must be paid each month to remain eligible. Please consult with the IM Agency or the [Medicaid Eligibility Handbook](#) for more information on Group B+ financial eligibility.2.2B.3.1

Medical/Remedial Expenses

Medical/remedial expenses for Group B+ are those recurring, monthly costs that directly relate to the person's care needs and/or costs incurred while treating or preventing or minimizing the effects of illness, injury or other impairments to the individual's physical or mental health. Allowable medical/remedial expenses include items and services that are purchased by the applicant and that are not covered by the Medicaid state plan, by Medicare, or by a private health plan and are not paid for by IRIS or by another funding source. Items or services that can be purchased under the IRIS program are not to be counted as a medical or remedial expense.

Allowable medical/remedial expenses for Group B+ include out-of-pocket medical/remedial expenses, as defined in Group B above, and may also include the costs of any planned services that would otherwise be funded by the IRIS program.

2.2B.3.2 Medicaid State Plan (Medicaid ForwardHealth Card) Covered Services

In addition, Group B+ allowable expenses include expected Medicaid State Plan (Medicaid card) covered services. These include any of the participant's monthly medical expenses covered by the Medicaid state plan that are paid by the participant.

2.2B.3.3 Medicaid Cost Share Obligation

After receipt of the list of medical/remedial expenses, service plan costs and Medicaid state plan costs, the IM worker calculates the applicant's financial eligibility and his/her monthly cost share amount using CARES.

If spousal impoverishment rules apply, then an additional step to determine the participant income allocation and cost share, if any, is completed by the IM using the [Spousal Impoverishment Income Allocation Worksheet](#).

The worksheet calculation determines any income amount to be allocated to the community spouse and/or dependent family members (Section A and B.) In Section C of the worksheet the IM enters the personal maintenance allowance, the income allocation amount(s), any exempt income, allowable medical remedial expenses, and health insurance premiums to determine any subsequent cost share obligation.

After completing the calculation, the IM staff provides information on the Group B+ determination to the IRIS applicant and the ADRC enrollment staff. As in Group B, the application status will be maintained in CARES as "pending" until the IM agency receives confirmation from the ICA that the applicant has chosen to proceed to enrollment. If enrollment goes forward, then the application is activated and CARES generates a notice to the participant of any cost share obligation, as applicable.

2.2B.3.3.1 ICA Monitoring

The ICA documents the participants cost share obligation as determined by IM at the time of referral. The ICA is informed of the monthly status of cost share payments by the FEA and the IRIS consultants discuss any concerns with the participant at the next consultant visit with the participant. Based on reports from the FEA if a participant fails to pay his/her monthly cost share obligation, then the ICA obtains DHS approval to initiate a program requested disenrollment. Once approved by DHS, the ICA refers the person to IM to initiate the Medicaid disenrollment process. The IM office sends formal disenrollment notice including the last date of Medicaid eligibility to the participant and informs the participant of the right to appeal. When the process is completed the participant's Medicaid eligibility ends.

2.2B.3.3.2 FEA Monitoring

The FEA receives participant cost share payments and documents the payment. Information on cost share payment history is sent monthly to the participant. The FEA forwards a record of payment history to the ICA monthly. The FEA deposits all cost share payments received and this income offsets IRIS program funded service costs.

2.2C Spousal Impoverishment

Spousal Impoverishment refers to the way in which the resources of a married couple are counted for purposes of IRIS financial eligibility. To prevent the impoverishment of both persons the rules allow the allocation of a portion of income or assets to the community spouse. A “community spouse” is a person who is married to an IRIS participant and who is not living in a nursing home or other medical institution for 30 or more consecutive days. When both spouses are IRIS applicants/participants, each spouse may allocate resources to the other. Spousal Impoverishment rules apply to all married couples except those where the non-applicant spouse resides in a Nursing Home, ICF-MR or medical institution and has lived there for 30 or more days. (See Section 18 of the [Medicaid Eligibility Handbook](#))

2.2C.1 Asset Allocation

The asset allocation process determines the amount of assets the married IRIS applicant may retain in order to still be considered eligible for Medicaid. The term “asset allocation” refers to the way assets may be divided between each spouse in the marital relationship for the purpose of establishing Medicaid eligibility under spousal impoverishment rules. Assets are counted on the date the applicant first requests Medicaid HCBS waiver services, or when s/he is institutionalized for 30 days or more, whichever is earlier.

Asset allocation will establish the Community Spouse Asset Share (CSAS). That is the amount of countable assets greater than the \$2,000 limit that the IRIS applicant’s community spouse is allowed to retain. Spousal impoverishment asset limits are adjusted annually and the maximum amount the IRIS applicant spouse may allocate varies depending on the couple’s total assets. In addition, when the community spouse asset share is a court-ordered amount or set by an administrative hearing, the total amount of assets allowed may be greater than the spousal impoverishment limit. Please refer to Section 18 the Medicaid Eligibility Handbook for the most current asset allocation information or consult with the IM agency staff.

2.2C.2 Income Allocation

Income allocation occurs after the IRIS applicant is determined to be Medicaid eligible. The IM worker completes the Spousal Impoverishment Income Allocation Worksheet to determine the amount of monthly income the IRIS program applicant may allocate to his/her community spouse. Depending on the amount, the income allocation may reduce or eliminate the applicant’s cost share.

After the eligibility determination, the applicant may choose to allocate all, part, or none of his/her available income to the spouse who, in turn, may choose to accept all, part, or none of the allocation. For the allocation to be applied to the cost share, the applicant must actually make the income available to his/her community spouse in a manner that can be verified. If SSI or Medicaid eligibility would be jeopardized, then the spouse may forego the allocation. If both spouses are IRIS applicants, then each may allocate income to the other.

The maximum amount of income that may be allocated to the community spouse is adjusted annually. Please refer to Section 18 of the Medicaid Eligibility Handbook or consult with the IM agency staff for more detailed information and current income allocation provisions.

2.2D Ongoing Eligibility

Once initial program eligibility has been established, all IRIS participants must complete an annual functional and financial eligibility review. Failure to maintain eligibility may result in disenrollment. Annual functional eligibility is completed by the ICA. Annual financial eligibility is completed by the IM Worker.

2.2D.1 Annual Eligibility Review

Functional eligibility redeterminations are made with the completion of a new LTC FS. The screens are conducted by qualified ICA staff in a face-to-face interview with the participant, in the place of their residence, if possible. To maintain functional eligibility, the participant must continue to receive an eligible level of care (LOC) at review.

Financial eligibility re-determinations are made with the completion of a Medicaid recertification review. The Medicaid recertification is conducted by the IM agency. To maintain financial eligibility, the participant must meet all Medicaid income and asset requirements annually at recertification. If continued financial eligibility for Medicaid is not confirmed, or continued or functional eligibility is not attained at recertification, then the participant is disenrolled (see 2.0, Enrollment).

2.2D.2 Reporting Changes

To ensure continued eligibility and accuracy in cost share calculations, the participant is responsible to report any change in his/her financial status to the IM agency within ten calendar days. Failure to report changes promptly could result in a cost share overpayment or an underpayment, and may affect ongoing eligibility. Examples of the changes that must be timely reported include: any increase or reduction of medical/remedial expenses; a change in a private health plan status or premium; or an increase or decrease in income.

The IM staff will enter the report then changes in the CARES system. If the new information impacts the cost share obligation, CARES will generate a ten day written notice informing the participant of the change, and of their right to appeal the determination.

2.2D.3 Cost Sharing Requirements

Important: IRIS participants who have a cost share obligation must make the monthly payment to maintain Medicaid HCBS waiver eligibility. Cost shares are collected and monitored by the FEA. The program expectation is that the cost share payment should be received by the FEA no later than the 5th of the month. The ICA provides support to the participant to ensure the cost share obligation is understood and will contact individuals when payments become delinquent. While support and assistance to understand cost share is available from the FEA and the ICA, making the cost share payment is the responsibility of the participant. Failure to meet this responsibility may result in disenrollment.

2.3 Nonfinancial Eligibility

The purpose of this section is to determine nonfinancial eligibility. Requirements including residency and permitted living arrangements are explained in this section.

2.3A Residency

Residency requirements are the same as the Wisconsin Medicaid rules. A person who is physically present in the state and who expresses their intent to remain in Wisconsin is a Wisconsin resident.

2.3B IRIS Program Availability

The IRIS self-directed support program is a choice available to persons residing in those counties, or regions of the state, where managed long-term care programs are also operating. IRIS is not available in those counties that have not transitioned under the state's long-term care reform initiative.

2.3C Community Living Arrangement

Applicants must reside in an eligible living arrangement to be eligible to participate in the IRIS program. The applicant/participant's living arrangement refers to their permanent residence. An applicant who routinely visits friends or relatives out of state does not give up their permanent residence. For example, the IRIS participant who visits a relative in Arizona for several months each winter, does not impact their state residency. Similarly, an IRIS participant who attends a college and resides on campus during the school year does not give up their permanent residence.

It should be noted that while the arrangements below are generally permitted, there are some restrictions. For example, IRIS program funds may not be used to pay for Community Based Residential Facilities (CBRFs). In addition, under most circumstances, Residential Care Apartment Complexes (RCACs) may not admit persons who have a guardian (DHS 89.29 (1)). IRIS participants and their legal representatives need to be aware of these limitations and should contact the ICA with questions regarding allowable living arrangements.

2.3C.1 Eligible Living Arrangements

Eligible living arrangements include:

2.3C.1.1 DD Target Group

Eligible living arrangements for participants with a DD include:

- A house, apartment, condominium or other private residence;
- A rooming/boarding house;
- A certified Adult Family Home (1-2 bed); and
- A licensed Adult Family Home (3-4 beds).

2.3C.1.2 PD and FE Target Group

Eligible living arrangements for persons with PD and FE include:

- A house, apartment, condominium or other private residence;
- A rooming/boarding house;
- A certified Adult Family Home (1-2 beds);
- A licensed Adult Family Home (3-4 beds); and
- A certified RCAC.

2.3C.2 Ineligible Living Arrangements

Ineligible living arrangements include:

2.3C.2.1 DD Target Group

Ineligible living arrangements for participants with a DD include:

- A hospital, Nursing Home or Institution for Mental Disease (IMD);
- An ICF-IDD or any of the state centers for people with developmental disabilities;
- A jail, prison or other correctional facility; and

2.3C.2.2 PD and FE Target Group

Ineligible living arrangements for participants who have a PD or are FE include:

- A hospital, Nursing Home or Institution for Mental Disease (IMD);
- An ICF-IDD including any of the state centers for people with developmental disabilities;
- A jail, prison or other correctional facility; and
- A registered Residential Care Apartment Complex (RCAC); and

Note: Persons seeking enrollment in the IRIS program may be residing in one of the ineligible settings listed above at the time of application. However, final eligibility cannot be established and services through the IRIS program may not begin until the person lives in an eligible setting.

If a current IRIS participant is admitted to a Nursing Home or hospital on a short-term basis, then the short-term stays for acute care or rehabilitation will not disrupt eligibility. Admissions intending to be short-term that become long term placements may lead to program disenrollment (see 2.0, Enrollment).

2.3C.3 Temporary Living Arrangements

In transitional situations, a participant may reside in a hotel, motel, homeless shelter, or other type of transitional housing. These are permitted living arrangements. All other eligibility requirements continue to apply including Wisconsin residency and being located in a county where IRIS is available.

2.3C.4 Short Term Institutional Stays

If an IRIS participant needs to stay in an institutional setting for short-term acute care and/or rehabilitative services, then these short-term stays do not change the participant's permanent residence or living arrangement and the person retains continued eligibility for enrollment in IRIS. IRIS services however, must be suspended while the person is in this short-term setting. The participant is required to report any institutional stay to the ICA. The ICA staff may assist the person with planning and relocation activities in order for the participant to return to an eligible community living arrangement. If the temporary stay becomes permanent, then this is considered a voluntary disenrollment. An IRIS participant who has an institutional stay that lasts longer than 90 days after the admission date to the facility must be disenrolled from IRIS.

2.3C.5 Incarceration

If a participant is incarcerated in a jail, prison or other correctional facility for 30 days or more, then ICA initiates disenrollment from IRIS since this is not an eligible living arrangement.

An individual disenrolled from IRIS under any of these circumstances may be enrolled again at a future date when they no longer reside in an ineligible setting, and as long as the other eligibility requirements are met.

2.3D Need for Services

Persons who have been determined to meet the non-financial and functional eligibility criteria for waiver participation, but who do not have an assessed need for waiver services, are not eligible for Medicaid using the special IRIS program eligibility criteria (Code of Federal Regulations 42CFR 435.217(c)). The Centers for Medicare and Medicaid Services defines "reasonable need" as follows: "In order for an individual to be determined to need waiver [IRIS] services, an individual must require (a) the provision of at least one HCBS waiver service, as documented in the service plan, and (b) the provision of HCBS waiver services occurs 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."

2.4 Supplemental Security Income Exceptional Expense (SSI-E)

Wisconsin Stat. § 49.77(3s)(b) specifies that persons receiving Supplemental Security Income (SSI) may be eligible for the exceptional “E” payment herein referred to as “SSI-E.” When eligible, the payment is added to an individual’s monthly SSI benefit payment. County staff (which may be staffed at the ADRC) is responsible for eligibility screening for those who are not enrolled in IRIS. The ICA completes eligibility screening for those who may become eligible after their IRIS enrollment and monitors the condition of SSI-E eligible persons to ensure the eligibility criteria are continuously met. The ICA cancels the eligibility for persons who no longer meet the eligibility requirements.

4.0 Health and Safety

Ensuring the health and safety of IRIS (Include, Respect, I Self-Direct) program participants is one of the six assurance areas in the approved 1915(c) Home and Community-Based Services waiver. The Centers for Medicare and Medicaid Services (CMS) requires states to document in the waiver application how the state will ensure the health and safety of program participants, including performance measures that measure compliance with the approved 1915(c) Home and Community-Based Services waiver.

IRIS participants may elect to exercise employer authority over their caregivers or workers (1915(c) Appendix E-1: 2 of 13). Under employer authority, the participant hires, schedules, and manages his or her own caregivers who are known as participant-hired workers (PHWs). DHS policy prevents a single PHW from providing more than 40 hours per week of paid caregiving to an individual participant, regardless of their employer. These hours may be any combination of supportive home care, IRIS self-directed personal care (SDPC), respite, daily living skills training, or other services paid at an hourly rate. The goal of this policy is to mitigate safety risks to both the participant and the PHW, while still allowing participants to exercise their employer and budget authority. This policy does **not** limit the total number of hours in a participant's care plan; it merely limits the number of hours that a single PHW can provide. Any exceptions to this policy are noted in the IRIS Work Instructions in Section 4.0A

Participants choosing to exercise their employer authority are required to be compliant with all U.S. Department of Labor regulations, including the Fair Labor Standards Act ([FLSA](http://www.dol.gov/whd/flsa/)). Information on FLSA is available online at: <http://www.dol.gov/whd/flsa/>.

4.1 Assessing Risk

The approved 1915 (c) Home and Community-Based Services waiver states the following about how the IRIS program assesses, monitors, and mitigates risk in Appendix D-1-e:

“Participation in a self-directed waiver provides participants with new opportunities, responsibilities, and risks. Finding the right balance between the participants’ right to make choices with OIM’s (Office of IRIS Management) obligation to ensure participant safety requires special consideration and careful planning.

ICAs are required to collaborate with participants to identify potential risks and to help identify and implement strategies to mitigate identified risks. ICAs [IRIS consultant agencies] are able to define their own practices for assessing risks to participants during the ISSP [Individual Support and Service Plan] development process.

OIM monitors the health and safety of participants through the record review process, which has indicators in place that ensure the ICA addressed all health and safety risks. Health and safety issues must be addressed in the ISSP based on the participant’s needs and preferences.

As part of risk mitigation, participants are required to have comprehensive emergency backup plans in the event that needed services are for any reason not accessible. Emergency backup plans must contain the following components:

- Medical needs
- Behavior needs
- Medication and medical equipment needs
- General overview of the participant’s daily schedule

- Contact information for emergency backup providers
- Contact information for service providers including medical providers and the IRIS consultant

Other pertinent participant-specific information

ICAs may implement their own emergency backup plan format approved by OIM. All formats must provide sufficient information to ensure a backup caregiver can provide the participant with needed care to ensure the participant's health and safety in the absence of the participant's primary caregiver.

The participant and IRIS consultant collaborate to develop the emergency backup plan as part of the ISSP development process. The participant and the IRIS consultant review the accuracy and effectiveness of the emergency backup plan during every face-to-face visit and every phone contact. The participant is responsible for notifying the IRIS Consultant of any changes to their emergency backup plan.”

4.2 Behavior Support

IRIS consultants are required to administer a behavior assessment for all participants for whom behaviors have been identified on an annual basis.

The approved 1915 (c) Home and Community-Based Services waiver describes the following requirements about the annual assessment of participant needs in Appendix G-2-i:

“On an annual basis, participants and IRIS consultants reassess the needs and long-term care outcomes of the participant by evaluating the results of the annual LTC FS (Long Term Care Functional Screen), the behavior assessment (when required), and the participant's progress on the outcomes identified on the previous year's ISSP. The participant and IRIS consultant collaborate to ensure the new ISSP is an accurate and current reflection of the participant's needs and the ISSP adequately supports the participant's long-term care outcomes with IRIS-funded services used as a last resort.”

4.3 Restrictive Measures

The term “restrictive measures” refers to specific behavior support techniques that restrict a participant's ability to move. Because of the risk of injury to either the participant or the caregiver when using restrictive measures, the use of restrictive measures must be approved by the Department of Health Services (DHS).

The approved 1915 (c) Home and Community-Based Services waiver states the following regarding the required approval process for the use of restrictive measures in Appendix G-2-i:

“The Office of IRIS Management (OIM) permits the use of restraints in limited situations as stated in Wisconsin Administrative Code § DHS 94.10, “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 and by the county department if the county department has authorized the community placement. In granting approval, a determination shall be made that use is necessary for continued community placement of the individual and that supports and safeguards necessary for the individual are in place.”

The approved 1915 (c) Home and Community-Based Services waiver defines “restraints” or restrictive measures in Appendix G-2-i:

“The OIM defines “restraints” as 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. (All long-term care programs in Wisconsin define restraints in this manner.) Examples include, but are not limited to:

- Manual restraint
- Holding limbs or body contingent upon behavior
- Restricting or preventing movement
- Applying devices to any part of a person’s body contingent upon behavior
- Restricting or preventing movement or normal use or functioning of the body part that cannot be easily removed by the individual

The State of Wisconsin does not permit the use of medications to manage behaviors (chemical restraints) in the IRIS program unless the participant is in a licensed nursing facility under the direct supervision of the attending physician. The DHS Division of Quality Assurance (DQA) provides oversight and monitoring of the use of chemical restraints in licensed nursing facilities. Licensed nursing facilities are not eligible living settings in the IRIS program except for stays of 90 days or less for respite or rehabilitation purposes.”

The approved 1915 (c) Home and Community-Based Services waiver describes the following requirements about the emergency use of restrictive measures in Appendix G-2-i:

“The use of restraints requires written approval by the Department of Health Services (DHS) prior to implementation. OIM permits exceptions to this rule as an emergency response to a crisis. The participant, legal representative, and/or provider must report emergency use of restraints using the form “Incident Report – Medicaid Waiver Programs” ([F-22541](#)) in accordance with the critical incident reporting process. The IRIS consultant must work with the participant, legal representative, and/or provider to determine if the crisis was an isolated incident, or if there is a need to submit a request for approval to use restrictive measures.”

The approved 1915 (c) Home and Community-Based Services waiver describes the following process for obtaining approval for the use of restrictive measures in Appendix G-2-i:

“The IRIS consultant and participant must submit the appropriate request for approval. For restraints to be used as part of a Behavior Support Plan (BSP), the form “Requests for Use of Restraints, Isolation, and Protective Equipment as Part of a Behavior Support Plan” ([F-62607](#)) is required. For restraints to be used as a medical restraint, the form ‘Request for Use of Medical Restraints’ ([F-62608](#)) is required. Both request forms collect information that thoroughly demonstrates the need for the restraint, including the other least restrictive options that were attempted. Specific content includes:

- Demographic information
- Summary of the participant’s strengths and needs
- Health considerations
- Prescribed medications
- Detailed description of challenging behavior(s)
- Previous attempted intensive behavior supports, including outcomes
- Current behavior supports (attach behavior support plan)
- Description of why the restraint is being requested
- Plan for monitoring, documenting, and reviewing the progress

- Plan for training caregivers
- Signatures of physician and behavioral support team

The ICAs are required to submit the completed request forms, including supplementary documentation, such as the participant's behavior support plan, to the OIM for a pre-review via the DHS Restrictive Measures SharePoint site. The OIM ensures that the request is complete and all required documentation is attached. The OIM follows up with the ICA to obtain any missing or incomplete information through the DHS Restrictive Measures SharePoint site. The OIM routes completed requests to the appropriate reviewing party via the DHS Restrictive Measures SharePoint site.

The Division of Long Term Care (DLTC) Restrictive Measures lead chairs a committee, which includes OIM representation, which reviews requests for the use of restraints from participants with developmental disabilities. DQA reviews requests for the use of restraints from participants who are elderly and/or have physical disabilities who reside in facilities regulated by DQA. The OIM reviews requests for the use of restraints, under guidance from the DLTC Restrictive Measures lead, from participants who are elderly and/or have physical disabilities, but do not reside in facilities regulated by DQA.

All three reviewing entities deny applications when there is an option available that is less restrictive. Each reviewing entity provides written notification to the participant of the committee's decision within 15 working days of the committee's receipt of the application following a successful pre-review unless other arrangements are made. Complex cases may require additional time."

4.4 Critical Incident Reporting

Ensuring the immediate and ongoing health and safety of the participants is one of the most important, and at times most difficult, aspects of a self-directed program such as IRIS. Incident reporting is an important way the IRIS consultant agencies (ICAs) and the DHS OIM help to ensure the participants' health and safety.

The approved 1915 (c) Home and Community-Based Services waiver states the following about the IRIS program's critical incident reporting process in Appendix G-1-b:

"The Department of Health Services (DHS) defines a critical incident as an event or situation that poses an immediate or serious risk to the participant's physical or mental health, safety, and well-being. DHS also includes the misappropriation of the participant's property and violation of the participant's rights. Examples of critical incidents include:

- Any alleged or confirmed abuse (mental/emotional, physical, sexual, verbal) or neglect, including self-neglect
- Death of the participant, including accidents and suicide
- Medical errors or medication administration errors that require medical attention
- Illnesses, injuries, or hospitalizations that require emergency medical treatment, including accidents, suicide attempts, and mental/behavioral health emergencies
- Law enforcement investigation when the participant is the alleged victim or the alleged perpetrator
- Damage to a participant's residence due to fire, natural disaster, or other cause
- Misappropriation of a participant's funds or property, including theft, damage, and exploitation
- Unexpected significant behavior that is not addressed through a behavior support plan
- Unapproved use of restrictive measures, including isolation and seclusion

ICAs are required to report critical incidents to the OIM using the form “Incident Report – Medicaid Waiver Programs” ([F-22541](#)). All Wisconsin Medicaid Waiver programs use this form for critical incident reporting in accordance with “Incident Reporting – Medicaid Waiver Programs – Instructions” ([F-22541i](#)).

OIM divides the critical incident reporting process into four components:

- The IRIS consultant (IC) learns of the critical incident through the participant’s self-report or other means—participants should report incidents within 24 hours to their IRIS consultant. Participants receive education about what is considered reportable and how to report critical incidents during orientation and annually.
- The IC notifies the state agency contact via phone within three business days. High-profile cases require notification of OIM within 24 hours. “High-profile” is defined as a case that involved serious and immediate consequences to the participant. Incident types that fall into this category and require a 24-hour report to the Department include deaths, including suicides, as well as injuries sustained as a result of suspected abuse or neglect. (There is a slight variation from the instructions for the IRIS program in that notification takes place through the DHS-owned Critical Incident Reporting SharePoint site instead of by phone.)
- The IC completes the form Incident Report – Medicaid Waiver Programs ([F-22541](#)) within seven calendar days, demonstrating assurance of the participant’s immediate and ongoing health and safety. The ICA attaches the form in the participant’s record in the IRIS centralized information technology system known as the Wisconsin IRIS Self-Directed Information Technology System (WISITS) and copies and pastes the required information into the participant’s record in the DHS Critical Incident Reporting SharePoint site.
- The ICA completes and documents all activities related to the participant’s immediate and ongoing health and welfare in both the case notes in WISITS and the DHS Critical Incident Reporting SharePoint site within 30 calendar days.

Fiscal employer agents have the responsibility to report all critical incidents identified in the course of interaction with participants and participant-hired workers.

IM facilitates the initial review of each critical incident through the DHS Critical Incident Reporting SharePoint site using the following procedure:

- ICAs enter each critical incident;
- OIM reviews each critical incident validating that the participant’s immediate and ongoing health and welfare have been ensured;
- OIM communicates required remediation tasks for individual negative findings;
- ICAs complete the required individual remediation activities;
- OIM validates the remediation activities and closes the incident when appropriate;
- OIM runs aggregate data reports each month that OIM shares and discusses with the ICAs.

The DHS Critical Incident Reporting SharePoint site provides several advantages including centralizing the communication and documentation of the remediation of individual negative findings. The DHS Critical Incident Reporting SharePoint site serves as the IRIS program’s system of record for critical incident reporting data. The DHS Critical Incident Reporting SharePoint site will inform the future module within WISITS. At present, each

ICA has its own SharePoint site to ensure compliance with the Health Information Portability and Accountability Act (HIPAA).

The OIM meets monthly with each ICA to share the data from the DHS Critical Incident Reporting SharePoint site, and discuss identified trends and develop prevention strategies. During this meeting, the team also reviews each death. In previous waivers, the review of participant deaths was a performance measure that consistently achieved 100 percent compliance. Per CMS' request, OIM has discontinued this performance measure, though the practice of reviewing each death will continue. In addition to reviewing each participant death, the team also reviews each case of alleged or actual abuse and neglect, such that OIM can provide greater oversight to the resolution of these incidents.”

4.5 Emergency Backup Plan

Each IRIS participant is required to maintain an emergency backup plan that meets the unique needs of the participant in the event of needing a backup caregiver in all situations, including those where there may be little or no notice. Each ICA is responsible for developing a DHS-approved emergency backup plan format.

The approved 1915 (c) Home and Community-Based Services waiver states the following regarding emergency backup plans in Appendix D-1-e:

“OIM monitors the health and safety of participants through the record review process, which has indicators in place that ensure the ICA addressed all health and safety risks. Health and safety issues must be addressed in the ISSP based on the participant's needs and preferences.

As part of risk mitigation, participants are required to have comprehensive emergency backup plans in the event that needed services are for any reason not accessible. Emergency backup plans must contain the following components:

- Medical needs
- Behavior needs
- Medication and medical equipment needs
- General overview of the participant's daily schedule
- Contact information for emergency backup providers
- Contact information for service providers including medical providers and the IRIS Consultant
- Other pertinent participant-specific information

ICAs may implement their own emergency backup plan format approved by OIM. All formats must provide sufficient information to ensure a backup caregiver can provide the participant with needed care to ensure the participant's health and safety in the absence of the participant's primary caregiver.

The participant and IRIS consultant collaborate to develop the emergency backup plan as part of the ISSP development process. The participant and the IC review the accuracy and effectiveness of the emergency backup plan during every face-to-face visit and every phone contact. The participant is responsible for notifying the IC of any changes to their emergency backup plan.”

5.0 Person-Centered Planning

The Centers for Medicare and Medicaid Services (CMS) require an assessment of IRIS participants' needs and preferences. CMS further requires IRIS participants' Individual Support and Service Plans (ISSPs) to address all needs and preferences identified in the assessment. CMS requires a person-centered approach during ISSP development.

The approved 1915 (c) Medicaid Home and Community Based Services (HCBS) waiver states in Appendix E (E-1):

“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.”

The approved 1915 (c) Medicaid HCBS waiver describes the aforementioned assessment process in Appendix D (D-1):

“Person-centered planning includes a discovery process, e.g., assessment process. There are tools, resources, and information available to help participants express their needs 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 FS assessment and content area experts. All ICAs will have initial conversations with participants to explore the following areas:

1. Long-term care outcomes
2. Strengths and capacities, including the areas of strength for the participant and the natural supports and other resources 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
8. Risk factors

As authorized by CMS through the approved 1915 (c) HCBS waiver, the Department of Health Services (DHS) requires each IRIS participant to maintain a current ISSP with achievable outcomes, including a back-up plan. DHS requires the ISSP to contain the type, scope, amount, duration, and frequency of authorized services. IRIS Consultants (ICs) update the IRIS participants' ISSP at least annually or when the needs of the IRIS participant change.

5.1 Person-Centered Planning

People participating in the IRIS program made a choice to self-direct all long-term care services and supports, providing the participant with a high degree of choice, control, and responsibility over services and supports received. The vision for participants utilizing the IRIS program includes:

- All participants have value and potential;
- IRIS participants shall:
 - Be viewed in terms of their abilities;
 - Maintain the same rights as non-IRIS participants;
 - Maintain the right to participate in, have access to, and be fully included in their communities; and,

- Maintain the right to live, work, learn, and receive all services in the most integrated and least restrictive settings within their communities.

IRIS participants, in conjunction with their IC, develop the ISSP within an established, individual budget, and direct all long-term care services and supports identified in these plans. The approved 1915 (c) Medicaid Home and Community-Based Services (HCBS) waiver states in Appendix E (E-1):

“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.”

5.2 Plan Development

CMS requires a current, completed ISSP for every IRIS participant enrolled in the program. CMS requires ISSP development at the time of enrollment, on an annual basis, and each time the IRIS participants' needs or long-term care outcomes change. The services and service providers identified on the plan must adequately support the participant's outcomes and preferences, must be developed in partnership with the participant, and when relevant, his/her legal representative. The IC and/or ICA review all ISSPs to ensure consistency and accuracy prior to approval, denial, or modification.

The approved 1915 (c) HCBS waiver states,

“The participant takes the lead, directs development of the plan, and 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 through 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. The plan stays 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.”

5.2A Outcome Development

IRIS participants develop outcomes with the help of the IC, as needed. Each IRIS participant develops goal-oriented outcomes focusing on identified long-term care needs. IRIS participants develop outcomes to support choice of needed supports and services. All outcomes included in the IRIS participant's plan include all necessary supports; regardless of

whether funding for the support is through the IRIS program. Each service on an IRIS participant's plan must support realistic and appropriate long-term care outcomes.

Outcomes ensure the following for the IRIS participant:

- A stable life
- Safety
- Freedom from abuse and neglect
- Best possible health
- Respect and fair treatment
- Choice of where and with whom to live
- Choice regarding living environment
- Access to the community
- Choice regarding employment
- Choice regarding relationships with family and/or friends
- Choice regarding daily activities
- Achievement of desired social roles
- Participation in chosen, desirable activities
- Community involvement when desired
- Privacy
- Lives life with self-determination

5.2B Service Plan Development

CMS requires ISSPs to address all IRIS participant needs and preferences identified during the assessment phase of development. The DHS reports compliance with these requirements through performance measure data collected during the record review process as described in IRIS Policy Manual Section 10.0. The aforementioned performance measures in approved 1915 (c) HCBS waiver Appendix D state:

- Number and percent of participants with service plans that address participant needs as indicated by the Long-Term Care Functional Screen.
- Number and percent of participants whose identified health and safety risks are addressed in their service plan.
- Number and percent of service plans that address participant identified outcomes/goals.

Each IRIS participant identifies the individual(s) to participate in the development of plan, and the ICs help IRIS participants explore options and make informed choices, based on individual needs. The participant's chosen IC and the ICA assist the IRIS participant to choose supports and services consistent with the principles of self-determination: freedom, authority, responsibility, confirmation, and support. The IC ensures the existence of a clearly identifiable link between the services authorized and the IRIS participant's identified long-term care outcomes. The IRIS participant creatively meets long-term care outcomes by identifying formal and informal supports that develop meaningful relationships, promote community participation, lead to competitive and integrated employment, and safe housing.

All outcomes must indicate the related support, regardless of the source of funding for the support. The IRIS program is the funding source of last resort; IRIS participants must exhaust all other avenues of public funding prior to implementing IRIS-funded services. IRIS participants must first use any available ForwardHealth Medicaid card services, natural supports, and services provided by other funding sources. Independent Consultants document all services, regardless of funding source, on the ISSP.

The IC assists the IRIS participant, legal representative, and others important to the participant to develop an effective ISSP based on the IRIS participant's individual situation and outcomes within the individual budget.

The ISSP must contain:

- a. Demographic information
- b. The person's identified, individual outcomes
- c. Services designed to address the person's identified, individual outcomes
- d. The IRIS authorized start and end dates for each service
- e. All service providers, whether paid or unpaid
- f. Service frequency
- g. Service costs
- h. Funding sources
- i. An emergency back-up plan for all services
- j. Signatures of the participant and legal representative, when appropriate

As stated in the approved 1915 (c) HCBS waiver Appendix D (D-2):

“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 relevant to the participant.”

5.2B.1 Individualized Supports and Services

IRIS participants choose the supports and services they wish to receive. See section 5.4, “Services” for more information on allowable supports, and services.

5.2B.2 Health and Safety Risk Assessment

As stated in the approved 1915 (c) HCBS waiver,

“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.”

If an IRIS Consultant receives initial information regarding a possible health or safety risk, from a participant or other involved person, then the IC must evaluate the situation, take appropriate action, and notify DHS staff as required (see 4.1, Risk Assessment).

5.2B.3 Emergency Back-Up Plan

CMS requires that each IRIS participant maintain an emergency back-up plan as described in Appendix D (D-1) of the approved 1915 (c) HCBS waiver:

“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.

Each IRIS participant, in conjunction with his/her IC, develops an emergency back-up plan in order to ensure his/her health and safety. Emergency back-up plans serve to ensure the participant does not go without services or support in case of emergency. Emergency back-up plans must identify emergency back-up workers, provide

contact information for back-up workers, identify the IRIS participant's schedule, any special needs he/she might have, information concerning medical equipment, and other such information.”

5.3 Budget

The individual budget is an estimate of the participant's expected needs, and is based on information documented in the participant's Long-Term Care Functional Screen (LTC FS). Appendix E (E-1) of the approved 1915 (c) HCBS waiver describes this process:

“The individual budget calculation for IRIS is based upon characteristics, and long-term support needs as collected on the Long-term care Functional Screen (LTC FS). 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.”

5.3A Flexible Spending

Participants have flexibility in how they manage their IRIS budget. Participants build a service plan with the help of their IRIS consultant based on the budget estimate provided at the aging and disability resource center (ADRC). The cost of services on the plan must be within the budget estimate. The CMS waiver gives IRIS participants “budget authority,” allowing IRIS participants flexibility regarding the IRIS budget to purchase allowable IRIS services. Appendix E (E-2) of the approved 1915 (c) HCBS waiver defines flexible spending in the following manner: “The participant has decision-making authority over a budget for waiver services. Modifications to the participant-directed budget must be preceded by a change in the service plan.”

5.4 Services

IRIS participants choose needed supports and services to meet long-term care outcomes. The DHS only permits qualified service providers, with current licensure and/or certification on record, to provide IRIS funded services. Appendix C of the waiver contains a complete list and description of IRIS approved services, supports, and goods. Customized Goods and Services, a unique service available to IRIS participants, intends to enhance participant opportunities to achieve outcomes related to living arrangements, relationships, community inclusion, work or functional medical status. The approved 1915 (c) HCBS defines Customized Goods and Services as:

“...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 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, regulations, or guidance including the Wisconsin's Procurement Code.”

5.4A Allowable Services

The DHS, through the authority of the 1915 (c) HCBS waiver, defines “Allowable Services” as those services identified and defined in Appendix C (C-1) of the waiver. The DHS provides further descriptions of allowable services in the IRIS Service Code and Definition Manual. Services, supports or goods identifying IRIS as the funding source on the ISSP not identified and defined in Appendix C of the approved 1915 (c) HCBS waiver are prohibited. All other services, supports or goods needed or desired by an IRIS participant require an alternative funding source. Allowable services, identified and defined in Appendix C of the current approved 1915 (c) HCBS waiver, include:

- Adaptive aids
- Adult day care
- Adult family home (1-2 bed)
- Adult family home (3-4 bed)
- Communication aids vendors/interpreter services
- Consumer education and training
- Counseling and therapeutic resources
- Customized goods and services
- Daily living skills training
- Day services
- fiscal employer agent services
- Home-delivered meals
- Home modifications
- Housing counseling
- IRIS Consultant services
- Relocation – housing start-up and related utility
- Costs Live-in caregiver
- Nursing services
- Personal emergency response system
- Prevocational services
- Residential care apartment complex
- Respite
- Specialized medical equipment and supplies
- Support broker
- Supported employment
- Supportive home Care
- Specialized transportation 1
- Specialized transportation 2
- Vocational futures planning

5.4B Non Allowable Services

The IRIS program requires IRIS participants to use an alternative funding source to cover the following services:

- Goods, supports or services not identified and defined in Appendix C of the approved 1915 (c) HCBS waiver;
- Goods, supports or services covered by health insurance, Medicaid or Medicare;
- Goods, supports or services that remain the responsibility of another agency, such as educational services for individuals up to 21 years of age or vocational services provided by the Wisconsin Division of Vocational Rehabilitation;
- Room and board including rent, mortgage payments or utilities;
- Experimental goods and/or treatments;
- Goods, supports, and services not directly related to IRIS participant goals or needs, or that primarily benefit someone else;
- Alcohol or illegal drugs;
- Illegal activities, supports or goods including but not limited to:
 - Payments to support or employ personnel in conflict with the Department of Labor laws and regulations;
 - Living environments in conflict with federal, state or local housing laws and ordinances;
 - Any other activities, supports or goods such as recreation and transportation which conflict with federal, state, or local ordinances, including any purchases not allowable under Medicaid Assistance (MA) rules;
 - Service or equipment purchases resulting in MA supplementation. For example, if Medicaid reimburses an MA provider for \$20 and the item costs \$40, then DHS prohibits IRIS participants from using IRIS funds to “supplement” the MA payment to mitigate the cost difference;

- Any measures interfering with individual rights, liberties, and privileges. IRIS participants may use certain types of restrictive measures, with prior approval, from the appropriate governing authority; and
- Payments to participant-hired workers without a completion of an approved criminal or caregiver background check on record.
- Items typically the responsibility of a home or apartment owner, including but not limited to roofing, siding, sidewalks, garages, water heaters, furnaces, and other such home maintenance tasks; and
- Legal fees of any type, including but not limited to guardianship, name changes, establishing trust funds, criminal or civil matters or parking tickets.

5.5 Plan Processing, Implementation, and Monitoring

Processing, implementing, and monitoring an ISSP is a collaborative effort between the IRIS participant, the IC, a provider agency and/or participant-hired workers, and other individual(s) the IRIS participant chooses to include.

The IRIS participant, in collaboration with the IC, is responsible for the implementation of the ISSP, identifying the services and supports to meet his or her needs, and to assure that the emergency back-up plan is current and effective. The IRIS participant and IC work together, meeting at least monthly for thorough, face-to-face consultations during the 90-day initial ISSP planning and implementation phase.

5.5A Plan Processing and Approval

Once an IRIS participant decides upon needed services, the process for obtaining approvals for service authorizations begins. All ISSPs require IC and/or ICA approval. The participant's IC and/or ICA cannot "approve" the ISSP when the total cost of the plan exceeds the approved budget amount. The approved 1915 (c) HCBS waiver states:

"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 FEAs can render payments accordingly."

Once completed, the ISSP is signed by the IRIS participant, and, when relevant a legal representative. The IC also signs and verifies that the plan is considered approved. The participant's signature ensures that they understand the following:

- a. The intention of the chosen goods, supports, and services to address long-term support needs and supports to reach individual outcomes.
- b. With signature, the IRIS participant indicates the choice to accept goods, supports, or services through the IRIS Program, and understands choice exists to leave the IRIS Program at any time, with or without cause.
- c. Services for new or updated plans will not receive authorization without signature of the IRIS participant/legal representative and, therefore, IRIS cannot pay for services. The IRIS participant/legal representative:
 - i. Receives notice requesting signature on IRIS participant's plan within ten days of the updated plan being finalized.
 - ii. Is informed when the participant does not agree to the plan, and to contact the IRIS consultant to amend in reflection of the appropriate changes.
 - iii. Is informed, in writing that IRIS cannot pay for services without the IRIS participant/legal representative's signature authorizing the services.

5.5B Enrollment Date

An IRIS participant's enrollment date refers to the date of activation of the service authorization; therefore, the IRIS program prohibits the payment of providers and/or participant-hired workers prior to the enrollment date. The approved IRIS 1915 (c) HCBS waiver describes timeframes relative to the enrollment date:

“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 “enrollment date” in the program is equivalent to the participant's ‘plan implementation’ date.”

Participant-hired workers must not bill for IRIS goods, supports, and services for days involving participant hospitalization or institutionalization. Participants entering the IRIS program following a long-term or temporary stay in a non-allowable setting must have an official discharge date on or before the participant's enrollment date in IRIS.

5.5C Plan Monitoring

Monitoring ensures that IRIS participants utilize IRIS funding appropriately and effectively, and promotes program integrity. The DHS monitors ISSPs through the record review process described in the IRIS Policy Manual Section 10.4.

5.5C.1 IRIS Consultant Agency – Plan Monitoring

The IRIS program requires the ICA and IC to engage in ongoing plan monitoring. The approved 1915 (c) HCBS waiver states the following in Appendix E (E-1):

“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 ICs maintain regular, in-person contact with IRIS participants, based on established level of support, with intent to assess safety, efficacy of ISSP services, and to measure outcome achievement. The DHS defines the requirements of IC contact frequency in the [ICA Certification Criteria](#) (P-00826).

IRIS participants who are dissatisfied with the outcome(s) of services can initiate the plan amendment process (see section 5.6, Plan Amendments).

5.5C.2 Fiscal Employer Agency (FEA) – Plan Monitoring

The FEA maintains responsibility to update service authorizations based on new ISSPs and ISSP amendments. The FEA further maintains responsibility to monitor spending, report issues of overspending to the ICA, and ensure the cost-effectiveness of the IRIS program through enacting payment limitations identified in Work Instruction Manual Section 5.3A – Flexible Spending.

5.6 Plan Updates

IRIS participants amend the ISSP upon the addition, removal, or change of a new good or support service to meet the needs of the participant's disability-related needs, or to reach individual, long-term care related outcomes. The IRIS

participant and IC review and update the ISSP at least annually, at the time of the participant's annual review. The IRIS participant may request an update to the ISSP at any time during the plan year when a new need or long-term care outcome is identified, or when the participant experiences a change in condition. The approved 1915 (c) HCBS waiver states:

“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.”

5.6A Prescreening

Once the participant identifies the change(s) or addition(s) to the service plan, the IC must have a conversation with the participant establishing the need for the change.

The plan update must:

- Relate to a need or goal identified in the approved person-centered service plan;
- Increase independence or substitute for human assistance;
- Promote opportunities for community living and inclusion;
- Be accommodated within the IRIS participant's budget without compromising the participant's health or safety; and
- Be provided to, or directed exclusively toward, the benefit of the IRIS participant.

The ICs must consider the following:

5.6A.1 Participant's Change in Condition

If the person experiences a decrease in function due to a recent health issue or progression of a disability, then a change of condition Long-Term Care Functional Screen (LTC FS) is administered prior to commencement of an update request. The LTC FS is required to substantiate the need for additional supports and services. The participant requests a LTC FS rescreen with the IRIS Consultant.

5.6A.2 Personal Care Eligibility

The participant may be eligible for personal care when he or she requires hands on care for tasks such as toileting, bathing, grooming, or transferring. If the participant needs, but is not receiving, hands on care through a Medicaid personal care agency or the IRIS Self-Directed Personal Care (SDPC) program in IRIS, he or she may be eligible for Medicaid reimbursement for personal care. The IRIS Consultant refers the participant to a Medicaid personal care agency for a nurse to perform an assessment. The consultant may also refer the participant to the IRIS SDPC Oversight Agency when the participant selects to use IRIS SDPC, or when MA agency care is not available to the participant. The IRIS Consultant refers the participant to the IRIS SDPC Oversight Agency by completing the IRIS SDPC Referral Form.

5.6A.4 Funding of Last Resort

The IRIS Consultant must ensure exhaustion of the primary payers before the IRIS participant makes a request for waiver-funded services, including determining whether the Medicaid ForwardHealth card, primary insurance, other governmental-funded programs, or other formal or informal supports, cover the requested good or service. CMS states, in the 1915 (c) HCBS waiver application:

“A State has the latitude to design a waiver program that is cost-effective.” CMS makes the additional requirement of the State in the Code of Federal Regulations (CFR) § 441.302, “Unless the Medicaid agency provides the

following satisfactory assurances to CMS, CMS will not grant a waiver under this subpart and may terminate a waiver already granted: ...**Financial accountability** – The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.”

The IC verifies the plan update is:

- a. An IRIS allowable service as identified and defined in Appendix C of the approved 1915 (c) HCBS waiver;
- b. Within the IRIS participant’s budget;
- c. Meets a need related to the IRIS participant’s long-term care needs and addresses at least one individual related outcome of the IRIS participant; and
- d. When the requested change is a pay raise for a participant-hired worker, it must be a justified.

5.6B Approved Plan Changes

If the requested update meets the above conditions, then the ICA sends the IRIS participant a confirmation letter notifying the IRIS participant of the approval of the plan update. The ICA also notifies the FEA of the changes to the service authorizations.

5.6B.2 Fiscal Employer Agent

When the plan update modifies the rate of pay or number of hours for participant-hired worker(s), the ICA must submit updated or new service authorizations to the FEA.

5.6C Denied Plan Updates

If the requested plan update does not meet the above conditions, then the IC reviews the requested plan update and relevant information, and seeks further information and/or justification as needed.

If the IRIS participant does not provide additional information, or the information provided does not justify the request, then the ICA sends a Notice of Action to the IRIS participant denying the requested service(s) and/or good(s) and informs the participant of his or her appeal rights (see section 11.0, Appeals and Grievances). The approved 1915 (c) HCBS waiver states:

“The participant will receive confirmation that requested plan updates 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 update within five business days of plan submission. A notice of action must be sent within 24 hours of decision.”

5.7 Budget Amendments

The DHS defines a “Budget Amendment (BA)” as a request made by the IRIS participant to increase the participant’s budget to pay for an ongoing need not met within the current budget. Typical supports, services or goods requested through the BA process include additional Supportive Home Care, Respite, Daily Living Skills, Supported Employment, and other such services needed by an IRIS participant on an ongoing basis. A change in condition Long-term care Function Screen (LTC FS) is required any time a participant requests a budget increase of 25% or more for any combination of the 5 following caregiving-related services: adult day care, adult day services, daily living skills,

supportive home care, and respite. Additional funds required for IRIS Self-Directed Personal Care do not occur through a BA. This type of increase is managed through the personal care screening tool.

The CMS authorized the DHS to increase an IRIS participant's budget through the BA process as stated in Appendix C (C-4) of the approved 1915 (c) HCBS Waiver. The approved waiver states:

“If a participant disputes the amount of the individual budget the first course of action is to request a review of his or her LTC FS 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.”

The approved 1915 (c) HCBS Waiver further states in Appendix E (E-2):

“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 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. A committee convened by the IRIS Section Chief conducts this review. 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.”

5.7A Budget Amendment Requests

Budget amendments and one-time expenses are managed in separate SharePoint lists within the same BA SharePoint site. Each ICA maintains its own BA SharePoint site. These sites contain a library consisting of the BA, one-time expense policies, and work instructions, detailing the process, applicable forms including instructions and examples, and, the BA and OTE SharePoint user's manuals. Each time a new IRIS consultant agency is certified, DHS staff meet with the new agency to define the process including identification of the participant's need, the completion of the paperwork, the use of the SharePoint sites, the decision-making process, and the independent review and Medicaid Fair Hearing appeal process.

Each BA or one-time request with the status “Pending Review,” indicates its readiness for DHS review. Requests with the status “Pending Review” received on Thursday undergo examination by the review committee on the following Tuesday (using the established timeframe for reviewing requests). Exceptions to this schedule are made for holidays and are communicated in advance to the ICAs and the review committee members.

5.8 One-Time Expenses

The DHS defines “One-Time Expenses (OTEs)” as requests made by the IRIS participant to increase the budget to pay for a good or service not in the current budget. Typical supports, services or goods requested through the OTE process include home modifications, adaptive aids, vehicle modifications, and other such services for which an IRIS participant may require a budget amendment to pay for a one-time cost.

CMS authorized the DHS to increase an IRIS participant’s budget through the OTE process as stated in Appendix E (E-2):

“If the actual support costs exceed the estimated budget, DHS has a budget amendment and a one-time expense processes to increase the budget upon approval...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 care Financing has developed a review group of DHS employees to review IRIS requests. This process ensures consistency in decision-making for such expense. The review group analyzes the request and recommends one of the following: approval, partial approval, 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. The committee 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 notified of Medicaid Fair Hearing appeal rights.

BAs and OTEs are contained on separate SharePoint lists within the same BA SharePoint site. Each ICA has its own BA SharePoint site. These sites each contain a library that consists of the BA and OTE policies and work instructions that detail the process; applicable forms including instructions and examples; and the BA and OTE SharePoint user’s manuals. Each time a new ICA is certified, DHS meets with the new agency to define the process including identification of the participant’s need, the completion of the paperwork, the use of the SharePoint sites, the decision-making process, and the independent review and Medicaid Fair Hearing appeal process.

Each BA or one-time request with the status “Pending Review,” indicates its readiness for DHS review. Requests with the status “Pending Review” received on Thursday undergo examination by the review committee on the following Tuesday (using the established timeframe for reviewing requests). Exceptions to this schedule are made for holidays and are communicated in advance to the ICAs and the review committee members.”

5.8A Home Modifications

Home modifications may improve a participant’s home for health, safety, or accessibility, and IRIS participants may use home modifications to increase independence. Home modifications include adding specific equipment or changing features within homes. The definition of “Home Modification” is located in Appendix C of the approved 1915 (c) HCBS waiver and provides the following information regarding limitations:

- “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 that the modification addresses disability related long-term care needs that increase self-reliance and independence, or ensure safe, accessible means of ingress/egress to a participant's living quarters, or 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.

Quotes from at least three providers must be obtained and submitted with the request for the home modification when the cost for modifications exceeds 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.”

5.8A.1 Allowable Modifications

Home modifications may include, but are not limited to:

- Accessible cabinetry, counter tops or work surfaces
- Adaptive door bells, locks/security items or devices
- Adaptive lighting/light switches
- Doors/doorways, door handles/door opening devices
- Faucets/water controls
- Fire safety adaptations
- Grab bars, handrails
- Medically necessary heating, cooling or ventilation systems
- Ramps (fixed, non-portable)
- Porch/stair lifts
- Plumbing, electrical modifications
- Shower, sink, tub and toilet modifications
- Specialized floor covering to address health and safety
- Wall protection
- Other modifications approved by the Wisconsin Department of Health Services

5.8A.2 Non Allowable Modifications

As stated in Appendix C of the approved 1915 (c) HCBS Waiver, “Modifications that are not allowable include, but are not limited to:

- Modifications to increase the square footage or value of a home;
- Modifications to create boat access;
- Modifications to create more than one accessible entrance/exit to a home;
- Modifications designed for socializing; and
- Modifications that do not address your independence, health, safety, or long-term care-related needs.”

5.8B Adaptive Aids

An adaptive aid is a control or appliance that helps a participant with daily activities or controls his or her environment including lifts, vehicle modifications, and control switches. It also includes a good or service to support the participant to participate in the community. The definition of “Adaptive Aid” is located in Appendix C of the approved 1915 (c) HCBS waiver.

5.8B.1 Allowable Adaptive Aids

Adaptive Aids may include:

- Lifts, control switches;
- Costs associated with vehicle modification maintenance; and,

- Van lifts, hand controls, equipment modifications for vehicles.

5.8B.2 Non-Allowable Adaptive Aids

Durable medical equipment (DME), available through the Wisconsin Medicaid Forward Health Card, are not an allowable IRIS expense.

5.8C Accessibility Assessment

All participants submitting an OTE request must have an accessibility assessment performed. The IRIS Consultant informs the participant of the need for an independent assessment and provides the participant information and assistance to secure an assessment. The approved 1915 (c) HCBS Waiver states the following in Appendix C (C-1):

“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 a cost to the participant’s budget.”

5.8C.1 Choosing an Assessor

Any qualified vendor may provide the assessment; however, the entity completing the assessment may not also be a potential provider of any material part of the proposed project or have any perceived conflict of interest. For instance, a contractor bidding on the proposed work may not complete the assessment. The ICA maintains a list of all individuals and entities qualified to provide assessments, and if a participant prefers the assessment to be completed by an entity not already qualified, then the ICA makes the decision whether to add the entity to the list of qualified providers.

The IRIS participant, with assistance as needed from the IC, completes and submits the accessibility assessment request form ([F-01213](#)) to the IC. The IRIS participant identifies an individual, or entity, to complete the assessment and the IC sends a letter to the appointed individual or entity along with a copy of the accessibility request form. This letter includes a description of the necessary assessment elements, assessment payment information and serves as authorization for the individual, or entity, to contact the IRIS participant. The ICA provides the participant a copy of this letter.

The completed assessment provides written recommendations, alternatives, and includes a comprehensive description of all cost effective approaches considered relative to the requested modification or related adaptation(s).

5.8D Submitting Requests for DHS Review

Once the vendor completes the accessibility assessment and collects all necessary information, the IC enters the information into the DHS/OTE SharePoint site, and DHS reviews the request.

5.8E Review Process

The DHS reviews submitted requests to ensure requests meet the IRIS participant’s stated need(s) in the most cost-effective manner. DHS will approve or deny the request, and may request additional information from the ICA. DHS also approves requests for modifications, conditions, and/or time restrictions. When the DHS Review Committee denies a request, the ICA sends a letter prepared by DHS to the IRIS participant informing him/her of DHS’ decision. The letter also includes information about requesting an independent review. The IRIS participant has ten business days to notify DHS of his/her request for an independent review. If the request remains denied after the independent review, or chooses not to engage in an independent review, then DHS issues a Notice of Action to the IRIS participant denying the request and informing him/her of his/her appeal rights (see section 11.0, Appeals and Grievances).

5.9 Employment Planning

As authorized by CMS through the approved 1915(c) HCBS Waiver, employment, and pre-employment training services are included in the IRIS waiver benefit package. In 2011, CMS released an informational bulletin to provide clarification of existing CMS guidance on the development and implementation of 1915(c) HCBS Waivers regarding employment and employment-related services ([CMCS Informational Bulletin, Sept. 16, 2011](#)).

The CMCS Informational Bulletin states:

“Work is a fundamental part of adult life for people with and without disabilities. It provides a sense of purpose, shaping who we are and how we fit into our community. Meaningful work has also been associated with positive physical and mental health benefits and is part of building a healthy lifestyle as a contributing member of society. Because it is so essential to people’s economic self-sufficiency and well-being, people with disabilities and older adults with chronic conditions who want to work should be provided the opportunity and support to work competitively within the general workforce in pursuit of health, wealth, and happiness. All individuals regardless of disability and age, can work – and work in optimally with opportunity, training, and support that build on each person’s strengths and interests.”

The DHS and the IRIS program supports the notion that all people can work for competitive wages in the community and supports that “all people, regardless of the severity of their disabilities are entitled to integrated employment with the correct job match and appropriate supports” ([Bergman 2013](#)) ([Office of Disability and Employment Policy](#)). The positive effect of work on a person’s health is well documented and evidenced by a report authored by Dr. Ellie Hartman, Ph.D., entitled, “[A Literature Review on the Relationship between Employment and Health: How this Relationship may inform Managed Long-term care](#).” The report states, “*the relationship between employment and health demonstrates a consistent association between employment and better health and unemployment and poorer health.*”

“Research has shown that employment results in cost savings, less reliance on public benefits, and more money going back into the local community.” Further supporting documentation was submitted to WI DHS via a report authored by Robert Cimera, Ph.D., entitled, “[An Evaluation of the Costs and Outcomes Obtained by Agency and Individual-Provided Follow Along Services](#).”

Employment and pre-employment training services may include*:

- Job coaching
- Job development
- Benefits counseling
- Vocational futures planning and support
- Transportation to and from work
- Personal care in the workplace
- Assistive technology
- Project SEARCH
- Job support
- Prevocational services*Detailed information regarding the above services, including but not limited to, the waiver service definitions, service provider qualifications, and service exclusions or exemptions, are available in the IRIS Service Definition Manual.

5.9A Employment Assessments

At a frequency of no less than once per year, the ICA and IC will complete a DHS prescribed employment assessment for each participant of working age. The assessment is designed to gather information on a participant's skills, interests, talents, work experiences, educational experiences, and potential job accommodations. The information collected in the employment assessment is consistent with information a potential employer or a job developer collects to find an appropriate job match. The employment assessment also elicits information from the participant about their desired career objectives. During calendar year 2015, the DHS-approved employment assessment will be completed within the IRIS Centralized IT System (or ISITS), and must be documented on the participant's plan (ISSP). If a participant is over the age of 65, then he or she may request an exemption from the annual employment assessment. The request must be submitted and approved by the DHS, prior to a participant being exempt.

5.9B Working with the Division of Vocational Rehabilitation (DVR)

The [Division of Vocational Rehabilitation](#) (DVR) is a division of the Wisconsin Department of Workforce Development (DWD). The Wisconsin DVR is committed to providing equal access to minorities and other underserved populations ([Wisconsin Vocational Rehabilitation Program Policy Manual](#)). When an IRIS participant is in the process of pursuing employment or developing an employment outcome, he or she must first seek eligibility for employment-related services provided by the DVR (see Policy 5.6A.4 Funding of Last Resort). If DVR services are unavailable, then the participant may use IRIS funds to pay for employment services.

Title I of the Rehabilitation Act of 1973, as amended, requires the State to provide:

"...comprehensive, coordinated, effective, efficient, and accountable programs of vocational rehabilitation that are designed to assess, plan, develop, and provide vocational rehabilitation services for individuals with disabilities, consistent with their strengths, resources, priorities, concerns, abilities, and capabilities, interests and informed choice, so that such individuals may prepare for and engage in gainful employment." [\[P.L. 105-220 s. 100 \(a\)\(2\)\]](#)

The [Rehabilitation Act Amendments of 1992 \[PL 102-569\]](#) requires the DVR program meet the following requirements:

“(3) It is the policy of the United States that such a program shall be carried out in a manner consistent with the following principles:

(A) Individuals with disabilities, including individuals with the most severe disabilities, are generally presumed to be capable of engaging in gainful employment and the provision of individualized vocational rehabilitation services can improve their ability to become gainfully employed.

(B) Individuals with disabilities must be provided the opportunities to obtain gainful employment in integrated settings.”

The DHS values the expertise and experience of its partner agency DVR; therefore, participants are encouraged to apply for DVR services. When a participant is receiving DVR services, the IRIS Consultant is required to document any progress toward employment outcomes and document on the ISSP any employment services and supports provided by DVR. If requested by the participant, guardian, or the participant’s DVR counselor, the IRIS Consultant is required to attend any DVR employment planning meetings and document on the participant’s plan the date and topic of the meeting.

If an IRIS participant is no longer eligible for DVR services or is on a waitlist for DVR services, then the IRIS program may fund long-term employment supports. DVR services are time limited. Once DVR funds are exhausted, or DVR determines the participant has reached stabilization, the ICA will work collaboratively with DVR to ensure a timely and successful transition of the payment of employment services to IRIS from DVR. This includes the timely completion and submission of IRIS BA requests to accommodate any additional funding needed to cover employment services (see Policy 5.7 Budget Amendments).

5.9C Benefits Counseling

As authorized by CMS through the approved 1915(c) HCBS Waiver, IRIS funds may be used to fund work incentive benefits counseling. People with significant disabilities may be apprehensive about working toward employment because of concerns that earnings will affect their eligibility for needed benefits, including disability benefits and Medicaid. Many studies indicate that the fear of losing disability benefits is a barrier for people with disabilities gaining employment, or career advancement. The purpose of Work Incentive Benefits Counseling (WIBC) is to provide people the information they need to make informed decisions about their employment options. The [DHS Family Care / Partnership Resource Memo 13-01](#) issued on 6/26/2013 provides additional information on the purpose, providers, and funding sources for WIBC.

Research shows that work incentive benefits counseling services are strongly associated with increases in employment outcomes. Researchers from the University of Wisconsin-Stout Vocational Rehabilitation Institute provided DHS an analysis of the effect of benefits counseling on Wisconsin residents who participated in the Wisconsin SSDI Employment Pilot. In summary, the report concluded, “work incentive benefits counseling helped pilot participants improve their employment outcomes. We think it likely that this conclusion would apply to many other populations of persons with serious disabilities.” ([Sell, Hartman, Delin 2009](#)) ([Delin et. al. 2012](#))

Therefore, the IRIS program encourages participants to seek WIBC services when pursuing, or maintaining employment opportunities. The Social Security Administration offers SSI and SSDI beneficiaries WIBC services free of charge as authorized through the [Ticket to Work and Work Incentives Improvement Act of 1999](#). As of July of 2014, there are three agencies in WI eligible to provide WIPA services: [Riverfront, ERI, and Independence First](#). Participants and consultants should inquire about participant eligibility for WIPA funds before requesting WIBC services funded by IRIS (see Policy 5.6A.4 Funding of Last Resort).

5.9D Pre-Employment and Employment Training Services

As authorized by CMS through the approved 1915(c) HCBS Waiver, pre-employment training services are included in the IRIS waiver benefit package in an effort to prepare individuals for integrated employment work experiences. Service types include prevocational services, day services, and Project SEARCH. These service types “should be designed to create a path to integrated community-based employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities ([CMCS Informational Bulletin, Sept. 16, 2011](#)). For prevocational services to be added to a participant’s plan, the participant must indicate and document a goal of competitive, integrated employment. Prevocational services are time-limited and the DHS reserves the right to request progress reports from ICA’s and/or providers of prevocational services on an ongoing basis. If the DHS determines that reasonable progress towards an integrated employment outcome is not being accomplished, then the DHS reserves the right to de-authorize that service or provider from a participant’s plan. Additional state standards and requirements for prevocational services can be found in the [Medicaid Waivers Manual, Chapter IV, Page IV-123](#).

5.9E Project SEARCH

The Project SEARCH Program is a unique, business led, one-year school-to-work program that takes place entirely at the workplace. Total workplace immersion facilitates a seamless combination of classroom instruction, career exploration, and hands-on training through worksite rotations (<http://www.projectsearch.us/OurPROGRAM.aspx>). The definition of a successful outcome is competitive employment in an integrated setting for each Project SEARCH intern:

- Employment in an integrated setting
- Year-round work
- 20 hours/week or more
- Minimum wage or higher

Based on the program model and the documented success rates of participants who complete the Project SEARCH program, the IRIS program will approve a BA request for successful Project SEARCH applicants to fund a portion of the Project SEARCH program fees as long as the participant remains in the program.

5.9F Employment Data

The DHS and the IRIS program require ICAs to collect and report data on participant employment outcomes. The DHS Employment Initiatives Section facilitates the collection of employment data every six months. At the discretion of the DHS, employment data is available to stakeholders to ensure program transparency. This data may also be provided as a resource for participants to make an informed choice of ICA.

5.9G Self-Directed Employment Services

As stated in the [CMCS Informational Bulletin, September 16, 2011](#):

“Self-directed service delivery models can also be used to provide employment supports. In a self-directed model, individuals may hire their own job coaches and employment support staff, rather than relying exclusively on agency based staffing models. This may be particularly useful as individuals seek to expand the pool of people who can provide employment supports and services to include friends, family members, co-workers, and other community members that do not view themselves as part of the traditional Medicaid provider employment supports workforce.”

Providers employed directly by the participant (e.g. not through an agency) for employment services, must meet the licensure and certification standards for providers of employment services. Provider licensure and certification standards are documented in the approved 1915 (c) HCBS Waiver and the IRIS Service Definition Manual.

6.0 Participant Choice of Qualified Providers

When developing his or her Individual Support and Service Plan (ISSP), the participant can choose any provider who is “willing and qualified” to provide his or her IRIS-funded services. Appendix C of the approved 1915 (c) Home and Community-Based Services waiver defines the requirements for a provider to be considered “qualified.”

6.1 Employer Authority

As part of the IRIS program, IRIS participants have “employer authority.” Employer authority gives participants the ability to serve as the employer of record, including having their own Federal Employer Identification Number (FEIN). Participants choosing to exercise employer authority rights have the responsibility to recruit, hire, train, supervise, discipline, and fire their participant-hired workers.

The approved 1915 (c) Home and Community-Based Services waiver provides the following definition of employer authority in the Brief Waiver Description:

“All IRIS participants make arrangements to purchase needed services and supports from vendors, with support from the IRIS consultant as needed. IRIS participants choosing to exercise employer authority recruit, hire, train, monitor, and discipline (when necessary) their own workers. Participants exercising employer authority review and approve timesheets and other documentation and submit them to their FEA [fiscal employer agent]. The state’s practice and policy are in compliance with the Fair Labor Standards Act (FLSA).

FEAs support the IRIS participant by completing payroll functions, maintaining the State Medicaid Agency Provider agreements for participant-hired workers and ensuring tax on other required verifications are in place for each provider. FEAs also serve as the claims administrator for supports and services authorized in the ISSPs, adjudicate all claims for payment, issue payments for services, and enter the services and supports in the Encounter data system.”

6.1A Choice of Participant-Hired Workers

IRIS participants are able to hire participant-hired workers who meet the criteria of “willing and qualified” as defined in Appendix C of the approved 1915 (c) Home and Community-Based Services waiver. Neither the Department of Health Services (DHS), nor the IRIS consultant agency (ICA) or FEA providers, contract with participant-hired workers. The IRIS program does not maintain a “provider network.” Participants are responsible for identifying participant-hired workers and negotiating a reasonable and customary rate. Participant-hired workers and individual providers are required to charge by hourly or 15-minute billing increments and are not permitted to charge a daily rate.

The approved 1915 (c) Home and Community-Based Services waiver states the following regarding provider selection and the IRIS consultants’ role in provider identification in Appendix D-1-d:

“The participant is responsible for identifying and retaining either participant-hired workers or agency providers or a combination of both. The participant is responsible for negotiating reasonable and customary rates with all providers. The IRIS consultant is required to provide the necessary tools, resources, and information to locate and retain providers. The IRIS consultants are further responsible to ensure that the ISSP and subsequent service authorizations reflect the providers, a usual and customary rate, the type of unit, the number of units, and the timeframe for which the service authorization is valid. It is not the IRIS consultants’ responsibility to recruit providers, retain providers, or negotiate rates with providers. It is the IRIS consultants’ responsibility to ensure

participants have the tools, resources, and information to hire, train, and otherwise manage participant-hired workers.”

The IRIS program permits family members, legal guardians, and legal representatives to receive payment with IRIS funds as indicated in Appendix C of the approved 1915 (c) Home and Community-Based Services waiver. However, all participant-hired workers must be compliant with the Centers for Medicare and Medicaid Services’ (CMS) conflict-free case management requirements.

6.1B Participant-Hired Worker Qualifications

Appendix C of the approved 1915 (c) Home and Community-Based Services waiver specifies the qualifications for each approved service. The FEAs verify all qualification requirements. All participant-hired workers and individual providers are required to pass a criminal and caregiver background check.

The approved 1915 (c) Home and Community-Based Services waiver states the following regarding the caregiver and criminal background check requirements in Appendix C-2-a:

“a. All participant-hired workers and agency care providers, including family members and legally responsible individuals, are required to pass the criminal and caregiver background checks in accordance with Wisconsin State Statute 50.065, Wisconsin Administrative Code Chapter 12, and IRIS Policy 6.1B.1.

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.

There is an increased vulnerability because of the unique relationship between the participant and participant-hired worker when the participant exercises employer authority. The fiscal employer agents review the applicants’ criminal background check for additional convictions as identified in the appendix of the IRIS work instruction manual section 6.1B.1. Because these convictions are not listed in the statutes or administrative code, there is an appeal process for applicants who are denied employment based on these convictions. Convictions of crimes listed in statute or administrative code are not eligible for appeal for any reason. The process for appeal is identified in IRIS work instruction manual section 6.1B.1.

c. The IRIS fiscal employer agents are required by contract to ensure that all persons working as paid caregivers have had required background checks completed. The fiscal employer agents conduct background checks for participant-hired workers. FEAs are required to communicate the applicant’s eligibility to the participant and the applicant. Applicants may request a copy of the background check. FEAs verify that agency providers comply with background check requirements by ensuring the agency’s attestation that the background checks were completed. OIM [Office of IRIS Management] conducts reviews of samples of participant-hired workers to ensure the completion of these background checks.”

6.2 Agency Providers

IRIS participants may choose to hire an agency to provide IRIS-funded services. Participants may use agency services in combination with participant-hired workers to meet their needs. Agencies must meet the requirements identified by their licensing or certifying entity in addition to the requirements identified in Appendix C of the approved 1915 (c) Home and Community-Based Services waiver. Agencies are required to ensure that caregivers pass the caregiver and criminal background checks prior to serving IRIS participants. Participants are responsible for negotiating a usual and customary rate with agency providers. Agencies are permitted to charge a daily rate, but maintain responsibility for remaining compliant with the Fair Labor Standards Act.

The approved 1915 (c) Home and Community-Based Services waiver describes the following requirements about the annual assessment of participant needs in Appendix D-1-d:

“The participant is responsible for identifying and retaining either participant-hired workers or agency providers or a combination of both. The participant is responsible for negotiating reasonable and customary rates with all providers. The IRIS consultant is required to provide the necessary tools, resources, and information to locate and retain providers. The IRIS consultants are further responsible to ensure that the ISSP and subsequent service authorizations reflect the providers, a usual and customary rate, the type of unit, the number of units, and the timeframe for which the service authorization is valid. It is not the IRIS consultants’ responsibility to recruit providers, retain providers, or negotiate rates with providers. It is the IRIS consultants’ responsibility to ensure participants have the tools, resources, and information to hire, train, and otherwise manage participant-hired workers.”

6.3 Medicaid Card Services

IRIS participants receive medical, behavioral, dental, private duty nursing, and other services through the Medicaid card, also known as the ForwardHealth Medicaid plan. IRIS participants who require personal care can choose Medical Assistance Personal Care (MAPC), which is funded by the Medicaid card. Home and Community-Based Services, or the IRIS waiver, is considered the funding source of last resort, and, therefore, all available Medicaid card services must be exhausted first. For example, an IRIS participant who qualifies for private duty nursing (PDN) may not use supportive home care hours in lieu of using PDN. A participant may decline to use Medicaid card services, but those services may not then be replaced with IRIS-funded services.

The Code of Federal Regulations (CFR) § 440.180 defines “Home and Community-Based Services” (including services provided by the IRIS Program) as,

“...services, not otherwise furnished under the State’s Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.”

6.4 Private Duty Nursing (PDN)

Wisconsin Medicaid covers private duty nursing (PDN) for participants with medical conditions that require eight or more hours of skilled nursing in a 24-hour period. PDN is defined under [Wisconsin Administrative Code § DHS 107.12](#). PDN includes the skilled nursing services for ventilator-dependent life-support participants, as well as for participants not dependent on a ventilator. Participants with medical conditions requiring less than eight hours of skilled care in a 24-hour period are eligible for skilled nursing from a home health agency through Wisconsin Medicaid as defined under [Wisconsin Administrative Code § DHS 107.11 \(2a\)](#). IRIS Medicaid Waiver participants qualifying for PDN must maximize the state Medicaid plan benefit prior to using IRIS waiver funds. Once the participant maximizes Medicaid state plan PDN services to the approved amount eligible, the participant may use IRIS waiver services, such as respite and supportive home care, for the provision of non-skilled care for those IRIS participants who are not authorized to receive

24 hours of skilled care. If an IRIS participant is eligible to use this Medicaid state plan benefit, then the participant may not opt to use IRIS funds in lieu of the Medicaid card to pay for unlicensed staff or family to provide this or similar services. The Code of Federal Regulations (CFR) § 440.180 defines “Home and Community-Based Services” (including services provided by the IRIS Program) as,

“...services, not otherwise furnished under the State’s Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.”

Nurses in independent practice (NIP/PDN nurses) provide PDN services, including services for recipients dependent on a ventilator for life support. The NIP/PDN delivers services to Medicaid recipients and, due to being classified as Medicaid providers, must meet certification in order to provide Medicaid PDN services.

6.4A Private Duty Nursing and Personal Care

Even though the primary purpose for PDN does not include provision of personal care services, nursing care remains similar to personal care. It is reasonable to assume that monitoring for any health condition, such as seizures, vital signs, or suctioning, does not prohibit the NIP/PDN from performing basic nursing cares integral to the recipient’s health, such as care in hygiene, hydration, nutrition, dressing, grooming, mobility, toileting, transferring, keeping linens clean and dry, and other comparable tasks.

Example: If a NIP/PDN provides a bath, then the NIP/PDN is expected to clean up after the bath, just as with any other activity the NIP/PDN performs in the course of duties. The NIP/PDN would be expected to clean and maintain equipment because this activity is included in general nursing care.

6.4B Case Coordination, Forms, and Supplies

Medicaid requires the NIP/PDN, as Medicaid providers, to maintain documentation in the participant’s home. The NIP/PDN must provide documentation forms and disposable medical supplies (DMS) such as gloves. The IRIS participant is not responsible for supplying forms and DMS, nor can forms or DMS be billed to the recipient or other programs, including the IRIS program. IRIS participants may not purchase forms and DMS through the IRIS plan. The Wisconsin Medicaid and BadgerCare Recipient Update from [December 2002](#) provides additional information on these requirements.

The NIP/PDN coordinates all medical care, completes the plan of care, obtains the prior authorization, makes and attends appointments, orders and stocks supplies, and provides this coordination under the PDN guidelines. The separate reimbursement of these activities with other funds, such as through supportive home care (SHC) using IRIS Waiver funds, is not allowable because this is covered within the nursing rates and is reimbursed through the Medicaid rate.

Example: A broker or prior authorization liaison (PAL) cannot be reimbursed with IRIS funds to provide these services as it is the responsibility of the private duty nurse to provide coordination of care as part of the PDN’s roles and duties as a NIP/PDN in independent practice.

6.4C Case Sharing

If a participant’s condition requires double staffing, and this double assistance is medically necessary, then the double staffing may be covered by Medicaid card services when prior authorized. Double staffing in the context of this policy is not related to two-to-one cares for other IRIS Waiver services. A Medicaid personal care (MAPC) agency supplements the PDN case and designates a “case share” between the two entities. The case share plan is reviewed and prior authorization granted by DHS. Upon prior authorization, this is a MAPC-billable card service and is therefore not billed to

the other provider (i.e., IRIS). IRIS Waiver funds cannot cover double staffing as this service is covered by the Medicaid card. Case sharing requires nurse oversight and nurse delegation. In IRIS Self-Directed Personal Care (IRIS SDPC) the nurse does not oversee or delegate responsibility to the workers. Therefore, IRIS participants are not eligible to use IRIS SDPC in a case-share situation. In MAPC, the MAPC nurses directly oversee workers and may delegate responsibility and train workers to perform tasks so unlicensed workers can provide care under the direction of the MAPC nurse. An MAPC agency may supplement the PDN through a case-share arrangement. The PDN and MAPC parties must follow the Nurse Practice Act requirements.

6.4D Duplication of Services

DHS considers the request for reimbursement for services already covered under the PDN rate as “duplication of services” or double billing: Recipients have a duty not to seek the same or similar services from more than one provider [DHS 104.02 (1), Wis. Admin. Rules].

DHS also works to ensure the best use of program resources:

- Among the reasons for prior authorization is promoting the most effective and appropriate use of available services and facilities, [Wis. Admin. Code § DHS 107.02 \(3\) \(b\) 5](#); and,
- The criteria for prior authorization includes the extent to which less expensive alternative services are available, [Wis. Admin. Code § DHS 107.02 \(3\) \(e\) 6](#).

6.4E Private Duty Nursing/Physician Order for Care/Staffing

The ForwardHealth Prior Authorization/Care Plan Attachment (PA/CPA) ([F-11096](#)) is a form used by the prior authorization (PA) nurse and the participant’s physician to order or obtain a prior authorization (PA) for PDN services through Medicaid.

The nurse or physician may not order IRIS-funded services, such as SHC, through an order on the Prior Authorization/Care Plan Attachment (PA/CPA) DHS form [F-11096](#). If the physician orders up to 24 hours of “skilled nursing care,” then unskilled and/or unlicensed staff cannot cover shifts ordered by a physician that an NIP/PDN must provide. Licensed nurses must provide all skilled nursing care billed through the Medicaid ForwardHealth card. Legal representatives or family members trained by the physician to care for a loved one, and not licensed nurses, may do so as a natural support. The IRIS program does not pay for skilled nursing tasks provided by unskilled and/or unlicensed staff as SHC, because these are not supportive home-care tasks. When natural supports provide skilled care, it is not considered skilled nursing and the liability shifts from the NIP/PDN to the physician. The NIP/PDN must develop and implement a backup plan and cover shifts to maintain safety for the participant and provide continuity of care as required by [Wis. Admin. Code § DHS 105.18\(8\)](#).

If a participant experiences difficulty locating an NIP/PDN, then the participant may contract a home health/skilled agency to provide this type of skilled service. In cases in which the participant is unable to fill all shifts, the PA will only authorize the number of hours for which there is coverage. For example, the PPOC may order 24 hours of nursing, but the PA authorizes 16 hours of nursing because the remaining shift is not filled. The IRIS program recognizes the PPOC as the doctor’s order and, therefore, IRIS funds may not support provision of skilled nursing services for uncovered PDN shifts.

An unlicensed worker, such as an SHC or respite worker, may never provide paid, skilled care. Because skilled care is reimbursable through the Medicaid card, it is not reimbursable through IRIS waiver funds.

If the physician determines it is safe for paid, unlicensed workers to cover shifts when nurses are not available, then only trained personal care workers with nurse oversight, such as through an MAPC agency, may be considered. IRIS SDPC

workers are not eligible to provide this service. Combining MAPC and PDN occurs through a case share with the PDN case to provide coverage when the NIP/PDN are not available. The nurse for the MAPC agency provides the delegation and oversight to workers only for tasks that are eligible for delegation. The MAPC agency obtains its own physician orders and the PDN case coordinator or PAL works with the agency to submit the prior authorizations to DHS for review and monitors to avoid overlaps in services (unless double staffing is approved). The system exists to ensure the NIP/PDN and the MAPC agency do not bill for the same service and to provide continuity of care. MAPC agencies are not obligated to take on skilled cases, such as those with PDN, as the agency must ensure the plan is safe and meets the person's care needs.

It is possible for an IRIS participant to utilize SHC hours while a skilled nurse is providing nursing services. The NIP/PDN maintains responsibility to ensure the participant has a clean bed and removes and replaces soiled linens with clean linens. Laundering soiled linens is not the responsibility of the NIP/PDN and, therefore, a paid, unskilled SHC worker may launder the linens. An NIP/PDN and an unskilled worker providing SHC can provide services simultaneously because each worker provides different services. Because of the division of labor between the NIP/PDN and SHC workers, within the same task (including something such as laundry), it is permissible that both individuals work at the same time without providing a "duplication of services" as discussed in section 6.4D. This assumes the SHC worker never removes the soiled linens or places clean linens on the bed, and the NIP/PDN never launders the linens. If the SHC worker **did** remove and replace the linens, then duplication of services occurred, as the tasks of removing and replacing the linens are the responsibility of the NIP/PDN.

The aforementioned division of labor is not limited solely to the NIP/PDN responsibility of ensuring the participant has a clean bed; a similar division of labor exists with bathing tasks. The NIP/PDN maintains responsibility to ensure the participant is clean; therefore, provision of baths is an expected part of nursing care. Upon completion of bathing the participant, the NIP/PDN maintains the responsibility of ensuring the bathroom is clean. The NIP/PDN is not responsible for laundering the towels or the participant's soiled clothing. An unskilled worker through SHC may complete this task without being considered to have engaged in duplication of services.

Unskilled workers also complete other SHC tasks, including cleaning of the home not related to the NIP/PDN nurse's tasks, certain meal preparation and meal cleanup activities, yard maintenance and/or snow removal, and other such activities. The SHC hours documented on the approved ISSP must comply with IRIS Work Instructions Manual Section 6.1B.2 – Caregiver Hours Assurance and Oversight. The participant and/or legal representative maintain responsibility to ensure that the SHC worker understands the job duties, including the importance of the division of tasks with the NIP/PDN to prevent duplication of services.

The IRIS Program requires participants to provide the IRIS consultant (IC) with a copy of the PPOC to ensure the participant's IRIS ISSP adequately ensures the participant's health and safety. Refusing to provide IRIS Program staff with a copy of the PPOC may be grounds for involuntary disenrollment. See IRIS Policy Manual Chapter 7 for further information concerning disenrollment.

6.4F Health and Safety

If a participant is receiving services from a Medicaid long-term care program, such as IRIS, then it is necessary for the program to ensure the health and safety of that participant. As a Medicaid provider, the NIP/PDN is held to these same standards.

IRIS participants who receive private duty nursing services must submit copies of the current [F-11096](#) to the IRIS consultant agency (ICA) to ensure continuity of care, and to avoid duplication of services. A copy of the PDN backup plan and emergency procedures is also required.

6.4G Private Duty Nursing Backup and Emergency Procedures

In accordance with [Wis. Admin. Code § DHS 105.19 \(8\)](#) and Medicaid Provider Agreement:

- a) A participant's NIP/PDN shall designate an alternate NIP/PDN to provide services to the participant in the event the NIP/PDN is temporarily unable to provide services. The NIP/PDN informs the participant of the identity of the alternate NIP/PDN before the alternate nurse provides services.
- b) The NIP/PDN shall document a plan for participant-specific emergency procedures in the event of a life-threatening situation, such as a fire or for severe weather warnings. The NIP/PDN makes this plan available to the participant and all caregivers prior to initiation of these procedures.
- c) The NIP/PDN shall take appropriate action and immediately notifies the participant's physician, guardian, if any, and any other responsible person designated in writing by the participant or guardian of any significant accident, injury, or adverse change in the participant's condition.

The PA/PCA form, as well as the PDN backup plan, remains in the participant's records in accordance with HIPAA regulations.¹ The NIP takes into consideration the course of action taken by the nurse, the alternate nurse, and the member's family should the backup or emergency plan fail for any reason. If unskilled family members were part of the backup plan, then IRIS does not reimburse for provision of these skilled services.

6.5 Medical Assistance Personal Care (MAPC)

IRIS participants who need personal care services can choose to receive Medical Assistance Personal Care (MAPC) or IRIS SDPC. MAPC is funded by the Medicaid ForwardHealth card while IRIS SDPC is funded through a 1915 (j) State Plan Amendment. Participants are not permitted to receive MAPC services in settings outside of the home, such as where they are employed. IRIS SDPC is further described in Chapter 13 of this policy manual.

The approved 1915 (c) Home and Community-Based Services waiver states the following related to personal care and person-centered planning in Appendix E-1-a:

“Participants develop their ISSPs, within the established individual budget estimate, and direct all services and supports identified in their plans. Participants have the additional option to self-direct personal care services through an s. 1915(j) State Plan Amendment for IRIS Self-Directed Personal Care. The services and supports identified on the ISSP must include all IRIS-funded waiver services, Medicaid ForwardHealth card services and other supports and services necessary for participants to live at home, go to school, work, and integrate into the community as independently as possible. Using a person-centered approach, the ISSP 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 all aspects of the development of the ISSP, which serves as the foundation for the participant's participation in this waiver.

¹ References:

Nurses in Independent Practice Handbook/March 2006;
[BadgerCare Plus and Medicaid Nurse in Independent Practice Online Handbook](#)
DHS 105.19 Nurses in independent practice;
ForwardHealth Private Duty **Update** March 2010 No. 2010-15

6.6 IRIS Consultant Agency Providers

IRIS participants are required to have an IRIS consultant and ICA to help them navigate the IRIS program. IRIS participants choose an ICA during enrollment counseling at the Aging and Disability Resources Center (ADRC). Because ICA services are required, the cost of the ICA services does not come out of the participants' budget. DHS certifies ICAs based on the criteria outlined in the document, "IRIS Consultant Agency Certification Criteria" ([P-00826](#)). DHS contracts with all willing ICA providers who successfully meet the certification criteria.

Appendix C of the approved 1915 (c) Home and Community-Based Services waiver defines IRIS consultant services as:

"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. All participants have the right to select their IRIS consultant by viewing consultant biographies and choosing the individual who best meets their needs. 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 waiver services and participant-hired workers. Examples of skills training include providing information on recruiting, 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 participants make the most informed choice about their long-term care outcomes, supports, and services as well as understand the responsibilities involved with directing services. The IRIS consultant is not responsible to directly coordinate services, hire, manage, schedule, train, or terminate participant-hired workers.

Through this service, the IRIS consultant provides the participant with the following tools, resources, and information:

- Person-centered planning and its application
- 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
- 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 an emergency backup plan
- Recognizing and reporting critical events
- Providing assistance in filing grievances and complaints when necessary

- Other areas related to managing services and supports.”

6.61 Transferring ICA Providers

IRIS participants may transfer between ICA’s provided the ICA is certified by DHS to serve IRIS participants in the area. Transfers are processed by the local ADRC and individuals who wish to transfer should contact their local ADRC. The ADRC provides DHS-approved information on the ICA options available and once selection is made the ADRC refers the participant to their chosen ICA provider. The transfer effective date is scheduled so that a smooth transition can occur.

6.7 IRIS Fiscal Employer Agent Providers

IRIS participants are also required to have an FEA to ensure providers meet the qualification described in Appendix C of the approved 1915 (c) Home and Community-Based Service waiver, as well as ensure providers receive payment for rendered services. IRIS participants choose an FEA during the development of their ISSP. IRIS participants choose an FEA from among the options offered to them by their IRIS consultant. Because FEA services are required, the cost of the FEA services does not come out of the participants’ budget. DHS certifies FEAs based on the criteria outlined in the document, “Fiscal Employer Agent Certification Criteria” ([P-00825](#)). DHS contracts with all willing FEAs who successfully meet the certification criteria.

Appendix C of the approved 1915 (c) Home and Community-Based Services waiver defines FEA services as:

“Fiscal Employer Agent Services include 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 with employer responsibilities, such as processing payroll; withholding Federal, state, and local tax; withholding garnishments as necessary; and making tax payments to appropriate tax authorities.
- (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-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.”

6.71 Transferring FEA Providers

IRIS participants may transfer between FEA's provided the FEA is certified by DHS to serve IRIS participants in the area. The IC provides DHS approved information on the FEA options available and once selection is made the IC refers the participant to their chosen FEA provider. The effective date of the transfers occurs on calendar quarters with sufficient time for all payroll and accounting tasks to be successfully transitioned from one FEA to another.

10.0 Program Integrity

The Centers for Medicare and Medicaid Services (CMS) documents in Appendices A, C, D, and I of the waiver application how the state will ensure the integrity of the program, including performance measures that measure compliance with the approved 1915 (c) Home and Community-Based Services Waiver. Ensuring program integrity is one of the most important aspects of a self-directed program such as IRIS. Program integrity is critical to the sustainability of the IRIS program. The IRIS program has preventive controls, detective controls, and corrective controls in place to ensure program integrity in the following areas:

- Fraud prevention, identification, and mitigation
- Budget monitoring
- Conflict of interest identification and mitigation
- CMS performance measures
- Contract compliance

10.1 Fraud Allegation Review and Assessment (FARA)

The IRIS program has the following responsibilities relative to fraud:

- Identify potential violations of Wis. Stat. § 946.91 (2) (a)
- Review all allegations of potential violations of Wis. Stat. § 946.91 (2) (a)
- Mitigate opportunities within the IRIS program for continued violations of Wis. Stat. § 946.91 (2) (a)
- Report substantiated allegations of Wis. Stat. § 946.91 (2) (a) to the Office of the Inspector General (OIG) and the Department of Justice (DOJ) for investigation and potential prosecution.

Wisconsin Stat. § 946.91 (2) states,

“(2) Whoever does any of the following is guilty of a Class H felony, except that, notwithstanding the maximum fine specified in s. 939.50 (3) (h), the person may be fined not more than \$25,000:

- (a) Intentionally makes or causes to be made any false statement or representation of a material fact in any application for any Medical Assistance benefit or payment.
- (b) Intentionally makes, or causes to be made, any false statement or representation of a material fact for use in determining eligibility for any Medical Assistance benefit or payment.
- (c) Having knowledge of the occurrence of any event affecting the initial or continued eligibility for any Medical Assistance benefit or payment or the initial or continued eligibility for any such benefit or payment of any other individual in whose behalf he or she has applied for, or is receiving such benefit or payment, conceals or fails to disclose such event with an intent to fraudulently secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.
- (d) Having applied to receive any Medical Assistance benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts the benefit or payment or any part thereof to a use that is not for the benefit of such other person.”

The approved 1915 (c) Home and Community-Based Services Waiver states the following related to fraud prevention in Appendix C-2-d,

“IRIS consultants report any concerns about potential payment for unworked hours to the individual(s) at their ICA [IRIS consultant agency] who are responsible for Fraud Allegation Review and Assessment (FARA). The FARA team completes a FARA and mitigates any risk. OIM [Office of IRIS Management] permits the IRIS consultants to make unannounced visits if necessary to determine if fraud is occurring. In situations wherein the guardian or legally responsible individual is the one committing the fraud, the participant may be disenrolled from the IRIS program as a result.”

The approved 1915 (c) Home and Community-Based Services Waiver states the following related to involuntary disenrollment from the IRIS program due to allegations of fraud substantiated through the FARA process in Appendix E-1-1,

“OIM makes the final determination regarding involuntary disenrollments. ICAs submit the appropriate request for disenrollment for OIM review and approval. As described in the Policy Manual: Work Instructions section 7.1A.1, the following reasons are reviewed for potential involuntary disenrollment by OIM:

- Failure to pay cost-share
- Failure to utilize IRIS funding (no spend)
- No contact
- Loss of financial eligibility
- Loss of functional eligibility
- Residing in an ineligible living setting
- Health and safety risks that participants are unwilling or unable to resolve
- Substantiated fraud
- Misappropriation of IRIS funds
- Mismanagement of employer authority”

The approved 1915 (c) Home and Community-Based Services Waiver states the following related to the responsibilities of the ICA and fiscal employer agents (FEA) relative to the FARA process in Appendix I-b-i:

“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 FEA, the contract the state holds with the FEA 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 FEA to the providers to help ensure accurate submission of claims.

The FEA are responsible for tracking and reporting issues with claims (timesheets) submitted to the FEA 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 FEAs 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 participants or participant employees, 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 FEA submitting documentation to reverse the incorrect claim and correct it using new information.

The state also requires training of both the ICA and FEAs 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. The contracted entities collaborate with the state to complete the Fraud Allegation Review and Assessment (FARA) process and report cases of substantiated fraud to the Department's Office of the Inspector General and Department of Justice when applicable."

10.2 Budget Monitoring

Each participant has an individual budget estimate calculated through an actuarially sound algorithm using information provided by the participant on his or her Long Term Care Functional Screen (LTC FS). Budget authority is a key component of a self-directed program such as IRIS. Budget authority gives participants the ability to determine which services available in Appendix C of the 1915 (c) Home and Community-Based Services Waiver they would like to purchase. Participants are also responsible for identifying willing and qualified providers and negotiating the rates. Participants are not permitted to exceed their individual budget estimate when developing his or her Individual Support and Service Plan (ISSP). Participants are not permitted to exceed their individual budget estimate when authorizing timesheets or claims.

The 1915 (c) Home and Community-Based Services Waiver states the following about the calculation of each participant's individual budget estimate in the "Brief Waiver Description" section:

"The Office of IRIS Management (OIM) will calculate the individual budget allocation for IRIS participants by entering their LTC FS results into an online tool that automatically inputs that information into the statistical model described above and generates a projected cost of services and supports for the individual. 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 1915 (c) Home and Community-Based Services Waiver states the following about the processing of claims and timesheets that exceed the authorized amount in Appendix I-2-b:

"The Department uses a FEA for claims adjudication and processing. There are two types of claims that 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 FEA's using industry standard best practice data required for claims adjudication, including but not limited to participant ID, provider ID, service type, frequency, service code, applicable modifier, unit, rate, date of service, and authorization period. The FEA will receive the claim from the provider and adjudicate that claim based on the participant's approved authorization within the Individualized Service and Support Plan (ISSP). Through the adjudication process the FEA will determine if the claim is authorized. If the claim is authorized, the FEA 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 FEA 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 FEA 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 FEA by the participant-hired worker (PHW). The payroll timesheet system will perform a validation against the participant's authorized service on the ISSP and notify the FEA of any errors, unauthorized services, or services exceeding the authorization amount for the participant-hired worker. After completion of the timesheet validation process, the FEA will conduct their payroll processing procedures to reimburse the participant-hired worker for services provided. The FEA will also submit a line-item claim to the Department. The state will then fund a zero-balance state-held bank account. The PHW will then receive reimbursement for the claim through electronic funds transfer. Payroll claims that are paid to the participant-hired worker in error (keying error from validation to check write) are the responsibility of the FEA to recoup, their reimbursement from the Department will be only in the amount authorized on the ISSP.

The Department conducts an audit of 20 percent all claim files submitted where the claim exceeds \$2500.

BFS [Bureau of Fiscal Services] 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 [Bureau of Long Term Care Financing] staff through encounter reporting and IRIS quality assurance staff 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 [self-directed services] encounter reporting. The FEA 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.”

The 1915 (c) Home and Community-Based Services Waiver states the following about the ICAs' responsibilities related to service plan implementation and monitoring in Appendix D-2-a:

“B) IRIS consultants monitor the use of IRIS funds by the participants by reviewing budget utilization in WISITS [Wisconsin Self-Directed Information Technology System]. IRIS consultants also respond to concerns expressed by other entities involved in the provision of services to the participants to ensure health and safety and successful implementation of the ISSP. Participants engage in continuous and ongoing monitoring of the service providers and participant-hired workers providing their services to ensure continued quality of service.”

10.3 Conflict of Interest

The IRIS program permits family members, guardians, and legal representatives to be paid caregivers and receive IRIS funds for providing services authorized in Appendix C of the 1915 (c) Home and Community-Based Services Waiver. The program is required to comply with all Home and Community-Based Services Waiver (?) conflict of interest regulations, including the Conflict-Free Case Management regulations. The IRIS program must ensure there are no conflicts of interest between participants and providers, including ICAs and FEAs. The IRIS consultants must ensure that the ISSP serves the needs and preferences of the participants.

The approved 1915 (c) Home and Community-Based Services Waiver states the following regarding conflict of interest in Appendix C-2-d:



“Guardians and active health care powers of attorney (POA-HC) are the types of legally responsible persons permitted by the IRIS program to receive payment as participant-hired workers. These individuals may only provide services indicated within Appendix C as being eligible to for provision by legal guardians, family members, and those considered legally responsible. Specifically, these services are 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.

The IRIS consultants employ a tool known as the Home and Community Support Assessment, which assists IRIS consultants, and participants to calculate the appropriate amount of supportive home care hours to meet the participants’ needs. This tool excludes tasks that are included as part of residing in a shared household meaning that only the “extraordinary” cares that are related to the participant’s disability and are above and beyond the tasks associated with habitation.

When legally responsible individuals, including legal guardians, are both paid caregivers and making decisions relative to the appropriation of the participant’s IRIS budget, the IRIS consultants evaluate the situation in accordance with the IRIS Conflict of Interest work instructions and policy. IRIS consultants must ensure that there are no concerns relative to health and safety, including caregiver burnout, and that the Individual Support and Service Plan (ISSP) meets the needs and preferences of the participant. Part of this review includes ensuring the participant is able to participate in the self-direction process.”

The approved IRIS Consultant Agency Certification Criteria ([P-00826](#)) states the following regarding requirements of the ICAs related to conflict of interest:

- “1. The ICA will provide consultants with Department-approved training regarding how to identify and mitigate conflicts of interest, including requirements to discuss this topic with participant and their families.
2. The ICA reviews all program integrity and conflict of interest education documentation and obtains all participant signatures as required per the IRIS policy manual (P-00708) and the IRIS policy manual: Work Instructions (P-00708A) (see 10.3A.1: Conflict of Interest – Participant and 10.3A.2: Conflict of Interest – Provider).”

The ICAs and FEAs must disclose formal business relationships with providers of long-term care services for any Wisconsin long-term care programs. The ICA certification criteria state the following:

“The ICA is required to disclose all formal business relationships in effect with any providers of long-term care services for any Wisconsin long-term care programs. This includes, but is not limited to, the following: Board Members, Managers, Supervisors, IRIS consultants and/or orientation consultants or their immediate family members who receive any financial gain from providers providing services in Wisconsin long-term care programs ([F-01310](#)).”

The FEA certification criteria state the following respectively:

“The FEA is required to disclose all existing informal, and formal, business relationships in effect with any providers of long-term care services for any Wisconsin long-term care programs. This includes, but is not limited to, the following: Board Members, Managers, Supervisors, line staff and their immediate family members who receive any financial gain from providers providing services in Wisconsin long-term care programs ([F-01310](#)).”

10.4 Quality Management

The OIM has an IRIS Quality Team consisting of one team lead and four quality assurance specialists. The IRIS Quality Team is responsible for the following activities, including, but not limited to:

- Collecting data for CMS performance measures
- Reporting data to CMS
- Writing and implementing amendments and renewals to the 1915 (c) Home and Community-Based Services Waiver
- Reviewing and approving critical incident reports
- Reviewing and approving FARA activities
- Reviewing and approving requests for restrictive measures
- Reviewing and approving budget amendments and one-time expense
- Reviewing, approving, and monitoring quality management plans
- Reviewing and approving requests for involuntary disenrollment or denial of enrollment
- Reviewing hearings and appeals data
- Resolving participant issues
- Developing IRIS policies and work instructions
- Providing training, technical assistance, and oversight to the ICA and FEA providers

The IRIS Quality Management Team Operations document ([P-01004](#)) and IRIS Quality Management Team Reference document ([P-01004A](#)) provide specific information regarding individual responsibilities of each member of the IRIS Quality Management Team.

10.4A Record Reviews

The DHS Quality Management Team completes participant record reviews to achieve the following:

- Collect data for CMS performance measures
- Provide quality oversight to the IRIS Self-Directed Personal Care (SDPC) Oversight Agency, and ICA and FEA providers
- Identify individual and systemic quality issues
- Ensure new ICA providers are developing quality ISSPs
- Identify problems or areas of success in IRIS expansion counties
- Provider compliance with waiver, policy, and contract requirements

IRIS consultant agencies, fiscal employer agents, and the IRIS SDPC Oversight Agency are required to provide individual and system remediation to all negative findings identified in the participant record reviews.

The approved 1915 (c) Home and Community-Based Services Waiver states the following regarding participant record review process in Appendix C-a-2:

“OIM completes participant record reviews. OIM examines the participants’ electronic records against a tool consisting of pre-determined indicators based on CMS performance measures and elements of best practice. OIM aggregates and reports on the data collected on a quarterly basis. OIM communicates the results to the ICAs through separate reports describing individual performance from the data recorded in the Record Review SharePoint site. OIM also prepares a report that compares the results across ICA provider agencies. Via the Record Review SharePoint site, OIM informs each ICA provider agency of the negative findings, the reason for the negative findings, and the required remediation activities. Each ICA is required to complete the required remediation activities and record the response in the participant’s record and within the Record Review SharePoint site. OIM validates the ICA’s response to each of the remediated negative findings by going back into the participant’s record and ensuring that the participant’s ICA contains adequate documentation of the completed remediation activities. OIM documents the approval or need for additional remediation activity in the SharePoint record. OIM does not close the record review in SharePoint until the remediation activity is completed according to the standards outlined in the criteria for the initial review. OIM provides each ICA with its own Record Review SharePoint site to ensure compliance with HIPAA.”

10.4B Quality Management Plans

The DHS Quality Management Team requires ICA and FEA providers to submit quality management plan templates and tracking mechanisms to address system issues identified through the participant record review or other quality activities.

The approved 1915 (c) Home and Community-Based Services Waiver states the following about ICA and FEA quality management plans in Appendix C-b-i:

“The ICAs and FEAs are responsible for remediating all identified individual issues and identifying quality management plans for all performance measures or other OIM systems measurements that fall below 86 percent. The IRIS Quality Management Team and/or IRIS Section Chief ensure the ICAs and FEAs perform identified corrections as described in the quality management plan and provide follow-up as needed. OIM validates all individual remediation of negative findings during data collection activities for performance measures.”

11.0 Appeals and Grievances

Per Wisconsin Statute § 51.61(5) (b), the Department of Health Services (DHS) oversees the implementation of the complaint, grievance, and appeals process. Contracted agencies must track and report complaints, grievances, and appeals made by participants, their representatives or providers in the IRIS program.

IRIS participants maintain the right to complain, grieve, and/or appeal any action or inaction by the IRIS program for which the participant perceives as negative. The overall system for appeals and grievances in the IRIS program offers participants various options to resolve differences. The IRIS program encourages participants to use informal procedures as a first attempt to resolve concerns, no prescribed hierarchy of procedures exist to address concerns.

In addition, 42 CFR Part 431, subpart E, and State Medicaid Manual sec. 4442.7.B, provides participants the right to a Medicaid fair hearing for certain actions.

11.1 Appeals

IRIS participants use the Medicaid State Fair Hearing process to appeal certain decisions and/or actions by the IRIS consultant agency (ICA) perceived by the participant as having a negative or undesirable impact. The IRIS participant submits formal appeal requests to the Division of Hearings and Appeals (DHA) within forty-five calendar days of the Notice of Action (NOA).

Upon request of a State Fair Hearing, participants receive notification in the mail explaining the administrative hearing process. The process allows the participant to share evidence and to counter information used to make the decision in question. The date, time, and location of the participant's fair hearing are included in the letter. For more information, visit: <http://dha.state.wi.us/home/WFS/wfsunit.htm>.

Upon hearing completion, the Administrative Law Judge (ALJ) issues a decision, in writing, within ninety calendar days, summarizes the facts of the case, recites the regulation governing the case, and applies the regulation to the facts. The written decision clearly states the outcome.

In cases wherein the ICA issues a Notice of Action (NOA), the IRIS participant can file a fair hearing request with the Division of Hearings and Appeals (DHA). NOAs provide participants with an explanation regarding the basis for denial, reduction, termination, or limitation of services by the ICA.

11.1A Appeals

An appeal is a formal request to the DHA requesting a change in, or confirmation of, a decision made by an ICA or fiscal employer agent (FEA) provider agency, or DHS.

Participants may appeal a decision upon receipt of an NOA, for the following situations:

- Reduced, terminated or denied requests for services;
- Denied request for payment;
- Failure to provide services or items included in a participant's support and service plan in a timely manner;
- Failure to resolve appeal or grievance in a timely manner; and
- Unacceptable support and service plan because it:

- Requires participant to live somewhere they do not choose to live;
- Fails to provide sufficient care, treatment or support; or
- Requires the participant to accept care, treatment, or support that is unnecessarily restrictive or unwanted.

The approved 1915(c) Medicaid Home and Community-Based Services waiver states:

“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 participant 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 they want to keep services in place until a decision is 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.”

11.1B Rehearing

If the participant is not in agreement with the ALJ’s decision and wishes to introduce new evidence to the case, then the participant makes a hearing request, in writing, within twenty calendar days following the ALJ’s written decision.

Upon submission of this written hearing request, the DHA has thirty calendar days to determine whether there is sufficient evidence to justify a rehearing. If the DHA does not issue a written response to the rehearing request within thirty calendar days, then the request is considered denied.

11.1C Judicial Review

If the participant is not in agreement with the ALJ's decision and the ALJ denied the participant's request for a rehearing, then the participant may choose to file a petition for a Judicial Review with his or her county of residence Circuit Court within thirty calendar days of the original, denied decision.

11.2 Notice of Action

The IRIS program must provide a Notice of Action (NOA) to program participants when an "adverse action," defined as a denial, reduction, termination or limitation of previously authorized services (meaning services/goods on a participant's plan) exists or when a participant is determined financially, or functionally, ineligible for the IRIS program. The 1915(c) Medicaid HCBS Waiver states the following regarding the NOA:

"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 they want to keep services in place until a decision is 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."

The participant must *receive* the NOA at least ten calendar days *before* the effective date of the action. If the participant decides to grieve or appeal the action, then he or she has 45 calendar days to do so. Information concerning procedures for exercising the participant's right to an appeal process accompanies the NOA.

11.2A Contents of NOA Letter

The NOA letter explanation must include the following information:

- The action the ICA provider agency has taken or intends to take including the effective date of action;
- The reason for the action, reflecting the specific reason(s) concerning the participant's situation;
- Alternative options the ICA explored with the participant prior to the decision;
- Applicable laws, regulations, statutes, or policy supporting the action;
- Procedures for exercising the participant's right to an appeal process;
- Availability of independent advocacy or ombudsman services and other local organizations able to assist the participant with the appeal process;
- The participant's ability to obtain, free of charge, copies of the IRIS record relevant to the appeal process and how to obtain copies; and,
- The participant's right to continuation of benefits pending resolution of the grievance/appeal; how to request benefits continuation; and, circumstances under which the participant may be required to re-pay the costs for these continued services.

The NOA uses easily understood language and includes a statement that written or oral interpretation is available for individuals whose native language is not English and indicates how to obtain such interpretation. The document, “IRIS Participant Appeal Rights,” ([P-00679](#)) must accompany the NOA.

11.3 Complaints

DHS defines “complaint” as any element of dissatisfaction experienced by an IRIS participant, while in the IRIS program, requiring intervention that the IRIS Consultant cannot resolve. An IRIS participant may file a complaint concerning any aspect of rights, services, ICA, FEA or regarding the IRIS program in general.

IRIS participants receive annual education regarding the complaints process via the “Participant Education – Complaint and Grievances” form ([F-01205F](#)).

Receipt of complaints related to the IRIS program may come from various sources including participants, legal representatives, agency providers, participant-hired workers, family members, community members, or other interested persons on behalf of the participant. Participants make complaints verbally or in writing, during visits with the IRIS Consultant; through the IRIS Call Center; through MetaStar (the independent, third-party mediator contracted by DHS), through a Legislators’ Office or the Office of the Governor.

Whenever a participant makes a complaint regarding an IRIS matter, an informal attempt to resolve the situation should occur. Typically, complaint resolution should occur, as close to the source as possible, with the appropriate ICA or FEA provider staff ensuring the complaint is properly addressed.

When participants and/or legal representatives have complaints, resolution attempts should begin with the consultant who will work to resolve the issues or concerns. If these issues or concerns involve the participant’s IC, or the IC is unable to address the issues or concerns, then the participant and/or legal representative contacts the relevant agency (ICA, FEA) for resolution.

Agency providers with complaints should contact the appropriate ICA or FEA provider agency to address their concerns.

If the ICA or FEA is unable to resolve the problem, then the participant, legal representative, or agency provider has the right to file a grievance. The agency conducts a review of the filing.

The DHS directs complaints to the MetaStar hotline for resolution. MetaStar is contracted by DHS to resolve complaints on behalf of DHS. Participants, legal representatives, and providers should contact MetaStar via the hotline number (888-203-8338) or email address (DHSIRISGrievances@wisconsin.gov) to make a complaint.

MetaStar and the ICA and FEA provider agencies are required to document and track all complaints received, including the date of the participant complaint; a description of the complaint; the outcome of complaint resolution process, and the date of resolution or conclusion. The contracted agency must provide DHS with data and reports. The DHS reviews reports for trends and systems issues, and ensures the agency implemented the processes or relevant policy as part of the DHS’ ICA and FEA agency provider monitoring and oversight.

Concerning complaints, the 1915(c) Medicaid HCBS waiver states:

“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, FEAs, 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 (FEAs) also has an established system to receive, respond to and track grievances or complaints from participants and providers related to the role of the FEAs, 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 FEAs 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 FEA'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 FEAs. 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 choose more than one avenue to resolve their issue simultaneously.

The ICAs, FEAs, 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.”

11.4 Grievances

A grievance is a formal complaint, based on an act, dispute, or omission concerning a participant's rights, services or with the IRIS program in general. Participants may file a grievance regarding any aspect of the IRIS experience viewed by the participant as unsatisfactory including appecption by the participant of violation or suppression of rights (see 8.0, Participant Rights and Responsibilities).

IRIS participants receive annual education regarding the grievance process via the “Participant Education – Complaint and Grievances” ([F-01205F](#)) form.

11.4A Grievance Process

Participants must submit formal grievances in writing, using the DHS Grievance – IRIS ([F-01212](#)) form. After receipt of the grievance, the agency (MetaStar, ICA, or FEA) has thirty days to review the grievance (and supporting documentation) to make a decision on necessary action or next steps. Participants, legal representatives, and providers can contact MetaStar via the hotline number (888-203-8338) or email address (DHSIRISGrievances@wisconsin.gov) to commence the grievance process.



Concerning grievances, the 1915(c) Medicaid HCBS waiver states,

“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, FEAs, and MetaStar. These documents also explain the state fair hearing process and ombudsman program options. The IRIS Consultants (ICs) 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/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 respond 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, FEAs, 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 (FEAs) also has an established system to receive, respond to, and track grievances or complaints from participants and providers related to the role of the FEAs, and respond 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 FEAs 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 FEA’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 FEAs. 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 choose more than one avenue to resolve their issue simultaneously.

The ICAs, FEAs, 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.”

11.5 DHS Review

The DHS contracts with MetaStar, an external organization, to resolve participant complaints and grievances on behalf of DHS. MetaStar addresses the following issues (list not all-inclusive):

- Issues of non-payment of participant-hired workers and vendors;
- Concerns regarding budget amendments or one-time expenses;
- Concerns regarding timeliness of ICA or FEA services;
- Concerns regarding quality of ICA or FEA services; and,
- Concerns regarding unauthorized changes to the plan or wages.

11.5A DHS Review Process

Participants, legal representatives, and providers can contact MetaStar via the hotline number (888-203-8338) or email address (DHSIRISGrievances@wisconsin.gov) to commence the DHS review request process.

The 1915(c) Medicaid HCBS waiver states:

“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).”

13.0 IRIS Self-Directed Personal Care (SDPC)

An approved Medicaid 1915 (j) Self-Directed Personal Assistance Services (PAS) waiver gives the Department of Health Services (DHS) authority to administer the Include, Respect, I Self-Direct (IRIS) Self-Directed Personal Care (SDPC) program. DHS contracts with a single IRIS SDPC Oversight Agency to operationalize the IRIS SDPC program. IRIS SDPC gives participants in that Medicaid 1915 (c) Home and Community-Based Services (HCBS) Self-Directed Supports waiver program, the opportunity to self-direct their personal care services.

42 Code of Federal Regulations (CFR) § 441.450 – Basis, scope, and definitions – describes self-directed personal assistance services as the following:

“§ 441.450 - Basis, scope, and definitions.

(a) Basis. This subpart implements section 1915(j) of the Act concerning the self-directed personal assistance services (PAS) option through a State Plan.

(b) Scope. A self-directed PAS option is designed to allow individuals, or their representatives, if applicable, to exercise decision-making authority in identifying, accessing, managing, and purchasing their PAS. This authority includes, at a minimum, all of the following:

- (1) The purchase of PAS and supports for PAS.
- (2) Recruiting workers.
- (3) Hiring and discharging workers.
- (4) Training workers and accessing training provided by or through the State if additional worker training is required or desired by the participant, or participant's representative, if applicable.
- (5) Specifying worker qualifications.
- (6) Determining worker duties.
- (7) Scheduling workers.
- (8) Supervising workers.
- (9) Evaluating worker performance.
- (10) Determining the amount paid for a service, support or item.
- (11) Scheduling when services are provided.
- (12) Identifying service workers.
- (13) Reviewing and approving invoices.

(c) Definitions. As used in this part:

Assessment of need means an evaluation of the needs, strengths, and preferences of participants for services. This includes one or more processes to obtain information about an individual, including health condition, personal goals and preferences, functional limitation, age, school, employment, household, and other factors that are relevant to the authorization and provision of services. Assessment information supports the development of the service plan and the subsequent service budget.

Individualized backup plan means a written plan that meets all of the following:

- (1) Is sufficiently individualized to address each participant's critical contingencies or incidents that would pose a risk of harm to the participant's health or welfare;
- (2) Must demonstrate an interface with the risk management provision at § [441.476](#) which requires States to assess and identify the potential risks to the participant (such as any critical health needs), and ensure that the risks and how they will be managed are the result of discussion and negotiation among the persons involved in the service plan development;
- (3) Must not include the 911 emergency system or other emergency system as the sole backup feature of the plan; and
- (4) Must be incorporated into the participant's service plan.

Legally liable relatives means persons who have a duty under the provisions of State law to care for another person. Legally liable relatives may include any of the following:

- (1) The parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child.
- (2) Legally-assigned caretaker relatives.
- (3) A spouse.

Self-directed personal assistance services (PAS) means personal care and related services, or home and community-based services otherwise available under the State plan or a 1915(c) waiver program that are provided to an individual who has been determined eligible for the PAS option. Self-directed PAS also includes, at the State's option, items that increase the individual's independence or substitutes (such as a microwave oven or an accessibility ramp) for human assistance, to the extent the expenditures would otherwise be made for the human assistance.

Self-direction means the opportunity for participants or their representatives to exercise choice and control over the budget, planning, and purchase of self-directed PAS, including the amount, duration, scope, provider, and location of service provision.

Service budget means an amount of funds that is under the control and direction of a participant, or the participant's representative, if any, when the State has selected the State plan option for provision of self-directed PAS. It is developed using a person-centered and directed process and is individually tailored in accordance with the participant's needs and personal preferences as established in the service plan.

Service plan means the written document that specifies the services and supports (regardless of funding source) that are to be furnished to meet the needs of a participant in the self-directed PAS option and to assist the participant to direct the PAS and to remain in the community. The service plan is developed based on the assessment of need using a person-centered and directed process. The service plan builds upon the participant's capacity to engage in activities that promote community life and respects the participant's preferences, choices, and abilities. The participant's representative, if any, families, friends and professionals, as desired or required by the participant, will be involved in the service-planning process.

Support system means information, counseling, training, and assistance that support the participant (or the participant's family or representative, as appropriate) in identifying, accessing, managing, and directing their PAS and supports and in purchasing their PAS identified in the service plan and budget.

Supports broker or consultant means an individual who supports participants in directing their PAS and service budgets. The supports broker or consultant is an agent of the participants and takes direction from the participants, or their representatives, if applicable, about what information, counseling, training or assistance is needed or desired. The supports broker or consultant is primarily responsible for facilitating participants' development of a service budget and effective management of the participants' PAS and budgets in a manner that comports with the participants' preferences. States must develop a protocol to ensure that supports brokers or consultants: are accessible to participants; have regularly scheduled phone and in-person contacts with participants; monitor whether participants' health status has changed and whether expenditure of funds are being made in accordance with service budgets. States must also develop the training requirements and qualifications for supports brokers or consultants that include, at a minimum, the following:

- (1) An understanding of the philosophy of self-direction and person-centered and directed planning;
- (2) The ability to facilitate participants' independence and participants' preferences in managing PAS and budgets, including any risks assumed by participants;
- (3) The ability to develop service budgets and ensure appropriate documentation; and
- (4) Knowledge of the PAS and resources available in the participant's community and how to access them.

The availability of a support broker or consultant to each participant is a requirement of the support system.”

13.1 IRIS SDPC Eligibility

The approved Medicaid 1915 (j) Self-Directed Personal Assistance Services Waiver states:

“The State determines eligibility for Self-Directed Personal Assistance Services in the same manner as eligibility is determined for traditional State Plan personal care services described in Item 24 of the Medicaid State Plan.”

Item 24.f of the Medicaid State Plan describes the following requirements for eligibility,

“Prior authorization is required for personal care services after a limited number of hours of service have been provided in a calendar year.

Services must be supervised by an RN who reviews the plan of care, the performance of the personal care worker and evaluates the recipient's condition every 60 days. Reimbursement for RN supervisory visits is limited to one visit per month.

Personal care workers can perform home health aide tasks when delegation, training, and supervision criteria are met. Housekeeping tasks performed by the personal care worker are limited to 1/3 of the time spent in the recipient's home.”

IRIS participants who reside in a 1-2 bed adult family home owned by an individual unrelated to the participant are not eligible for IRIS SDPC.



42 CFR 441.460 – Participant Living Arrangements states:

“§ 441.460 Participant living arrangements.

- (a) Self-directed PAS are not available to an individual who resides in a home or property that is owned, operated, or controlled by a PAS provider who is not related to the individual by blood or marriage.
- (b) States may specify additional restrictions on a participant's living arrangements if they have been approved by CMS.”

As stated in the 1915 (j) Self-Directed Personal Assistance Service Waiver, Wisconsin will not impose additional restrictions on participant living arrangements. The 1915 (j) Self-Directed Personal Assistance Service Waiver provides additional clarification stating:

“Self-directed personal assistance services will only be available to individuals participating in the IRIS waivers. Those waivers are being implemented in conjunction with expansion of Wisconsin’s managed long-term care program, Family Care. Self-directed personal assistance services will be available to IRIS participants where the program currently exists and will become available in additional counties as Family Care and IRIS expand.”

13.2 IRIS SDPC Referral Process

Section 13.2 of the IRIS Work Instructions Manual outlines the IRIS SDPC referral process.

13.3 IRIS SDPC Representative

Participants in the IRIS SDPC program may appoint a representative to help with planning, decision-making, and billing if they choose. IRIS SDPC representatives must not also be paid providers of IRIS SDPC services. Legal representatives may appoint someone else the IRIS SDPC representative so they may be a paid provider of IRIS SDPC services.

The 1915 (j) waiver states the following about appointing an IRIS SDPC representative:

“The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.”

42 CFR 441.480, Use of a representative, further describes an IRIS SDPC participant’s ability to designate an IRIS SDPC representative:

“§ 441.480 Use of a representative.

- (a) States may permit participants to appoint a representative to direct the provision of self-directed PAS on their behalf. The following types of representatives are permissible:
 - (1) A minor child's parent or guardian.
 - (2) An individual recognized under State law to act on behalf of an incapacitated adult.
 - (3) A State-mandated representative, after approval by CMS of the State criteria, if the participant has demonstrated, after additional counseling, information, training or assistance, the inability to self-direct PAS.

(b) A person acting as a representative for a participant receiving self-directed PAS is prohibited from acting as a provider of self-directed PAS to the participant.”

13.4 IRIS SDPC Forms and Individual Support and Service Plan

Every IRIS participant receiving IRIS SDPC services must have a care plan detailing the participant’s needed services, the frequency by which the participant receives personal care services, and a description of how the participant would like the personal care services administered. This information is obtained using the IRIS Self-Directed Personal Care (SDPC) – My Cares ([F-01566](#)) and the IRIS Self-Directed Personal Care (SDPC) – Physician Order & Plan of Care ([F-01566A](#)) forms. The participant must also read and acknowledge the IRIS Participant Education: Self-Directed Personal Care ([F-01205J](#)) form. The participant and/or legal representative, the IRIS SDPC Registered Nurse (RN), and the participant’s Primary Care Physician must sign these forms prior to implementation, and annually. IRIS SDPC hours are added to the participant’s Individual Support and Service Plan to identify the paid caregivers and to facilitate payment.

The approved Medicaid 1915 (j) Self-Directed Personal Assistance Services Waiver states:

“The entity responsible for assisting the participant to develop the self-directed personal assistance services service plan will be the IRIS consultant agency [IRIS SDPC Oversight Agency] for IRIS. This entity does not provide additional Medicaid services to the individual beyond the consultant [IRIS SDPC Oversight] role.”

42 CFR 441.468 – Service Plan Elements describes the required components of the service plan:

“§441.468 Service plan elements.

- (a) The service plan must include at least the following:
 - (1) The scope, amount, frequency, and duration of each service.
 - (2) The type of provider to furnish each service.
 - (3) Location of the service provision.
 - (4) The identification of risks that may pose harm to the participant along with a written individualized backup plan for mitigating those risks.

- (b) A State must develop a service plan for each program participant using a person-centered and directed planning process to ensure the following:
 - (1) The identification of each program participant's preferences, choices, and abilities, and strategies to address those preferences, choices, and abilities.
 - (2) The option for the program participant, or participant's representative, if applicable, to exercise choice and control over services and supports discussed in the plan.
 - (3) Assessment of, and planning for avoiding, risks that may pose harm to a participant.

- (c) All of the State's applicable policies and procedures associated with service plan development must be carried out and include, but are not limited to, the following:
 - (1) Allow the participant, or participant's representative, if applicable, the opportunity to engage in, and direct, the process to the extent desired.
 - (2) Allow the participant, or participant's representative, if applicable, the opportunity to involve family, friends, and professionals (as desired or required) in the development and implementation of the service plan.
 - (3) Ensure the planning process is timely.

- (4) Ensure the participant's needs are assessed and that the services meet the participant's needs.
- (5) Ensure the responsibilities for service plan development are identified.
- (6) Ensure the qualifications of the individuals who are responsible for service plan development reflect the nature of the program's target population(s).
- (7) Ensure the State reviews the service plan annually, or whenever necessary due to a change in the participant's needs or health status.
- (8) Ensure that a participant may request revisions to a service plan, based on a change in needs or health status.

(d) When an entity that is permitted to provide other State plan services is responsible for service plan development, the State must describe the safeguards that are in place to ensure that the service provider's role in the planning process is fully disclosed to the participant, or participant's representative, if applicable, and controls are in place to avoid any possible conflict of interest.”

The IRIS SDPC forms must be completed using person-centered planning principles. The 1915 (j) Self-Directed Personal Assistance Services Waiver states the following regarding person-centered planning:

“The principles of person-centered, self-directed planning are central to the IRIS waiver and the self-direct personal assistance services under 1915 (j). Participants are central to the planning process and are assisted by the independent consultant [IRIS Consultant], not directed, in the planning process. This is also reflected in the risk assessment and risk management process. Participants may have a representative who would be intimately involved in the service planning process and may invite others to participate as desired. Independent consultants [IRIS Consultants] are expected to accommodate the participant’s choice to involve others in the planning process. In the case of risk management, care providers and those who provide back-up may be critical to the discussion.”

13.5 IRIS SDPC Budget

Participants receiving IRIS SDPC services receive a budget which equals the number of hours of care identified by the Personal Care Screening Tool times the standard hourly wage for IRIS SDPC, \$12.07/hour. This budget is separate from the IRIS Waiver Services budget. Section 13.5A further defines the budget calculation process. In cases wherein the participant, SDPC nurse, and physician agree, the participant can request an IRIS SDPC increase. Section 13.5B details the IRIS SDPC budget increase process.

13.5A IRIS SDPC Budget Calculation

Assurance J of the approved Medicaid 1915 (j) Self-Directed Personal Assistance Services Waiver states:

“The State assures that the methodology used to establish service budgets will meet the following criteria:

- i. Objective and evidence based, utilizing valid, reliable cost data.
- ii. Applied consistently to participants.
- iii. Open for public inspection.
- iv. Includes a calculation of the expected cost of the self-directed personal assistance services (PAS) and supports if those services and supports were not self-directed.
- v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
 - vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.



- vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.
- viii. Include a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.
- ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget."

13.5B IRIS SDPC Hours Increase

IRIS SDPC participants can request a reassessment that may result in an increase in IRIS SDPC hours when the participant, IRIS SDPC nurse, and physician agree that the IRIS SDPC participant has had a change in medical condition, functional status, or living situation.

42 CFR 441.472 states:

“§ 441.472 – Budget methodology.

- (a) The State shall set forth a budget methodology that ensures service authorization resides with the State and meets the following criteria:
 - (1) The State's method of determining the budget allocation is objective and evidence based utilizing valid, reliable cost data.
 - (2) The State's method is applied consistently to participants.
 - (3) The State's method is open for public inspection.
 - (4) The State's method includes a calculation of the expected cost of the self-directed PAS and supports, if those services and supports were not self-directed.
 - (5) The State has a process in place that describes the following:
 - (i) Any limits it places on self-directed services and supports, and the basis for the limits.
 - (ii) Any adjustments that will be allowed and the basis for the adjustments.
- (b) The State must have procedures to safeguard participants when the budgeted service amount is insufficient to meet a participant's needs.
- (c) The State must have a method of notifying participants, or their representative, if applicable, of the amount of any limit that applies to a participant's self-directed PAS and supports.
- (d) The budget may not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.
- (e) The State must have a procedure to adjust a budget when a reassessment indicates a change in a participant's medical condition, functional status, or living situation.

13.6 IRIS SDPC Participant-Hired Workers

IRIS participants are not permitted to hire an agency to perform IRIS SDPC services. Personal care provided by an agency is called Medical Assistance Personal Care (MAPC) and is a ForwardHealth card service. The sole exception to this rule is the use of microboards, as recognized in the State of Wisconsin.



42 CFR §440.180 defines “Home and Community-Based Services” (including services provided by the IRIS Program) as, “...services, not otherwise furnished under the State’s Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

Specifically, in the case of personal care, the 1915 (j) waiver under which the Department has the authority to administer the IRIS SDPC program waives the requirement of using an agency to provide personal care, thus allowing an individual to hire his or her own workers. To use an agency to provide IRIS SDPC violates the purpose of the waiver and the Code of Federal Regulations and is not permitted. All agency-provided personal care must be provided as Medical Assistance Personal Care (MAPC) funded through the State Medicaid Plan.

IRIS participants hire workers to provide IRIS SDPC services as described in their IRIS Self-Directed Personal Care (SDPC) – My Cares ([F-01566](#)) and their IRIS Self-Directed Personal Care (SDPC) – Physician Order & Plan of Care ([F-01566A](#)) forms. IRIS participants can hire any willing and qualified individual meeting the criteria described in IRIS Policy Manual Chapter 6.0. This includes legally liable relatives as stated in the 1915(j) waiver:

“The State elects to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.”

42 CFR 441.468, Service plan elements, states the following:

“§441.468 Service plan elements

- (e) An approved self-directed service plan conveys authority to the participant, or participant's representative, if applicable, to perform, at a minimum, the following tasks:
- (1) Recruit and hire workers to provide self-directed services, including specifying worker qualifications.
 - (2) Fire workers.
 - (3) Supervise workers in the provision of self-directed services.
 - (4) Manage workers in the provision of self-directed services, which includes the following functions:
 - (i) Determining worker duties.
 - (ii) Scheduling workers.
 - (iii) Training workers in assigned tasks.
 - (iv) Evaluating workers performance.
 - (5) Determine the amount paid for a service, support, or item.
 - (6) Review and approve provider invoices.”

42 CFR 441.478, Qualification of providers of personal assistance states the following:

“§ 441.478 Qualifications of providers of personal assistance.

- (a) States have the option to permit participants, or their representatives, if applicable, to hire any individual capable of providing the assigned tasks, including legally liable relatives, as paid providers of the PAS identified in the service plan and budget.
- (b) Participants, or their representatives, if applicable, retain the right to train their workers in the specific areas of personal assistance needed by the participant and to perform the needed assistance in a manner that comports with the participant's personal, cultural, and/or religious preferences. Participants, or their

representatives, if applicable, also have the right to access other training provided by or through the State so that their PAS providers can meet any additional qualifications required or desired by participants, or participants' representatives, if applicable.

(c) Participants, or their representatives, if applicable, retain the right to establish additional staff qualifications based on participants' needs and preferences.”

13.7 IRIS SDPC RN Oversight Visits

The IRIS SDPC nurse must conduct a face-to-face visit with the participant every 60 days unless the IRIS SDPC nurse grants a deviation and the participant’s physician signing the [F-01566A](#) approves the deviation. Possible deviations include semi-annual, quarterly, or annual oversight visits. The standard Section 13.7 of the IRIS Work Instructions Manual further outlines the implementation of the IRIS SDPC oversight visit requirements.

13.8 IRIS SDPC Disenrollment

Participants receiving IRIS SDPC services have the right to disenroll themselves from the IRIS SDPC Program at any time. This process is described in Section 13.8A. The IRIS SDPC Oversight Agency retains the right to involuntarily disenroll participants from the IRIS SDPC Program for the reasons outlined in Section 13.8B.

13.8A IRIS SDPC Voluntary Disenrollment

IRIS SDPC participants can choose to disenroll from IRIS SDPC and return to the traditional service delivery system, MAPC, at any time.

42 CFR 441.456, Voluntary Disenrollment, states the following:

“§ 441.456 - Voluntary Disenrollment.

- (a) States must permit a participant to voluntarily disenroll from the self-directed PAS option at any time and return to a traditional service delivery system.
- (b) The State must specify in a section 1915(j) State plan amendment the safeguards that are in place to ensure continuity of services during the transition from self-directed PAS.”

Regarding voluntary disenrollment, the approved Medicaid 1915 (j) Self-Directed Personal Assistance Services Waiver states:

“The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

Participants may voluntarily disenroll from the self-directed personal assistance option at any time. It is the responsibility of the participant or his/her representative to inform the agency operating the program regarding the intent to disenroll. The independent consultant agency staff will explore the reasons for the disenrollment and offer assistance to mitigate any issues. If the participant prefers to disenroll, he/she can go directly to a personal care agency to arrange for services or can be referred to the Aging and Disability Resource Center for further assistance. The Aging and Disability Resource Centers (ADRCs) will assist these individuals to understand all of their service and funding options. The participant can elect to receive regular agency-based personal assistance services or enroll in managed care (the individual would also have to disenroll from the IRIS waiver). Services will continue to be provided to the participant, if needed, during the transition to another personal care provider or program.”

13.8B IRIS SDPC Involuntary Disenrollment

The Department of Health Services and the IRIS SDPC Oversight Agency reserves the right to involuntarily disenroll IRIS SDPC participants when any of the following conditions are present:

1. The participant's health and/or safety are jeopardized;
2. The participant mismanages his/her purchasing authority;
3. The participant refuses to report information necessary to adequately monitor the situation; or
4. The participant chooses to move to an ineligible living situation.

Following an involuntarily disenrollment from IRIS SDPC, the IRIS SDPC participant is connected with MAPC providers to ensure continuity of care.

42 CFR 441.456, Involuntary Disenrollment states:

“§ 441.458 Involuntary disenrollment.

(a) States must specify the conditions under which a participant may be involuntarily disenrolled from the self-directed PAS option.

(b) CMS must approve the State's conditions under which a participant may be involuntarily disenrolled.

(c) The State must specify in the section 1915(j) State plan amendment the safeguards that are in place to ensure continuity of services during the transition from self-directed PAS.”

The approved Medicaid 1915 (j) Self-Directed Personal Assistance Services Waiver states the following regarding involuntary disenrollment:

“The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below.

The criteria for involuntary disenrollment of participants for self-directed personal assistance services include: 1) the participant's health and safety is jeopardized; 2) purchasing authority is mismanaged; 3) the enrollee refuses to report information necessary to adequately monitor the situation; or 4) the enrollee chooses to move to an ineligible living arrangement. The independent consultant agency [IRIS SDPC Oversight Agency] will make reasonable efforts to assist the participant to address any issues that may lead to involuntary disenrollment (training or other assistance). If these efforts are unsuccessful, the agency operating the program makes the recommendation to the state Medicaid agency to disenroll the individual, but the state makes the final decision to disenroll. The Medicaid agency's role includes a conversation with the consumer and/or any legal representative and a review of the case file. The decision to restrict participation in self-directed personal assistance services can be appealed through the Fair Hearing process.”

The approved Medicaid 1915 (j) Self-Directed Personal Assistance Services Waiver states the following regarding transitioning services after involuntary disenrollment:

“The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

When action is taken to involuntarily disenroll a participant from self-directed personal assistance services, the independent consultant agency in collaboration with the ADRC assists the participant in accessing needed and appropriate agency-based personal assistance services or enrolling in a managed care organization. The independent consultant agency [IRIS SDPC Oversight Agency] will ensure that there is no lapse in necessary funding and services for which the participant is eligible while the participant is transitioning to another program.”

13.9 IRIS SDPC Interaction with MAPC and PDN

IRIS participants receiving Private Duty Nursing (PDN) are not eligible for IRIS SDPC.

Section 6.4C of the IRIS Policy Manual addresses Private Duty Nursing and specifically states:

“In IRIS Self-Directed Personal Care (IRIS SDPC), the nurse does not oversee or delegate responsibility to the workers. Therefore, IRIS Participants are not eligible to use IRIS SDPC in a case share situation. In Medicaid Personal Care (MAPC), the MAPC nurses directly oversee workers and may delegate responsibility and train workers to perform tasks, so unlicensed workers can provide care under the direction of the MAPC nurse. Any MAPC agency may supplement the PDN through a case share arrangement. The PDN and MAPC parties must follow the Nurse Practice Act requirements.”

13.10 IRIS SDPC Oversight

DHS contracts with a single-entity IRIS SDPC Oversight Agency procured through a Request-For-Bid (RFB) process in compliance with Subchapter IV of the Wisconsin State Statute 16. The IRIS SDPC Oversight Agency is responsible for administering the IRIS SDPC Program and ensuring compliance with all IRIS Program policies and work instructions. DHS contracts with a third-party quality organization to complete IRIS SDPC record reviews and ensure remediation of all negative findings.
