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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
* Removed references to Third Party Administrator (TPA): The TPA is not yet established and all references have been removed from the application. The Fiscal Employer Agent(s) will continue to administer all aspects of the financial management services including the verification of provider qualifications, payment of participant-hired workers, and payment of vendors. The Office of IRIS Management (OIM) will submit an amendment if, and when, OIM implements the TPA.

* Change to Individual Budget Allocation methodology: The Bureau of Long Term Care Financing (BLTCF) has updated the methodology by which the individual budget allocation is calculated. Historically, the regression model has used 2008 data from individuals with similar needs in Family Care. The new model uses 2013 data from IRIS participants. The Long Term Care Functional Screen (LTC FS) will continue to serve as the data source specific to each participant's needs. Appendix E contains a full explanation of the new methodology for the IRIS Individual Budget Allocation.

* Description of the utilization of the Wisconsin IRIS Self-Directed Information Technology System (WISITS) and SharePoint sites as part of the processes and procedures: WISITS became available on June 29, 2015 and serves as the primary data source for the IRIS program. Many of the quality oversight activities are completed using SharePoint sites. Descriptions of how WISITS and the SharePoint sites fit into IRIS activities and program oversight are included in the application.

* Removal of Individual Daily Living Skills Training providers: Historically, participants were able to hire individual workers to provide daily living skills. This application requires daily living skills to be provided by an agency to better ensure integrity of the service provided.

* Match language in service definitions with Family Care definitions: When appropriate, the language in the service definitions has been updated to match the language in Appendix C to that of Wisconsin's managed care program, Family Care.

* Updated language and terminology: The language and terminology was updated to match current practice and policy and include the use of WISITS and SharePoint sites and other changes since the beginning of the previous waiver cycle.

* Rearrangement of information: The language in this application was updated and restructured to be less duplicative and to answer the questions, or requests for information, posed by the application template.

* Updated performance measures to better reflect current IRIS program operations and policies, as well as be responsive to previous discussions between OIM and CMS during the evidence-based reporting process. For example, CMS requested that OIM replace performance measures for which OIM consistently reported 100 percent compliance.

* OIM is not adding or removing any services via this application. It should be noted that OIM did divide Supported Employment into "Supported Employment - Individual" and "Supported Employment - Group".

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

1. Request Information (1 of 3)

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

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

Self Directed Support Waiver - Intellectual/Developmental Disability and Aged/Physical Disability

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Draft ID: **WI.004.02.00**

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

Regular Waiver

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

01/01/16

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☑ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

○ **Not applicable**

◉ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

☐ **§1915(b)(2) (central broker)**

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

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

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

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

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

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

DHS' Bureau of Long Term Care Financing (BLTCF) worked with their contracted actuaries to develop a regression model that predicts an individual's IRIS expenditures using the members' Long Term Care Functional Screen (LTC FS) information. The model was developed based on individuals' expenditures in IRIS and their corresponding LTC FS. The resulting statistical models are used to set the budgets for IRIS participants. This model will be updated annually.

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

IRIS participants may not use IRIS waiver funded services in lieu of available State Plan Medicaid services. 42 CFR §431.10 states, "(a) Description and requirements for services. ''Home or community-based services'' means 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." The Federal Department of Health and Human Services' State Medicaid Manual (SMM) 4442.3A 3. requires that "No services may be provided under the waiver if it is already provided under the state plan unless the nature or amount of the service, when provided under the waiver, would not be covered if provided under the state plan." That regulation also states "The amount chargeable for waiver services is that amount incurred after any limits in State Plan services have been reached."

Each potential participant receives "enrollment counseling" from the Aging and Disability Resource Center (ADRC)in which they receive information in order that they may make an informed choice of program. Individuals choosing IRIS as their long-term care program then receive information about available IRIS consultant agencies from which they can choose. Participants then meet with an IRIS Consultant to receive orientation information. Once the person has developed their Individual Support and Service Plan (ISSP) with support from the IRIS Consultant as needed, the IRIS Consultant reviews the ISSP to ensure that it is consistent with the waiver-allowable services and addresses assessed needs including health and safety. The IRIS Consultant conveys this information to the participant's IRIS Consultant Agency to ensure that all waiver requirements are met and to convey the information from the approved plan to the Fiscal Employer Agent (FEA) via the Wisconsin IRIS Self-Directed Information Technology System (WISITS), as well as the IRIS participant.

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. The state's practice and policy is 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.

OIM has an IRIS Advisory Committee that meets bi-monthly. This is an active advisory group with subcommittees that meet as needed to address issues and projects.

3. Components of the Waiver Request

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

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

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

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

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

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

H. **Quality Improvement Strategy.Appendix H** contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

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

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

- ( ) **No**
- (●) **Yes**

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

- [✓] **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
OIM must offer IRIS in all counties in which Family Care is available.

As of December 31, 2015, participants can choose IRIS in the following counties in Wisconsin:

Ashland
Barron
Bayfield
Brown
Buffalo
Burnett
Calumet
Chippewa
Clark
Columbia
Crawford
Dodge
Door
Douglas
Dunn
Eau Claire
Fond du Lac
Green Lake
Iron
Jackson
Jefferson
Juneau
Kenosha
Kewaunee
La Crosse
Lafayette
Langlade
Lincoln
Manitowoc
Marathon
Marinette
Marquette
Menominee
Milwaukee
Monroe
Oconto
Outagamie
Ozaukee
Pepin
Pierce
Polk
Portage
Price
Racine
Richland
Rusk
St. Croix
Sauk
Sawyer
Shawano
Sheboygan
Trempealeau
Vernon
Walworth
Washburn
Washington
Waukesha
Waupaca
Waushara
Winnebago
Wood

The Governor of Wisconsin signed into law a bill requiring statewide implementation of Family Care and IRIS during the next budget biennium. Prior to June 30, 2017, Family Care and IRIS will expand to the following counties:

Adams
Dane
Florence
Forest
Oneida
Rock
Taylor
Vilas

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

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

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

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

The Department has an IRIS Advisory Committee that meets bi-monthly. The Committee provides input and makes recommendations to the Department related to IRIS Program operations and policies. Members of this advisory group include IRIS participants, family members of IRIS participants, and representatives from a wide variety of providers and advocacy groups representing the needs and interests of all three target groups served by the IRIS program.

In addition, the Department follows the CMS guidance regarding public comment referenced §441.301.

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

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

7. Contact Person(s)

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

Last Name: Engelke

First Name: Kari

Title: IRIS Quality Lead

Agency: Department of Health Services

Address: One West Wilson Street, Room 418

Address 2: P O Box 7850

City: Madison

State: **Wisconsin**

Zip: 53707-7851

Phone: (608) 267-7841 **Ext:** ☐ **TTY**

Fax: (608) 267-2913

E-mail: kari.engelke@wisconsin.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **Wisconsin**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name: Moore

First Name: Kevin

Title: State Medicaid Director

Agency: Wisconsin Department of Health Services

Address: 1 West Wilson

Address 2: Rm 350

City: Madison

State: **Wisconsin**

Zip: 53707

Phone: (608) 267-3229 **Ext:** **TTY**

Fax:

E-mail: kevin.moore@wisconsin.gov

Attachments

Attachment #1: Transition Plan
Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

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

Specify the transition plan for the waiver:

This application is intended to serve as a renewal of the existing waiver incorporating the changes in the "Major Changes" section, but does not meet any of the criteria in this section.

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

A crosswalk of services yields the following similarities and differences between the Community Integration Program (CIP), Community Options Program (COP), IRIS, and Family Care Programs:

SERVICES PROVIDED BY IRIS, CIP, COP, and FAMILY CARE

- Adult Day Care
- Daily Living Skills Training
- Prevocational Skills
- Respite
- Supported Employment
- Nursing Services
- 1-2 bed Adult Family Home
- 3-4 bed Adult Family Home
- Adaptive Aids

• CBRF (IRIS will discontinue 12/31/2014)
• Communication Aids Vendors/Interpreter Services (CIP does not include Interpreter Services in the title)
• Consumer Education and Training
• Counseling and Therapeutic Services
• Day Services
• Home Delivered Meals
• Home Modification
• Housing Counseling
• Personal Emergency Response System
• Relocation – Housing Start Up and Related Utility Costs (slightly different names)
• Specialized Medical Equipment and Supplies
• Specialized Transportation
• Supportive Home Care

SERVICES PROVIDED BY IRIS and CIP

• Live-in Caregiver

SERVICES PROVIDED BY IRIS, COP, and FAMILY CARE

• Vocational and Futures Planning
• Residential Care Apartment Complex

SERVICES PROVIDED BY IRIS ONLY

• IRIS Consultant Services
• Customized Goods and Services
• Specialized Transportation 2
• Support Broker
• Fiscal Employer Agent Services

SERVICES PROVIDED BY CIP, COP, and FAMILY CARE

• Financial Management Services
• Self-Directed Supports

SERVICES PROVIDED BY COP and FAMILY CARE

• Care/Case Management (including assessment and care planning)

SERVICES PROVIDED BY CIP ONLY

• Support and Service Coordination

SERVICES PROVIDED BY COP ONLY

• Community Supported Living

SERVICES PROVIDED BY FAMILY CARE ONLY

• Alcohol and Other Drug Abuse Day Treatment Services (in all settings except hospital based)
• Alcohol and Other Drug Abuse Services (except those provided by a physician or on an inpatient basis)
• Community Support Program
• Durable Medical Equipment
• Home Health
• Medical Supplies
• Mental Health Day Treatment Services (in all settings)
• Mental Health Services (except those provided by a physician or on an inpatient basis)
• Non-Emergency Medical Transportation (except ambulance)
• Nursing Facility (all stays) including Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and for people under age 21 or 65 and older in an Institution for Mental Disease (IMD)
• Occupational Therapy
• Personal Care
• Speech and Language Pathology Services (in all settings except for inpatient hospital)

The services provided by Family Care only are services that are available to IRIS participants under the State Plan rather than through the 1915 (c) HCBS waiver.

THE IRIS TRANSITION PLAN

The PDF document containing this waiver's timeline table that was posted for public comment was submitted to CMS via email. The official document name is "IRIS Transition Plan for HCBS Waivers Final Rule (CMS 2249-F CMS 2296-F).pdf."
NOTE: Updated versions of the IRIS Transition Plan will be shared with CMS with filenames referencing the version of the plan.

Available for public view September 2nd, 2014, the transition plan and the proposed waiver amendments are posted for no less than thirty days at www.dhs.wisconsin.gov/IRIS. Wisconsin DHS will notify the general public of the transition plan's release through listserv email communications and advertise the release in seventeen regional and statewide Wisconsin newspapers. A hard copy is available to be mailed upon request. Requests can be made at any county health and human services agency. The DHS welcomes public comments, submitted via email at DHSIRIS@wisconsin.gov. Standard, unencrypted public email is not considered appropriate for sending confidential information. Please do not send sensitive, personal information such as an account number or social security number when corresponding at the email address provided. To ensure proper receipt, indicate "IRIS Transition Plan" in the subject line. Written comments will also be accepted when mailed to the address, below:

The Department of Health Services
IRIS Program Transition Plan
P.O. Box 7851
1 W. Wilson St., Room 418
Madison, WI 53707-7851

*The IRIS program will provide CMS proof of public comment procedure compliance by providing supplemental documention via E-mail.

TRANSITION PLAN FOR COMPLIANCE WITH RESIDENTIAL SETTINGS REQUIREMENTS
PHASE 1: IDENTIFICATION (Dates: 08/01/2014 – 03/16/2015)

1. Provide CMS Regional Lead proposed transition plan for preliminary review. Confirm via phone or email that State understands and addresses all compliance standards in the transition plan.

2. Release transition plan for public comment by at least two methods (electronic link and mailing address). Develop method for collecting public comments.
• Provide transition plan to IRIS Advisory Committee and solicit committee input.

3. Analyze all public comments and update transition plan as necessary.

4. Create a Frequently Asked Questions document based on the public comments received. Post to the Department's IRIS website for stakeholder review.

5. As evidenced by §441.301, The State must provide to CMS:
"(B) A summary of the comments received during the public notice period, reasons why comments were not adopted, and any modifications to the transition plan based upon those comments"
• Analyze additional CMS Guidance and update transition plan based on CMS feedback.

6. Submit waiver amendment effective January 1, 2015, including transition plan for residential and non-residential settings requirements as specified in the HCBS Waivers Final Rule.

7. Identify residential services funded by IRIS where providers may be subject to HCBS Waivers Final Rule compliance. Residential Services in IRIS include Adult Family Homes, 1-2 beds; Adult Family Homes, 3-4 beds; and Residential Care Apartment Complexes (RCACs).
• Query DHS encounter claims to determine which providers served IRIS participants.
• Analyze three years of historical claims data.
• Submission, by the IRIS Fiscal Employer Agent (FEA), the list of certified or licensed providers of residential services.
• Identify the number of IRIS participants currently utilizing these services.

8. Create a central-point-of-contact for provider, stakeholder, and participant questions regarding HCBS Waivers Final Rule compliance.
• Create and publish, to the IRIS website, the HCBS Waivers Final Rule compliance, and the IRIS Program.
• Create a Listserv for the dissemination of information to interested stakeholders.
• Continually update frequently asked questions gathered through the IRIS Transition Plan email address.

9. Develop and disseminate training regarding the HCBS Waivers Final Rule to identified providers requiring compliance with the HCBS Waivers Final Rule before March 17, 2019 or have providers declare that they will not serve IRIS participants through HCBS waiver funds. Send providers a copy of the CMS provided exploratory questions that will drive the Department's development of an assessment tool.

10. Develop and disseminate training materials for participants regarding the HCBS Waivers Final Rule. Materials will explain that as an

additional check of compliance as well as an opportunity to empower participants, they may assess their own service providers and provide that information to DHS. Final compliance designation will be made by DHS based on all methods of assessment collection. Materials will explain how participants will be affected if providers fail to meet compliance standards by March 17, 2018. (UPDATED V2.0)

11. Develop and disseminate training materials to IRIS Consultant Agencies (ICAs), for IRIS consultants, explaining the HCBS Waivers Final Rule's effect on the ICAs' relationship with participants and providers.

12. Solicit stakeholder interest to form a rule workgroup. The workgroup will provide valuable insight on transition activities, utilize stakeholder networks to disseminate planning information, and provide DHS additional resources to ensure compliance.
• Explore the formation of a Transition Plan workgroup. This could include members of the IRIS Advisory Committee.

13. Removed based on public comment (UPDATED V2.0)

14. Lutheran Social Services (LSS) oversees the licensure and certification of 1-2 Bed Adult Family Homes for the IRIS program. The Division of Quality Assurance (DQA) oversees the licensure and certification of 3-4 Bed Adult Family Homes. Both entities will be advised of the new rule.

PHASE 2: ASSESSMENT (01/01/2015 – 07/15/2016)

15. Review DQA regulatory requirements and oversight processes for provider licensure or certification. Develop a crosswalk of state regulations, procedures and standards for providers of residential services against the HCBS Waivers Final Rule regulation.
Determine whether Wisconsin Administrative Code and State Statutes are consistent with the HCBS final rule requirements for allowable settings and provider certifications and licensures.

16. Leverage the functionality of Wisconsin's Provider Management System (WPM) to require providers to complete a provider assessment prior to being able to register as an authorized IRIS provider. Prior to the claim being adjudicated, the TPA will have validation that the provider is in compliance with HCBS regulations.
New provider paperwork could include checkboxes with statements in alignment with the CMS guidance listed above. Providers will sign off and be subject to random, unannounced site visits to confirm compliance. Generally, the setting must meet the CMS final rule statement below:
"integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS." (UPDATED V2.0)

17. In additional to the State's Transition Plan Assessment tool, develop an additional IRIS assessment tool that familiarizes IRIS providers with the new HCBS rule and allows an opportunity to explore compliance within a self-directed model. The assessment tool will identify the areas of the new rule for which the provider is non-compliant, thereby allowing providers to target compliance efforts. The assessment tool will include:
• Questions that accurately assess provider compliance while maintaining the integrity of a self-directed model; and
Methods to quantify provider assessment results.
(UPDATED V2.0)

18. Determine the method of distribution and the parties responsible for conducting the assessment, for example, online or mail submissions.
• All providers currently serving IRIS participants will be assessed.
• If providers and/ or participants are required to "self-assess," then the DHS Quality Team, or identified third party, will conduct an in-depth review of a stratified random sample of assessments.
• In addition to serving IRIS participants, some providers also serve Family Care or other waiver members. The IRIS program will collaborate with Family Care, other waivers to assess providers serving individuals from multiple long-term care programs.

19. Develop an Assessment Data Report with assigned categories of provider compliance. Final compliance designation will be determined by DHS or a DHS approved entity.
• 'Yes – Settings meet HCBS characteristics'
• 'Not Yet – Settings currently do not meet HCBS characteristics but may, with remediation'
• 'No – Settings cannot meet HCBS settings; setting cannot conform, setting is presumptively institutional and state determines setting is incompatible with the HCBS final rule
• Settings found presumptively institutional must submit evidence to the DHS to be reviewed through a heightened scrutiny process.
• The DHS report will include: number of providers assessed; number of participants served by these providers; and number of providers by compliance designation. (UPDATED V2.0)

20. Upon collection of assessments, an aggregation and analysis of data, the DHS will provide the information to CMS. In response, CMS may provide additional guidance and direction based on the assessment data, public comment, and ongoing comments/questions received through the central-point-of-contact email address. The IRIS Program transition plan will be updated accordingly.

21. Develop a methodology, no later than July 2015, to assess residential setting compliance, at least annually. Update methodology as

needed.
• Sites may be subject to random, unannounced site visits.
• A stratified random sample of assessments may be reviewed annually by the IRIS Quality Team.

PHASE 3: REMEDIATION (7/1/2016 – 1/1/2019)

22. The State will use guidance from CMS; the data collected during its assessment phase; and public comments to influence the remediation requirements for providers not in compliance.

23. Complete Feasibility Analyses in the following areas:
• A provider de-certification or payment suspension policy.
• Corrective Action Plan including unannounced, random site visit by the DHS or DHS-approved third party, to assess ongoing compliance.
• A provider appeal process.
• Any site specific modifications to these rules require a standard for justification.

24. Inform providers of assessed compliance designation. Notify providers at risk of non-compliance and required remediation activities. Also, notify FEA and ICA of non-compliant providers.

25. Implement a prior authorization policy within the IRIS Self-Directed IT Sytem (ISITS) for services subject to HCBS Waivers Final Rule.
• Policy would require providers to be compliant before a service would be approved.
(UPDATED V2.0)

26. Explore implementation of ICA requirements to foster compliance with the CMS final rule.

27. Develop a one year transition plan for participants residing in a non-compliant setting.
• Identify participants requiring transition;
• Mail notification letter to participants regarding the need to change providers;
• Provide training to ICAs and IRIS Consultants regarding participants requiring transition; and,
• Identify timeline for participant transitions.

28. The Department will use guidance from CMS, the data collected during its assessment phase, and public comments, to develop, as needed, a waiver amendment regarding administrative and infrastructure changes for compliance with the HCBS Waivers Final Rule.

29. All substantive changes to the waiver must be available for 30- day public comments.
"(1) Substantive changes include, but are not limited to, revisions to services available under the waiver including elimination or reduction of services, or reduction in the scope, amount, and duration of any service, a change in the qualifications of service providers, changes in rate methodology or a constriction in the eligible population (79 FR 3032)."

30. Submit a waiver amendment, effective March 17, 2018, with changes to waiver regarding remediation activities for HCBS Waivers Final Rule.
• Update Waiver Appendix C regarding residential service definitions and IRIS Service Definition Manual to include statements that providers of these services must allow participants the opportunities listed in the CMS guidance referenced above.

31. As an additional check of provider compliance as well as to empower IRIS participants, update the Participant Satisfaction Survey to include questions addressing residential service providers and ongoing HCBS Waivers Final Rule compliance.
• Add functionality to the IRIS Centralized IT System to support participant access to the Participant Satisfaction Survey. The IRIS Centralized IT System is currently under development. The DHS anticipates releasing the first phase of the system in 2015. (UPDATED V2.0)

32. Provide education to ICAs and IRIS Consultants on the approved changes to the IRIS program. The changes implemented will be based off of public comment, CMS guidance, and CMS approval of waiver amendments.
• ICAs and IRIS Consultants understand participants served must transition to a compliant provider and may require assistance in this transition.

33. Notify all residential service providers of new requirements and program infrastructure changes. Notice includes reinforcing the notion that a violation of the HCBS residential settings requirements could result in a suspension from providing services. (UPDATED V2.0)

34. Update the IRIS policy manual and IRIS service definition manual to reflect the HCBS final rule requirements and the Department's approved response to those changes.

35. Establish business rules for the Third Party Administrator (TPA) that allows for payments to be withheld, or pended, when a service is provided by a provider that is out of compliance with the final CMS rule. The issuance of payments will only occur when qualified/certified providers also meet the requirements set forth by the HCBS Waivers Final Rule.

36. Develop functionality and business rules within the IRIS Centralized IT system (ISITS) to address HCBS Waivers Final Rule

compliance:
• Participant, provider self-disclosure/ assessment forms;
• Prior authorization process;
• Certified provider list; and,
• Allow provider assessment data viewing by participants through ISITS which supports participant choice based on quantitative data.

37. Create training materials for new residential service providers addressing the requirements of the HCBS settings final rule. Also, develop training for new participants enrolling in the IRIS program.

38. Develop informational resources for participants at Aging and Disability Resource Centers (ADRCs) to use during options counseling.

TRANSITION PLAN FOR COMPLIANCE WITH NON-RESIDENTIAL SETTINGS REQUIREMENTS

PHASE 1: IDENTIFICATION (Dates: 01/01/2015 – 01/01/2017)
Note: PHASE 2 (Assessment) and PHASE 3 (Remediation) will be added to the Transition Plan once CMS issues further guidance on the requirements of non-residential services.

39. The Department will address IRIS Program HCBS waiver compliance with non-residential settings following the CMS release of that guidance. The Department anticipates that the lessons learned through the assessment of residential settings will allow for more efficient planning and assessment procedures for non-residential settings upon receipt of further CMS guidance.

40. Submit additional non-residential guidance and compliance activities for public comment.
• Provide public comments to CMS.

41. Identify non-residential services funded by IRIS where providers may be subject to HCBS Waivers Final Rule compliance such as Prevocational, Day Services, and Adult Day Care.
• Query DHS encounter claims to determine which providers served IRIS participants. Analyze three years of historical claims data.
• Request FEA submit list of certified and licensed providers of these types of services.
• Identify number of IRIS participants currently utilizing these services.

42. Develop and disseminate training materials to ICAs and IRIS consultants explaining the effect of the HCBS Waivers Final Rule on their relationship with participants and providers.

43. Develop and disseminate training materials to identified providers regarding the HCBS Waivers Final Rule and compliance requirements associated with the rule, on or before March 17, 2019.

44. Develop and disseminate training materials to identified participants regarding the HCBS Waivers Final Rule and compliance requirements associated with the rule on or before March 17, 2019.

NOTE: Steps 45 through 56 are not relevant to the residential or non-residential settings transition plan.
Steps 57 through 71 are added in V2.0 of the IRIS transition plan.

57. In coordination with Department stakeholders, develop a quantifiable definition of "community integration" as it relates to non-residential services.

PHASE 2: ASSESSMENT (1/1/2015 through 12/31/2015)

58. In additional to the State's Transition Plan Assessment tool, develop an additional IRIS assessment tool that familiarizes IRIS providers with the new HCBS rule and allows an opportunity to explore compliance within a self-directed model..The assessment tool will identify the areas of the new rule for which the provider is non-compliant, thereby allowing providers to target compliance efforts. The assessment tool will include:
• Questions that accurately assess provider compliance while maintaining the integrity of a self-directed model; and
• Methods to quantify provider assessment results.

59. Provide a draft assessment to stakeholders for review and comments. Incorporate stakeholder feedback and update assessment tool as appropriate.

60. Complete assessment of providers. Determine the method of distribution and the parties responsible for conducting the assessment, for example, online or mail submissions.
• All providers currently serving IRIS participants will be assessed.
• If providers and/ or participants are required to "self-assess," then the DHS Quality Team, or identified third party, will conduct an in-depth review of a stratified random sample of assessments.
In addition to serving IRIS participants, some providers also serve Family Care or other waiver members. The IRIS program will collaborate with Family Care, other waivers to assess providers serving individuals from multiple long-term care programs.

61. Develop an Assessment Data Report with assigned categories of provider compliance. Final compliance designation will be determined

by DHS or a DHS approved entity.
• 'Yes – Settings meet HCBS characteristics'
• 'Not Yet – Settings currently do not meet HCBS characteristics but may, with remediation'
• 'No – Settings cannot meet HCBS settings; setting cannot conform, setting is presumptively institutional and state determines setting is incompatible with the HCBS final rule
• Settings found presumptively institutional must submit evidence to the DHS to be reviewed through a heightened scrutiny process.
The DHS report will include: number of providers assessed; number of participants served by these providers; and number of providers by compliance designation.

62. Upon collection of assessments, an aggregation and analysis of data, the DHS will provide the information to CMS. In response, CMS may provide additional guidance and direction based on the assessment data, public comment, and ongoing comments/questions received through the central-point-of-contact email address. The IRIS Program transition plan will be updated accordingly.

63. Inform providers of assessed compliance designation. Notify providers at risk of non-compliance and required remediation activities. Also, notify FEA and ICA of non-compliant providers.

64. Leverage the functionality of Wisconsin's Provider Management System (WPM) to require providers to complete a provider assessment prior to being able to register as an authorized IRIS provider. Prior to the claim being adjudicated, the TPA will have validation that the provider is in compliance with HCBS regulations.
New provider paperwork could include checkboxes with statements in alignment with the CMS guidance listed above. Providers will sign off and be subject to random, unannounced site visits to confirm compliance. Generally, the setting must meet the CMS final rule statement below:
"integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS."

PHASE 3: REMEDIATION (1/1/2015 - 12/31/2017)

65. Add additional program infrastructure/supports to improve community integrated vocational service options. Examples of program supports could be improving self-directed employment options, vocational futures planning service options and community-based prevocational services.

66. The State will use guidance from CMS; the data collected during its assessment phase; and public comments to influence the remediation requirements for providers not in compliance.

67. Complete Feasibility Analyses in the following areas:
• A provider de-certification or payment suspension policy.
• Corrective Action Plan including unannounced, random site visit by the DHS or DHS-approved third party, to assess ongoing compliance.
• A provider appeal process.
Any site specific modifications to these rules require a standard for justification.

68. Provide education to ICAs and IRIS Consultants on the approved changes to the IRIS program. The changes implemented will be based off of public comment, CMS guidance, and CMS approval of waiver amendments.
ICAs and IRIS Consultants understand participants served must transition to a compliant provider and may require assistance in this transition.

69. Notify all non-residential service providers of new requirements and program infrastructure changes. Notice includes reinforcing the notion that a violation of the HCBS residential settings requirements could result in a suspension from providing services.

70. Update the IRIS policy manual and IRIS service definition manual to reflect the HCBS final rule requirements and the Department's approved response to those changes.

71. Create training materials for new non-residential service providers addressing the requirements of the HCBS settings final rule. Also, develop training for new participants enrolling in the IRIS program.

SUMMARY OF PUBLIC COMMENT - THE IRIS TRANSITION PLAN
The Department identified 34 comments from 14 unique stakeholders specific to the IRIS transition plan.

Of the thirty-four comments, four referenced non-residential settings requirements. Two of the four stated that choice of employment and prevocational services should not limited to community integrated settings options only. The remaining two requested the state build provider capacity for more integrated service options statewide.

Twelve comments were specific to transition plan activities and offered suggestions on how best to operationalize the plan. Some major themes from these comments were to provide more participant and IRIS consultant education on the final rule, implement a transition plan implementation task force, hire an independent assessor for assessing compliant settings, allow for regular public input, maintain consistency across all WI Long Term Care programs, and make adjustments to the timelines/deadlines included in Version 1.0 of the

transition plan.

The remaining comments requested clarification on specific items including questions on the State's and / or CMS' interpretation of the certain aspects of the final rule. Some items also referenced specific items that did not allow for a thematic generalization. These items require additional discussion.

At this time, the Department requests additional time to discuss the feasibility of the proposals obtained through public comment before making formal changes to the IRIS transition plan. The Department appreciates the thoughtful comments from stakeholders and other WI residents and intends to have further internal discussions prior to the update and release of Version 2.0 of the transition plan. The IRIS program will consult with other Long Term Care programs to maintain a consistent approach and messaging. The state believes a careful, transparent, and multi-faceted approach is consistent with a successful transition to compliance with the HCBS final rule. The IRIS program anticipates releasing an updated version 2.0 of the transition plan prior to 12/15/2014 that will incorporate feedback from the public comment process completed on 10/2/2014.

The state assures that the settings transition plan included with this waiver amendment will be subject to any provisions or requirements included in Wisconsin's approved Statewide Transition Plan. The state will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Following the public comment period, OIM will enter a summary of comments received and OIM's response.

Appendix A: Waiver Administration and Operation

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

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

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

   ○ **The Medical Assistance Unit.**

   Specify the unit name:

   (Do not complete item A-2)

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

   Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.
   Division of Long Term Care
   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

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

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

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

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

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
Aging and Disability Resource Centers (ADRCs) are public entities that:

* serve as the gateway to all long-term care programs
* provide information and assistance
* provide pre-admission counseling
* conduct level of care evaluation activities using the State's automated long-term care functional screen
* coordinate other program eligibility activities on behalf of the SMA
* carry out prevention activities

These functions include coordination with the Income Maintenance Unit, or Consortia, to assist participants with the Medicaid financial eligibility processes as needed; administer the Long Term Care Functional Screen (LTC FS) to determine functional eligibility and level of care, and inform individuals considering enrolling in IRIS of their individual budget estimate.

DHS contracts with Disability Rights Wisconsin (DRW) for ombudsmen services as an additional benefit for IRIS participants. The ombudsmen program does not supplant any rights the participant has under the Medicaid Waiver. The ombudsmen program provides the following services upon participant request:

* investigates complaints
* resolves and mediates issues
* provides information and education on consumer rights
* assists in negotiating individual support and service plans
* assists with denials of services or changes in services with which the participant disagrees works with enforcement and regulatory agencies.

Lutheran Social Services certifies 1-2 bed Adult Family Homes as an administrative function.

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

Appendix A: Waiver Administration and Operation

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

Not applicable

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

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

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

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
The Office of Resource Center Development within the Department of Health Services, Division of Long-Term Care is responsible for the oversight for the contracts with local ADRCs and conducts its assessment of operational and administrative functions with the contracts with the Department. Although the ADRCs play a key role in the process to refer potential enrollees to the IRIS program and process disenrollments, these contracts are not managed as part of IRIS self-directed supports Waiver program.

The Office of IRIS Management (OIM) also contracts with Lutheran Social Services to certify 1-2 bed Adult Family Homes. OIM has a dedicated contract specialist monitoring the LSS AFH Certification contract.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
The State Medicaid Agency (SMA), primarily the Office of IRIS Management (OIM) maintains direct administrative oversight of the waiver consistent with 42 CFR 431.10(3). DHS maintains sole authority to provide administrative direction and issue policies, rules, and regulations. Contract agencies including the Aging and Disability Resource Centers (ADRCs) do not have the authority to change or disapprove any administrative decision of the SMA authority or otherwise substitute their judgment for that of the SMA with respect to the application of policies, rules, and regulations. This requirement is defined through the DHS contract with these agencies. The performance of the contracted agencies is evaluated through multiple oversight functions by the SMA as described below.

The DHS assures that contracted agencies adhere to policies and procedures through participant record reviews, analysis of aggregated data, and through other oversight functions. Where oversight of contracted agencies overlaps between Department agencies, there are centralized processes to ensure consistency is applied across programs.

DHS centralized processes include:
* Maintenance and oversight of the Long-Term Care Functional Screen (LTC FS) related to level of care (LOC) determinations
* Management of unbiased options and enrollment counseling by ADRCs that refer potential enrollees to IRIS and other long- term care waiver program
* Financial oversight of IRIS and other long-term care adult waiver programs

IRIS Advisory Committee, and the associated ad-hoc sub-committees, is an external public entity that serves as an advisory group providing recommendations for improvements and policy changes to OIM. The committee provides insight to proposed changes to IRIS waiver program policies and procedures, implementation of program operations and infrastructure, and reports produced by contracted provider agencies. The IRIS Advisory Committee meets every other month. Subcommittees of the IRIS Advisory Committee meet on an as needed basis upon specific program needs. OIM maintains agendas and meeting summaries of all IRIS Advisory Committee and sub-committee activities.

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

Lutheran Social Services is contracted to certify 1-2 Bed Adult Family Homes. LSS is contractually required to submit quarterly reports to OIM.

In addition to the above, the OIM contract specialist validates the invoices submitted by LSS against the number of homes certified in that month. The OIM contract specialist also cross-validates critical incidents reported by the LSS-certified AFH's against the critical incidents reported by the ICA to ensure that both agencies have satisfied their critical incident reporting requirements.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.**In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. Performance Measures

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of provider records containing completed Medicaid Provider agreements. Numerator/Denominator: Number of provider records containing completed Medicaid Provider agreements over the number of provider records reviewed.

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

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

Data Aggregation and Analysis:

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

Performance Measure:

Number and percent of completed residential provider self-assessments. Numerator/Denominator: Number of completed residential provider self-assessments over the number of residential providers identified.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of completed non-residential provider self-assessments. Numerator/Denominator: Number of completed non-residential provider self-assessments over the number of non-residential providers identified.

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of Fraud Allegation Review and Assessments (FARA) completed within 30 days. Numerator/Denominator: Number of FARA completed within 30 days over the number of FARA opened.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OIM-owned FARA SharePoint sites

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

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The performance measures in this section related to administrative authority will ensure that the ICAs and FEAs implement program operations as indicated in their contract with OIM. Performance measures within other appendices in this waiver also ensure administrative oversight in the implementation of program operations, policies, and processes, as indicated in the waiver program and OIM requirements, but are not duplicated in this section.

OIM employs additional discovery methods related to administrative oversight including issues that arise in the implementation of program operations identified by contracted provider agencies (ICAs and FEAs). Collaboration with other areas of DHS yields additional discovery methods. OIM and the identifying area of DHS collaborate to resolve any identified issues.

OIM is able to obtain most of the required IRIS program-related data from the WISITS system, which OIM uses to monitor the performance of the provider agencies in meeting contract expectations and waiver requirements. Some of these reports provide data for performance measures, while OIM uses other reports for monitoring contract expectations. If OIM identifies concerns in the monthly reports, OIM addresses the issue with the provider and ensures that remediation occurs.

OIM employs an administrative assistant as well as a contract specialist. The administrative assistant coordinates OIM's overall administrative requirements. The contract specialist is responsible for overseeing the receipt of contract deliverables for all providers. OIM has control of all data using WISITS and OIM-owned SharePoint sites unique to each provider, which

will improve the OIM's ability to provide oversight of multiple agencies through technological means.

Data Sources and Performance Measures
For all performance measure utilizing service plan data, the source data originates from the WISITS system, which holds the participants' current and historic plans. OIM carefully considered the data needs for each performance measure during the development of WISITS, the development of the SharePoint sites, and the identification of the performance measures. As a result, OIM built the appropriate data elements and necessary reporting functionality into WISITS or the SharePoint sites. OIM controls the source data and the reports produced from that source data. There are business rules and workflows built into WISITS that ensure that WISITS captures valid and accurate information.

OIM complete 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 comparing 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 is not closed 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.

OIM will build the record review process into a future iteration of the WISITS system using the current Record Review SharePoint site as a foundation for the record review module.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
OIM works with providers to correct any issues discovered through administrative oversight activities. OIM conducts group meetings with all to discuss global programmatic changes and other non-participant specific issues. OIM conducts meetings with individual providers to address participant-specific issues as well as issues of provider performance. OIM is exploring ways to discuss the specific Fraud Allegations Review and Assessment (FARA) cases across programs to ensure program integrity while maintaining compliance with the Health Information Portability and Accountability Act (HIPAA). The provider agencies are responsible for correcting all individual issues discovered. OIM may also require immediate remedial action using Quality Management Plan templates and tracking mechanisms to address these issues. OIM ensures documentation that the appropriate actions have occurred.

The Long Term Care Functional Screen (LTC FS) section within the Bureau of Managed Care and the Office of Resource Center Development (ORCD) provide quality oversight and address individual issues related to initial level of care determinations completed by the Aging and Disability Resource Centers (ADRCs).

Certified screeners employed by the ICAs conduct all annual level of care redeterminations and change in condition screens. Any individual issues related to these types of screens area addressed by the ICAs. OIM provides oversight to issues of quality and timeliness of screens conducted by ICA provider agencies.

The majority of quality assurance activities, including the documentation of issue resolution, take place through SharePoint sites dedicated to the following subjects: Critical Incident Reporting, Program Integrity, Notice of Action and Appeals, Complaints and Grievances, Restrictive Measures, Record Reviews, and Budget Amendment and One-Time Expenses. Each ICA and FEA has a replication of each needed site to ensure consistency in process while maintaining HIPAA compliance. OIM designed each SharePoint site for use in an environment with multiple provider agencies. OIM will incorporate existing and future SharePoint sites into WISITS through continue enhancements of the system.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

Specify:

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

    Specify the percentage:

  - **Other**

    Specify:

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

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

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

  - **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

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

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	15716
Year 2	16739
Year 3	17772
Year 4	19006
Year 5	

Waiver Year	Unduplicated Number of Participants
	20638

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

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

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

As new counties are added to the reform effort all waiver participants in the legacy waivers (Community Integration and Community Options Waivers), as well as children aging-out of the Children's Long-Term Support Waivers are offered the choice of long-term program and make the transition to the program of his or her choice without delay. Wisconsin then serves

people on waiting lists in those areas on a first-come, first-serve basis until the wait lists are eliminated. After the waitlist is eliminated, typically three years after transition, entitlement begins. At this point, people who meet eligibility requirements receive options counseling and are immediately enrolled in the program of his or her choice and there will no longer an ADRC role in managing waiver capacity.

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

All persons who are eligible for Medicaid home and community-based services under s. 1915 (c) waiver will receive options and enrollment counseling through the Aging and Disability Resource Center. When a person is found to be functionally (meeting Level of Care) and financially eligible for a waiver program, the applicant receives counseling to make an informed choice between community care and institutional care. If the individual chooses to receive services in the home and community, he/she is asked to make a second choice among the managed care programs available in his/her area or the IRIS waiver. Should the individual choose IRIS, the ADRC will provide the individual with information to inform their choice among available IRIS consultant agencies. Based on the individual''s choice, he or she would be referred to the identified IRIS Consultant Agency for enrollment in IRIS.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (•) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (•) **No**
   - ( ) **Yes**

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

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

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [x] **Optional State supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

    Specify percentage:

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**

☐ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**

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

Specify:

• Other caretaker relatives specified in 42 CFR 435.110
• Pregnant women specified in 42 CFR 435.116
• Children specified in 42 CFR 435.118

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

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

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

Select one:

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

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

Specify percentage:

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

Specify dollar amount:

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

☐ **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

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

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

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Medically needy with spend down: For persons who are aged or have a physical disability , the State Medicaid Agency will use the average monthly cost for private patients in nursing facilities as used for assessing a transfer of assets penalty to reduce an individual's income to an amount at or below the medically needy income limit. For persons with an intellectual disability , the State Medicaid Agency will use the average of the monthly rates charged Family Care PIHPs for inpatient care in a State Center for the Developmentally Disabled to reduce an individual's income to an amount at or below the medically needy income limit.

Appendix B: Participant Access and Eligibility

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

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

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

Note: For the five-year period beginning January 1, 2014, the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☑ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after December 31, 2018.

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018 (select one).

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

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

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

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

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

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

Select one:

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

(*select one*):

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

Specify the percentage:

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

Specify dollar amount:

A percentage of the Federal poverty level

Specify percentage:

Other standard included under the State Plan

Specify:

The following dollar amount

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

The following formula is used to determine the needs allowance:

Specify:

The basic needs allowance, indexed annually by the percentage increase in the state''s SSI-E payment; plus an allowance for employed individuals equal to the first 65 dollars of earned income and ½ of remaining earned income; plus special exempt income which includes court-ordered support amounts (child or spousal support) and court-ordered attorney and/or guardian fees; plus a special housing amount that includes housing costs over $350 per month. The total of these four allowances cannot exceed 300% of the SSI federal benefit.

Other

Specify:

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

Not Applicable

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

Specify:

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

SSI standard

Optional State supplement standard

Medically needy income standard

The following dollar amount:

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

The amount is determined using the following formula:

Specify:

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

Not Applicable (see instructions)

AFDC need standard

Medically needy income standard

The following dollar amount:

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

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

  Specify:

- **Other**

  Specify:

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

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

Select one:

- **Not Applicable (see instructions)***Note: If the State protects the maximum amount for the waiver participant, not applicable must be selected.*
- **The State does not establish reasonable limits.**
- **The State establishes the following reasonable limits**

  Specify:

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

i. Allowance for the personal needs of the waiver participant

(*select one*):

- **SSI standard**
- **Optional State supplement standard**

- **Medically needy income standard**
- **The special income level for institutionalized persons**
- **A percentage of the Federal poverty level**

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

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

  Specify formula:

  The basic needs allowance, indexed annually by the percentage increase in the state's SSI-E payment; plus an allowance for employed individuals equal to the first 65 dollars of earned income and ½ of remaining earned income; plus special exempt income which includes court-ordered support amounts (child or spousal support) and court-ordered attorney and /or guardian fees; plus a special housing amount that includes housing costs over $350 per month. The total of these four allowances cannot exceed 300% of the SSI federal benefit.
- **Other**

  Specify:

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

Select one:

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

  Explanation of difference:

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

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

Select one:

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

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

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

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

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

Specify the entity:

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

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

Other
Specify:

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

Anyone who performs the Long Term Care Functional Screen, the web-based application/tool that determines a participant's level of care for eligibility determination (initial evaluations and re-evaluations), must meet the same certification and education/experience standards. The "screener" must be either a registered nurse or certified social worker in Wisconsin, or have a 4 year Bachelor's degree in a related field, and have at a minimum one year of experience working with at least one of the long-term care target groups and/or specialized knowledge of the long term care target populations.

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

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

The IRIS consultant agencies (ICAs) ensure that the screeners employed to conduct re-evaluations of Level of Care (annual and change-in-condition) meet qualifications and certifications which are maintained in their employee records. The ICAs have a tracking mechanism in place that documents qualifications and certification standards. The ICAs will provide a report to the SMA on an annual basis related to its screener qualifications.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The levels of care criteria are the same as the criteria for Medicaid reimbursement of in Intermediate Care Facilities for Persons with Intellectual Disabilities in Wisconsin. Intermediate care (ICF-1) is professional, general nursing care needed to maintain the stability of patients with long-term illnesses or disabilities. Limited care (ICF-2) includes simple nursing procedures required to maintain the stability of patients with long-term illnesses or disabilities. Personal care (ICF-3) is limited to assistance, supervision and protection for individuals who need periodic medical services, but not ongoing nursing care. Residential care (ICF-4) is provided to disabled individuals who need social services or activity therapy based on a physician’s directive.

The long-term care functional screen applies these criteria when determining level of care for this waiver.

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

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

The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.

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

The levels of care criteria are the same as the criteria for Medicaid reimbursement of care in Intermediate Care Facilities for Persons with Persons with Intellectual Disabilities in Wisconsin. The specific developmental disability levels of care allowed are DD-1A, DD-1B, DD-2 and DD-3. The level of care tool used is the Wisconsin Long-Term Care Functional Screen (LTC FS). It can be administered by trained screeners in addition to registered nurses. The functional screen was developed with the registered nurses in the State Medicaid Agency who evaluate Physician Plans of Care to determine Medicaid eligibility for ICF -ID and institutional admission. It has been evaluated by the State Medicaid Agency and determined to be valid, reliable and to result in comparable level of care.

The levels of care criteria are the same as the criteria for Medicaid reimbursement of care in nursing home level of care in Wisconsin. The specific level of care allowed for people with physical disabilities and the frail elderly is nursing home level of

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

On a biennial basis the Department conducts Continuing Skills Testing (CST) of all certified LTC FS screeners in Wisconsin. The test results are maintained by the Department. When a screener does not pass the CST, the screener's employer receives notification with details about how to proceed to help screener get into compliance. If screener is unable to meet the improvement expectations in the Corrective Action Plan (CAP), they would be de-certified.

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

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

Annual and change in condition re-evaluations are a requirement of the IRIS consultant agencies.

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

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

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

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

The process identified is the same for all three target groups for both types of levels of care.

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

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

  Specify the other schedule:

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

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

  Specify the qualifications:

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

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. **Sub-Assurances:**

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

Performance Measures

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

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

Performance Measure:
Number and percent of LTC FS indicating continued functional eligibility.
Numerator/Denominator: Number of LTC FS indicating continued functional eligibility over the number of LTC FS administered by ICAs during the calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
WISITS and OIM-owned NOA SharePoint Sites

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

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

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of waiver participants who received an annual LTC FS within 365 days of their of their last LTC FS. Numerator/Denominator: Number of participants whose most recent screen is within 365 days of the previous LTC FS over the number of records reviewed.

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

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

		☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

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

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

Performance Measure:
Number and percent of LTC FS indicating continued functional eligibility.
Numerator/Denominator: Number of LTC FS indicating continued functional eligibility over the number of LTC FS administered by ICAs during the calendar year.

Data Source (Select one):
Other
If 'Other' is selected, specify:
WISITS or OIM-owned NOA SharePoint sites

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Long Term Care Functional Screen (LTC FS) is a web-based application/tool that is used statewide to determine an individual's level of care (LOC) and eligibility for multiple adult waiver programs, including IRIS. The quality and administrative oversight of the LTC FS is centralized within the Division of Long Term Care through a cross-unit team with Department staff members who are jointly responsible for ensuring that the quality standards for the LTC FS are consistently

applied across programs, agencies, and screeners statewide. These standards include ensuring that screeners meet all required qualifications before being granted access to the web-based LTC FS for the purpose of conducting the functional eligibility and level of care determination, implementing Continuing Skills Testing (CST) to ensure screeners are applying the LTC FS criteria appropriately, and conducting quality review of screens at both the agency and individual screener levels.

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

LTC FS Screener qualifications and certifications are maintained in employee files at the agencies by which they are employed. The SMA maintains a central list of qualified screeners (who passed certification and CST). Screeners only gain access to this system after completing all required training and after the agency verifies the screener's qualifications.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Quality issues or inaccuracies associated with individual LOC determinations are addressed through the correction of the LTC FS through edits or a rescreen as appropriate. These screens are updated by either an ADRC or ICA screener as necessary.

Individual issues related to the screener qualifications and certification are addressed by the statewide CST developed by the Division of Long-Term Care. This CST is conducted on a biennial basis at the agency level. If an individual screener does not pass the initial CST, quality staff at the agency level will work with the screener to develop a corrective action plan and individualized remediation. Failure to successfully complete the corrective action plan results in the loss of certification to administer the LTC FS for the screener.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

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

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

This is being documented on the Individual Support and Service Plan (ISSP) and verified by the participant or legal decision-makers signature. The participant will verify they were informed by signing the document which will be maintained in the participant's record and will be verified during the SMA's Record Review.

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

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

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

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

Appendix B: Participant Access and Eligibility

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

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):
ADRCs are required to have enrollment and other materials related to Family Care - managed long term care and IRIS - the SDS waiver, including an SMA-developed brochure and the participant handbook, available in the prevalent foreign languages spoken in Wisconsin:– Hmong, Russian and Spanish, and are required to obtain interpreters or telephonic interpretation services when needed by an applicant.

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

Appendix C: Participant Services

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

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Adult day care services include the provision of services, part of a day, in a non-residential group setting, to adults needing an enriched social or health-supportive experience or needing assistance with ADLs, supervision and/or protection.

Services may include: personal care and supervision; light meals; medical care and, transportation to and from the day care site. Transportation between the individual's place of residence and the adult day care center may be provided as a component of adult day health services. The cost of transportation is included in the rate paid to providers of adult day health services. Meals provided as part of adult day care may not constitute a "full nutritional regimen" (three meals per day). For providers of this service, Wis. Stats. Chapter 49.45 applies.

Special services, such as bathing, at the adult day care site may also be included in this category, if not already included in the program fee. Funding for adult day care is separate from the substitute care rate. Adult day care is permissible for up to eight hours per day.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Adult day care services provided as part of the residential facility program cannot be paid separately as adult day care as this represents billing twice for the same service and violates Medicaid rule requiring providers accept one single payment as payment in full.

Adult day care cannot be provided within a substitute care setting.

Adult day care is available up to 8 hours per day.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care provider

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:
Agency
Provider Type:
Adult Day Care provider
Provider Qualifications

License *(specify):*

Certificate *(specify):*

• Persons providing these services shall comply with all relevant provisions of Chapter IV of the Medicaid Waivers Manual SPC 102 – Adult Day Care: https://www.dhs.wisconsin.gov/waivermanual/index.htm.
• Adult day care must be provided in a state certified facility. Providers of services are governed by the certification standards for adult day care issued by the DHS, Division of Quality Assurance.
• Certification Standards for Adult Day Care for six or fewer people can be found at: https://www.dhs.wisconsin.gov/forms1/f6/f62611.doc.
• Certification Standards for adult day care for more than six people can be found at: https://www.dhs.wisconsin.gov/forms1/f6/f60947.doc.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Day Habilitation

Alternate Service Title (if any):
Daily Living Skills Training

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Daily living skills training services provide education and skill development or training to improve the participant's ability to independently perform routine daily activities and effectively utilize community resources. Services are instructional, focused on skill development and are not intended to provide substitute task performance. Daily living skills training may include education and skill development such as:
• Personal hygiene
• Food preparation
• Home upkeep/maintenance
• Money management
• Accessing and using community resources
• Community mobility
• Parenting
• Computer use
• Driving evaluation and lessons

When a participant selects an agency for the provision of daily living skills training services, the agency must document that the provided services relate to the areas listed above. The IRIS participant works with the agency to ensure individual needs are met; the IRIS Consultant verifies the need for continued assistance on an annual basis, at a minimum.
Daily living skills training is intended as a service designed to allow a participant to acquire additional skills to meet long-term care related outcomes in a time frame necessary to learn the skill. The DHS requires bi-annual reports, included in the participant's record, of the participant's progress toward obtaining the daily living skill and outcome identified on the ISSP. The bi-annual report ensures the participant-provided training is effective in acquiring the skill identified.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
No more than 8 hours of daily living skills training is provided per day.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Daily Living Skills training agency

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Daily Living Skills training agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Providers of Daily Living Skills training must meet the standards set forth in Chapter IV of the Medicaid Waivers Manual.
Other Standard *(specify):*
Providers of daily living skills training must meet the certification standards set forth in Chapter IV of the Medicaid Waivers Manual: http://www.dhs.wisconsin.gov/bdds/waivermanual/waiverch04_10.pdf. When a participant selects an agency for the provision of services, the agency must maintain this documentation. The IRIS participant works with the agency to ensure individual needs are met.

Providers of daily living skills training must have a minimum of two years' experience working with the target

population. However, a consumer may employ less experienced, qualified providers. In that event, the participant ensures the provider receives comprehensive, participant-specific training, which supports the provision of competent work with the participant to meet the objectives outlined in the ISSP. In addition, all staff must pass a caregiver and criminal background check.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Case Management

Alternate Service Title (if any):
IRIS Consultant Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*
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
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Providers of Consulting Services cannot provide other Wisconsin long-term care waiver services to the same participant.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	IRIS Consultant Agency (ICA)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: IRIS Consultant Services

Provider Category:
Agency
Provider Type:
IRIS Consultant Agency (ICA)
Provider Qualifications
License *(specify):*
N/A
Certificate *(specify):*
IRIS Consultant Agencies are certified using the DHS' IRIS Consultant Agency Certification Criteria and Process. IRIS Consultant Agencies shall ensure that all individuals providing consultant services meet the criteria specified within the certification criteria:

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

OR

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

OR

3. Current IRIS Consultants in good standing who do not meet the above criteria may petition the DHS to receive an exemption. These consultants must also pass a nationwide caregiver and criminal history screening pursuant to the DHS policy and complete all required IRIS orientation and training courses as outlined in Appendix F of the IRIS Consultant Agency Certification Criteria.
The IRIS Consultant Agencies will ensure that hired consultants have the following attributes to aid in their success as a consultant: be well-organized, have good written and oral communication skills, have knowledge of community resources, have effective critical thinking abilities, have effective negotiation skills, have sufficient knowledge of technology to be able to use and teach others to use the IRIS Self-Directed Information Technology System (ISITS), and the ability to provide excellent customer service.

The IRIS Consultant Agencies will ensure all employees providing consultant services attend all state-required orientation and trainings and demonstrate knowledge of and competence with the IRIS policies and procedures, philosophy, including self-direction, financial management processes and responsibilities, behavior management, risk and needs assessments, person-centered planning and service plan development, and adhere to all other training requirements as specified by the state. Training requirements are further clarified in Appendix F of the IRIS Consultant Agency Certification Criteria.
Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
OIM is responsible for the annual certification of each IRIS Consultant Agency. Each IRIS Consultant Agency is responsible for the verification of the qualifications of the individual IRIS Consultants.

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

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

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Live-in Caregiver (42 CFR § 441.303 (f) (8)) is the payment of rent and food costs reasonably attributable to an unrelated, live -in personal caregiver residing in the participant's household. The service intends to meet the needs of participants requiring assistance with ADLs to ensure adequate functioning in the home and to permit safe access to the community. The Live-In Caregiver service is not available in situations where the participant lives in the provider's home (i.e. the lease or deed is in the name of the provider).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Legally responsible persons. (i.e., spouses, relatives, guardians, or HC-POA) cannot serve as allowable providers of live-in caregiver's services.
• Excludes situations/payment wherein the participant resides in the provider's home (the lease or deed is in the name of the provider of Medicaid services).
• Excludes services available through the Medicaid State Plan.
• Excludes training provided to a participant intended to improve the participant's ability to independently perform routine daily living tasks, which may be provided as daily living skills training.
• This service may not duplicate any service provided under another waiver service definition.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Worker

Appendix C: Participant Services

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

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

Provider Category:

Individual

Provider Type:
Individual Worker
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Live-in caregivers may provide services only after the receipt of sufficient training and employer-orientation. In addition, the live-in caregiver must meet all other employment eligibility requirements including passing the caregiver and criminal background check prior to service provision, and every four years thereafter.

Verification of Provider Qualifications
Entity Responsible for Verification:
FEAs verify the provider qualifications of individual providers.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Prevocational services are services that provide learning and work experiences, including volunteer work, where the participant can develop general on-the-job-task-specific skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the participant and his/her IRIS Consultant through an ongoing participant-centered planning process and only until integrated community employment can be obtained. Participants receiving prevocational services must have integrated employment related goals with clearly defined benchmarks in their participant-centered services and support plan. Services are expected to specifically involve strategies that enhance a participant's employability in integrated, community settings. Competitive employment and/or supported employment are considered successful outcomes of prevocational services.

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

Support of employment outcomes is a part of the participant-centered planning process, which must be directed by the individual and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process. This process includes identification of the participant's personal Long Term Care outcomes and identification of services and items, including prevocational services and other employment-related services that advance achievement of the participant's outcomes. The participant and his or her IRIS Consultant will identify the most effective supports available to achieve a competitive employment and/or supported employment outcome.
Participants who receive prevocational services during some days or parts of days may also receive supported employment, educational, or day services at other times.

Participants participating in prevocational service may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment situation. Prevocational services should be designed to create a path to integrated community-based employment for which an individual is compensated at or above 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.
Prevocational service providers offering paid work opportunities incidental to the delivery of prevocational services follow OSHA health and safety standards and prohibit unpaid contract work or engaging in training that involves doing unpaid contract work.

Participation in prevocational services is not a required pre-requisite for supported employment services provided under the waiver. Prevocational services should be provided in the most integrated setting preferred by the participant, and may be provided in a variety of community locations including but not limited to work centers operated by Community Rehabilitation Programs (CRPs). Some example sites may include a private employer, a non-profit community organization or site, local government offices and others.

If the individual has not successfully achieved and maintained integrated employment within two years, although demonstrable, reasonable and continued progress has been made, the participant and IRIS consultant must meet to determine what actions have been taken and which have been successful or unsuccessful and a new action plan must be developed that reflects the discussion.

Participants must receive the necessary tools, resources, and information to make an informed decision relative to choosing supports and services, including integrated employment, to meet their employment outcomes. This must occur annually and be documented in the participant's record.

IRIS funds may fund Project SEARCH under Pre-vocational services. Project SEARCH is a 9-12 month program which provides training and education leading to integrated employment for individuals with disabilities. Project SEARCH serves as a workforce alternative for students in their last year of high school. Interested participants need to apply for the program and if accepted can request IRIS funds to braid with DVR funds for the program. Project SEARCH is based on a partnership that includes a local business, a school, DVR, a vocational services agency and a disability services agency. Each day, accepted students report to the host business, learn employability skills in the classroom and job skills while participating in three to four internships during the year.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Prevocational services by definition are time-limited. Individuals requesting prevocational services must indicate a goal of integrated employment and must justify that the prevocational service is building the skills needed to attain an integrated/competitive job.

Waiver funding is not available for the provision of vocational services delivered in facility-based or sheltered workshop settings, where individuals are supervised for the primary purpose of producing goods or performing services.

Prevocational services furnished under the waiver are not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17). Prevocational services may be provided to supplement, but may not duplicate services provided under supported employment or vocational futures planning and support services provided under the waiver. IRIS is the funding source of last resort for employment services. If the participant has an open case with WI DVR, those funds must be used before any IRIS funds can be utilized.

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

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

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

Only activities or assistive technology that contributes to the participant's work experience, work skills, or work-related knowledge that leads to paid integrated employment in the community can be included in prevocational services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Provider, Supported Employment Agency or Facility-Based Workshop

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:
Agency
Provider Type:
Prevocational Provider, Supported Employment Agency or Facility-Based Workshop
Provider Qualifications

License *(specify):*

Certificate *(specify):*

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

care or personal care shall meet the appropriate provider qualifications.

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

Participants must adhere to 42 CFR 440.180 (c)(2) (i), including, if the participants receive prevocational services they are compensated at less than 50 % of minimum wage.

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

3. There shall be a direct service staff person or persons who shall possess skills and knowledge that typically would be acquired through:
a. A course of study that would lead to a bachelor's degree in one of the human services; or
b. A minimum of 2 years of academic, technical or vocational training consistent with the type of work to be supervised; or
c. A minimum of 2 years experience in a work situation related to the type of work supervised.
d. Additional staff or consultants who are knowledgeable and skilled in adapting or modifying equipment and environments, and the application of special equipment for persons with physical disabilities shall be available, as needed.

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

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

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

7. Vocational counseling shall be available.

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

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

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

11. Pre-vocational Services shall be provided as recommended in the individual service plan and supported by an integrated employment goal in an approved setting.

12. Must also be a qualified provider of supported employment services.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Respite
Alternate Service Title (if any):

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Respite care services include those services provided to an IRIS participant on a short-term basis to relieve the participant's primary caregiver(s) from care demands. Provision of respite care services may occur in a residential setting, the home of the participant, or in another community setting.
1. Residential respite:
Residential respite may be provided in the following allowable settings:
a. Adult family home certified for one or two persons – Wisconsin Administrative Code DHS ch. 82 (http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/82)
b. Adult family home licensed for three or four persons – Wisconsin Administrative Code DHS ch. 88 (https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/88.pdf)
c. Licensed community based residential facility – Wisconsin Administrative Code DHS ch. 83 (https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/83)
d. Certified residential care apartment complex – Wisconsin Administrative Code DHS ch. 89 (http://docs.legis.wisconsin.gov/code/admin_code/dhs/030/89.pdf)
Residential respite may involve overnight stays or partial day stays by the participant. Costs for room and board in these settings may be included in the charge to the IRIS program. The actual length of the respite stay must be specified in the participant record.
2. Home-based respite:
When respite care service is provided in the home of the participant, the service is defined as home-based respite. Home-based respite care services may occur in partial day or overnight increments. Costs for room and board in these settings cannot be included in the charge to the IRIS program. The length of the respite stay must be specified in the participant record. The standards for respite provided within an individual's home are determined primarily by the participant and/or their legal decision-maker. However, the respite provider is still subject to a background check, similar to other providers.
3. Other setting respite:
Other settings in which respite services may be provided include institutions such as a certified Medicaid setting (hospital, nursing home) or other licensed facility. Services may involve overnight or partial day stays by the participant. The actual length of the respite stay must be specified in the participant record. The standards for other setting respite are determined primarily by the participant and/or their legal decision-maker. However, the respite provider is still subject to a background check.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• The receipt of respite precludes the participant from receiving other waiver services such as adult day care, nursing services, and supportive home care on the same day the participant receives respite care, unless clear documentation exists that service delivery occurred at distinct times from respite services regardless of how the respite payment is structured.

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Individual
Provider Type:
Adult Family Home - 1 to 2 Bed, Individual respite provider
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
1-2 bed home - Administrative Rule DHS 82
Other Standard *(specify)*:
Individual Respite Provider – Appendix T of the Medicaid Waivers Manual (https://www.dhs.wisconsin.gov/sites/default/files/legacy/bdds/waivermanual/app_t.pdf)

Home-based respite: The standards for respite provided within an individual's home are determined primarily by the participant and/or their legal decision-maker. The respite provider is subject to a background check.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

FEAs verify the provider qualifications of individual providers.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:
Agency
Provider Type:

Institution

Provider Qualifications

License *(specify):*

Institutions must be a certified Medicaid setting and comply with Wisconsin Administrative Code DHS ch. 124, ch. 132 and ch. 134 as applicable.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Family Home 3 to 4 Bed

Provider Qualifications

License *(specify):*

Certificate *(specify):*

3-4 Bed Home - Administrative Rule DHS 88

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

CBRF or RCAC

Provider Qualifications

License *(specify):*

CBRF – Wisconsin Administrative Code DHS ch. 83

Certificate *(specify):*

RCAC – Wisconsin Administrative Code DHS ch. 89

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Statutory Service

Service:
Supported Employment

Alternate Service Title (if any):
Supported Employment - Individual

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Supported Employment-Individual services are the ongoing supports to participants who, because of their disabilities, need intensive on-going support to obtain and maintain an individual job in competitive or customized employment or self-employment, including home-based self-employment, in an integrated work setting in the general workforce 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.

Supported employment services can be provided though many different service models. Some of these models can include evidence-based supported employment or customized employment for individuals with significant disabilities. Customized employment means individualizing the employment relationship between employees and employers in ways that meet the needs of both. It is based on an individualized determination of strengths, needs, and interests of the person with a disabilities, and is also designed to meet the specific needs of the employer. It may include employment developed though job carving, self -employment, or entrepreneurial initiatives or other job development or restructuring strategies that result in job

responsibilities being customized and individually negotiated to fit the needs of participants.

In a self-directed supported employment individual employment support model, participants may hire their own job coaches and employment support staff, rather than relying exclusively on agency based staffing models. This model of support may be particularly useful as participants seek to expand the pool of people who can provide individual supported 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.

The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting within the general workforce, in a job that meets personal and career goals. Supported employment services are individualized and may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job supports, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits support, training and planning, asset development, transportation and career advancement services, and tools/equipment needed to work effectively. Other workplace support services including services not specifically related to job skill training may also be provided based on the needs of the specific participant served that enable the participant to be successful in integrating into the job setting.
Supported employment individual employment supports may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker, supervisor or other personnel and these individuals meet the qualifications established below for individual providers of service. Employers may be reimbursed for supported employment services provided by co-workers. This is referred to as a "paid co-worker supporter." Paid co-worker supports on the job have proven to be less intrusive than a typical job coaching situation as well as providing a more inclusive and integration environment for the participant.

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

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

Supported employment individual employment support may include services and supports that assist the participant in achieving self-employment and operating a microenterprise; however, IRIS waiver funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include: (a) aiding the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched.

A participant's person-centered plan may include two or more types of non-residential services.
Other workplace support services, including services not specifically related to job skill training, may also be provided based on the needs of the specific participant served.

Supported employment includes benefits counseling, a service for people considering employment, or with current employment and experiencing changes (e.g., pay raises, increased hours, and additional benefits). Benefits counseling provides people with information to make informed decisions about employment options. Work incentive benefit counseling may be provided by a Work Incentive Benefits Specialist (WIBS). The WIBS may practice independently or work for independent living centers, community rehabilitation providers or non-profit organizations. Although no formal licensure requirement exists for WIBS; an association exists, Work Incentive Benefits Specialist Association (WIBSA). Information, including a list of association members, can be found at http://www.wibsa.org. WIBS counseling can be funded within the Supported Employment or Vocational Futures Planning and Support wavier, as long as the participant is not also receiving the service through the Department of Vocational Rehabilitation (DVR). If the IRIS participant is actively working with DVR, the ICA staff should support the IRIS participant to express the need for this service to his/her DVR counselor.

DHS ensures that prevocational, educational, and supported employment services or a combination of these services, if provided as habilitation services under the waiver are: 1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, 2) furnished as part of expanded habilitation services.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Waiver funds may not be used to defray expenses associated with starting up or operating a self-employment business.

Supported employment individual employment supports does not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business. IRIS is the funding source of last resort for employment services.

If the participant has an open case with WI DVR, those funds must be used before any IRIS funds can be utilized.

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

Federal financial participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment;

or

2. Payments that are passed through to users of supported employment services

Supported employment individual employment supports do not include volunteer work.

Different types of non-residential services may not be billed for the same period of time.

Vocational services provided in facility-based work settings or other types of vocational services furnished in specialized facilities that are not part of general community work places.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Employment Agency
Individual	On-the-job support person

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual

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

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Providers of Supported Employment services must meet the applicable standards set forth by the Wisconsin Department of Vocational Rehabilitation (WI DVR). Information on the certification requirements for WI DVR can be found at: https://dwd.wisconsin.gov/dvr/service_providers/agreement_for_services.pdf.

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

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

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment - Individual

Provider Category:

Individual

Provider Type:

On-the-job support person

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of Supported Employment services must meet the applicable standards set forth by the Wisconsin Department of Vocational Rehabilitation (WI DVR). Information on the certification requirements for WI DVR can be found at: https://dwd.wisconsin.gov/dvr/service_providers/agreement_for_services.pdf.

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

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

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).

Verification of Provider Qualifications

Entity Responsible for Verification:

FEAs verify the provider qualifications of individual providers.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Nursing Services

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Nursing services include those medically necessary, skilled nursing services provided safely and effectively by a nurse practitioner, a Registered Nurse or a licensed practical nurse working under the supervision of a Registered Nurse. The nursing services provided must occur within the scope of the Wisconsin Nurse Practice Act and not otherwise available to the participant under the Medicaid state plan or federal Medicare.

Nursing services are typically a Medicaid ForwardHealth Card coverable service or Medicare service, and are not included in ISSP; however, when nursing service needs exceed the Medicaid ForwardHealth allowable services, IRIS funds may be used to pay for nursing services.

Professional skilled nursing means the observation of care of the ill, injured or infirm, or for the maintenance of health or prevention of illness that requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences. Professional skilled nursing includes any of the following:
a. The observation and recording of symptoms and reactions;
b. The execution of procedures and techniques in the treatment of the sick under the general or special supervision or direction of a physician, podiatrist licensed under Wis. Stats. ch. 448, dentist licensed under Wis. Stats. ch. 447, or optometrist licensed under Wis. Stats. ch. 449, or under an order of a person who is licensed to practice medicine, podiatry, dentistry or optometry in another state if the person making the order prepared the order after examining the patient in that other state and directs that the order be carried out in this state;
c. The execution of general nursing procedures and techniques; or
d. The supervision of a patient and the supervision and direction of licensed practical nurses and less skilled assistants in accordance with Wis. Stats 441.

Nursing services may include the periodic assessment of the participant's medical condition when the condition requires a skilled nurse to identify and evaluate the need for medical intervention, or to monitor and/or modify the medical treatment services provided by non-professional care providers. Services may also include regular, ongoing monitoring of a participant's fragile or complex medical condition as well as the monitoring of a participant with a history of noncompliance with medication or other medical treatment needs.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Exclusion includes services available through the Medicaid State Plan. The Statewide IRIS-SDPC oversight agency provides review of the need for nursing services to ensure the need exceeds the State Plan benefit limitations. Results of the analysis serve as the prior authorization for this service. The DHS reviews all prior authorizations on a quarterly basis.

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

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

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

☑ **Legally Responsible Person**
☑ **Relative**
☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency-directed registered nurse/LPN
Individual	Registered Nurse/ Licensed Practical Nurse

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Agency-directed registered nurse/LPN
Provider Qualifications
License *(specify):*
Agency-directed and individual Registered Nurses/Licensed Practical Nurses must comply with licensing, accreditation and practice standards under Wisconsin Statute ch. 441: http://docs.legis.wisconsin.gov/statutes/statutes/441.pdf.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Registered Nurse/ Licensed Practical Nurse
Provider Qualifications
License *(specify):*
Agency-directed and individual Registered Nurses/Licensed Practical Nurses must comply with licensing, accreditation and practice standards under Wisconsin Statute ch. 441: http://docs.legis.wisconsin.gov/statutes/statutes/441.pdf.
Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Supports for Participant Direction
The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
Support for Participant Direction:
Financial Management Services
Alternate Service Title (if any):
Fiscal Employer Agent Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Providers of Fiscal Employer Agent Services cannot provide other Wisconsin long-term care waiver services to the same participant.
• Representative payee services.
• Consulting services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Employer Agent

Appendix C: Participant Services

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

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

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

Verification of Provider Qualifications
Entity Responsible for Verification:
OIM is responsible for the annual certification of each Fiscal Employer Agent.
Frequency of Verification:
IS Fiscal Employer Agents are subject to recertification by OIM annually.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

1 -2 Bed Adult Family Home

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

An Adult Family Home (AFH) is a residence where one or two adults in which care, treatment, support or service above the level of room and board is provided. The residence is the AFH operator(s) primary residence.

An AFH also includes “community care home.” A community care home is a residence where one or two adults reside and in which care, treatment, support or service above the level of room and board is provided. In the community care home the operator owns, rents, or leases the residence and employs staff who provides the care, treatment, support or service. The community care home is not the provider’s primary residence. It includes homes which are the primary domicile of the operator or homes which are controlled and operated by a third party that hires staff to provide support and services.

Participants of the IRIS waiver choose an AFH and collaborate with the AFH operator to identify services including but not limited to supportive home care, personal care, and supervision (provided by the home and included in the AFH rate). Additional services include transportation, behavioral and social supports, daily living skills training, and recreational activities; IRIS participants can purchase these services from separate providers. In these instances, the AFH must provide access to and coordination with identified service providers. Furthermore, AFH services coordinate with services received by the participant including health care and employment or vocational services. Each provider maintains an agreement with the IRIS participant which specifies the nature and scope of the AFH services provided. Additional requirements are described in the 1-2 bed adult family home certification standards. Each 1-2 bed AFH operator must maintain current certification to provide services as a 1-2 bed AFH.

AFHs must communicate with designated IRIS program representatives and other providers, within confidentiality laws, about any critical incidents occurring in the home. In addition, the AFH must report to the county adult protective services unit, any incident, situation or condition which endangers the health or safety of the IRIS participant/AFH resident.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• IRIS funds may not be used to pay for the cost of room and board.
• Supportive Home Care (SHC) is not available to persons residing in an AFH unless the SHC is provided outside the home and supports the participant to have access to the community.
• A participant may not obtain the same services they receive from an AFH from another provider. The services provided by the AFH are described in the participant provider agreement.
• Supplementation of care and supervision costs by the participant, or others, is prohibited.

IRIS participants living in an adult family home are ineligible to have their budget increased if the increase is intended to pay an increased rate to the AFH or is necessary because the rate charged by the AFH is higher than the average rate paid for similar AFH services by Family Care in the relevant county. However, if an IRIS participant resides in an AFH but plans to move to their own home, then a temporary budget increase, for up to 90 days, may occur for the preparation and accomplishment of the move. In addition, a budget increase is permissible when the participant needs AFH services as part of their backup plan or for respite services.

Additional funding, for temporary residential care services, is available under the following conditions:
• Residential care is needed as part of the back-up plan, when primary services/supports are not available;
• Residential care is needed, temporarily, for recuperative purposes; and,
• The person lives in residential care upon entry to the IRIS waiver, but wants to move to their own apartment/home.
Residential care is approvable, for up to three months, while the person develops necessary services and transitions to the community.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Adult Family Home

Appendix C: Participant Services

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

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

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

Certificate *(specify):*
A description of AFH standards, in the Medicaid Waiver Standards for Adult Family Homes, can be found under section 202.01 or DHS publication P-00638:
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

3-4 Bed Adult Family Home

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

An AFH is a residence where three or four adults who are not related to the licensee live, in which care, treatment; support or service above the level of room and board is provided. This may include up to seven hours per week of nursing care per resident. The residence is the AFH operator(s) primary residence.

An AFH also includes “community care home.” A community care home is a residence where three or four adults who are not related to the licensee live, in which care, treatment, support or service above the level of room and board is provided. In the community care home, the operator owns, rents, or leases the residence and employs staff who provides the care, treatment, support or service. The community care home is not the provider’s primary residence.

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

All providers of AFH services must communicate with designated IRIS program staff and other providers within confidentiality laws about any critical incidents that occur in the home. In addition, the home must report to the county adult protective services unit regarding any incident, situation or condition that endangers the health or safety of the participant living in the home.

This service type also includes homes of 3-4 beds, specified under s. 50.01 (1)(a) of the Wisconsin Statutes, which are licensed as foster homes under s. 48.62 of the Wisconsin Statutes and certified by the certifying agency as defined under DHS 82 of the Wisconsin Administrative Code. The latter are owner-occupied homes for persons with intellectual disabilities who are aging out of foster care. This category of homes permits such persons to remain in the same home, promoting continuity of care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• IRIS funds may not be used to pay for the cost of room and board.

• Supportive Home Care is not available to persons living in this residence unless it is SHC provided outside the home that assists the participant to access the community.

• The same services provided, that are described in the participant provider agreement, may not be provided by another service provider.

• Care and supervision costs cannot be supplemented by the participant or others.

IRIS participants living in an adult family home are ineligible to have their budget increased if the increase in intended to pay an increased rate to the AFH or is necessary because the rate charged by the AFH is higher than the average rate paid for similar AFH services by Family Care in the relevant county. However, in the case where the participant lives in an AFH but plans to move to his/her own home, a temporary increase in budget for up to 90 days may be made to allow the participant to prepare for and accomplish the move. A budget increase is also permissible when the services of the AFH are needed as part of a backup plan or when the AFH services are to be used as respite services.

Additional funding for temporary residential care services is available when:

• Residential care is needed as part of the back-up plan when primary services/supports are not available.

• Residential care is needed temporarily for recuperative purposes.

• The person is living in residential care when coming onto the Self-Directed Services waiver, but wants to move to his or her own apartment/home. Residential care could be approved for up to three months while the person develops necessary services and transitions to the community.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Licensed Adult Family Homes

Appendix C: Participant Services

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

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

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

Chapter 88 of Wisconsin DHS Administrative Code.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Adaptive Aids

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

This service may also include the initial purchase of a service animal and routine veterinary costs for a service animal. Wisconsin Statute § 106.52 (1) (fm) states: "Service animal" means a guide dog, signal dog, or other animal that is individually trained or is being trained to do work or perform tasks for the benefit of a person with a disability, including the work or task of guiding a person with impaired vision, alerting a person with impaired hearing to intruders or sound, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items.

The Americans with Disabilities Act states service animals are dogs (and in some cases, miniature horses) trained to perform major life tasks to assist people with physical disabilities. For a person to legally qualify to have a service dog, he/she must have a disability that substantially limits his/her ability to perform at least one major life task without assistance.

To qualify as a service dog, the dog must be individually trained to perform that major life task. All breeds and sizes of dogs can be trained as service animals. The federal American Disabilities Act (ADA) does NOT require certification or registration of service animals.

While no special accreditation is required by the state of Wisconsin, it is recommended that you strongly consider service dog certification training to realize the full potential of your assistance animal.

When required by the IRIS One Time Expense policy, a qualified assessor independent of the good or service requested must complete an accessibility assessment. The cost of this assessment is funded by the IRIS Program and is not considered to be a cost to the participant's budget. Three viable provider estimates must be obtained and submitted with each request for an adaptive aid. In all cases, the provider with the most reasonable costs and the assurance of the appropriate level of quality will be selected.

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

• If IRIS funds pay for the installation of grab bars, the program considers such use of funds as a home modification and, consequently, the grab bars are not billed as adaptive aids.
• Durable Medical Equipment (DME) obtained through Wisconsin's approved Medicaid State Plan is excluded. IRIS funds may pay for aids exceeding the allowable Medicaid paid goods and services, or aids denied by Medicaid.
• Excludes food, grooming and non-routine veterinary care for service animals based on DHS guidelines.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adaptive Aids Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Adaptive Aids

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

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Assistive Technology/Communication Aids/Interpreter Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Assistive technology means an item, piece of equipment or product system, whether acquired commercially, modified or customized, that is used to increase, maintain, or improve functional capabilities at home, at work, and in the community. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device.

Assistive technology includes:

(A) The evaluation of the assistive technology needs of a member, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices;

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;

(D) ongoing coordination and use of necessary therapies, interventions or services with assistive technology devices, such as therapies, intervention, or services associated with other services in the service plan;

(E) ongoing training or technical assistance for the member, or where appropriate, the family members, guardians, advocates or authorized representative of the participant;

(F) ongoing training or technical assistance for professionals or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Assistive technology includes communication aids that are devices or services needed to assist with hearing, speech, communication or vision impairments. The services assist the individual to communicate with service providers, family, friends and the general public. Results of improved communication may include a decrease in reliance on paid staff, an increase in personal safety, an enhanced independence and an improved social and emotional well-being.

Communication aids include: communication devices, speech amplifiers, aids and assistive devices, and cognitive retraining aids and include costs related to the repair of these aids. Communication aids also include electronic technology such as tablets or mobile devices and related software that assists with communication. Applications for mobile devices or other technology are also covered under this service, when the use is primarily medical in nature or provides assistance to a person who needs such assistance due to his/her disabilities.

If the appropriate need is validated and documented, the purchase of a license for specific computer-based fonts that improve accessibility or ability to meet a long-term care outcome, may be an eligible expense to be paid for with IRIS waiver funds. These types of requests will be reviewed and approved by DHS. An example of a font that may be approved is the Dyslexie font. (http://www.dyslexiefont.com/en/dyslexia-font/). Individuals who are Dyslexic may establish and justify a need for the purchase of a license to use this font.

This list is intended to be illustrative and is not exhaustive.

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

• Interpreter services may not be paid when provided by a spouse, relative or guardian.

• Interpreter services required by a participant to interact with their IRIS Consultant are considered administrative expenses and would not be considered a long-term care service.

• IRIS funds cannot be used to provide interpreter services that are the responsibility of another entity (school, court, hospital, etc.).

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Interpreters
Agency	Communication Aids vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology/Communication Aids/Interpreter Services

Provider Category:
Individual
Provider Type:
Individual Interpreters
Provider Qualifications

License *(specify):*

Certificate *(specify):*
A qualified interpreter for the deaf is a person certified by the National Registry of Interpreters for the Deaf or one who has successfully participated in the DHS Office for the Deaf and Hard of Hearing program, "Wisconsin Interpreting and Transliterating Assessment (WITA)."
Other Standard *(specify):*
Qualifications and requirements for Interpreter Services are the responsibility of the participant to ensure that qualifications meet their needs.

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

Electronic devices must meet UL or FCC standards.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology/Communication Aids/Interpreter Services

Provider Category:
Agency
Provider Type:
Communication Aids vendor
Provider Qualifications

License *(specify):*

Certificate *(specify):*
• Vendors of communication aids should meet the requirements in Wisconsin Medicaid Waiver Manual - CHAPTER IV – SPC 112.47 http://www.dhs.wisconsin.gov/bdds/waivermanual/waiverch04_10.pdf.
Other Standard *(specify):*
• The providers of systems or devices purchased as communication aids shall ensure that such items meet all the applicable standards of manufacture, safety, design and installation (Federal Communication Commission, etc.) and should be obtained from authorized and qualified dealers.
• Items purchased must meet a reasonable buyer expectation of quality and performance.

Verification of Provider Qualifications

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

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Consumer Education and Training

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Consumer education and training services are designed to help a person with a disability develop self-advocacy skills, support self-determination, exercise civil rights and acquire skills needed to exercise control and responsibility over other support services; includes education and training for members, their caregivers and/or legal representatives that is directly related to building or acquiring such skills. Covered expenses may include enrollment fees, books and other educational materials and

transportation related to participation in training courses, conferences and other similar events. Excludes educationally related services available under Individuals with Disabilities Education Act (IDEA) (20 U.S.C.1401 et seq) or other relevant funding sources.

Providers must have expertise in problem solving, self-advocacy skills development, self-determination, community integration, financial management and decision-making.

Covered services may include: enrollment fees, books and other educational materials, transportation related to participation in trainings, courses, conferences and other similar events addressing the objectives of this service category.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Education/training costs exceeding $2500 per participant annually.
• Payment for hotel and meal expenses while members or their legal representatives attend allowable training/education events.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal assistant, teacher
Agency	Education and Training Agency

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Personal assistant, teacher
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:
Certification from the Department of Public Instruction is required if the individual is a teacher.
Other Standard *(specify)*:
The participant ensures competent and qualified providers of participant education and training services hold the necessary required credentials. Certification from the Department of Public Instruction is required if the individual is a teacher.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Education and Training Agency
Provider Qualifications
License *(specify):*
Certificate *(specify):*
Certification from the Department of Public Instruction if the individual is a teacher.
Other Standard *(specify):*
The participant ensures competent and qualified providers of participant education and training services hold the necessary required credentials. Certification from the Department of Public Instruction is required if the individual is a teacher.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Counseling and Therapeutic Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Counseling and therapeutic services include the provision of professional, treatment-oriented services to address the participant's identified needs for physical, medical, personal, social, behavioral, cognitive, developmental, emotional, mental, or substance abuse treatment. The goal of treatment is to maintain or improve participant health, welfare or functioning, in the community.

Counseling and therapeutic resources may include: assistance adjusting to aging and disability, which includes understanding capabilities and limitations; assistance with interpersonal relationships; recreational therapy; music therapy; art therapy; nutritional counseling; medical and legal counseling; grief counseling; weight counseling (except for Medicare participants); massage therapy; aquatic therapy; and, health club memberships. Services provided in a camp setting require specific coding (see below).

Therapies or treatment services may be provided in a natural setting or in a service provider's office and includes therapies or treatments provided by state-licensed or certified medical professionals or practitioners of the healing arts, not available under the Medicaid State Plan. Costs associated with memberships, parking, passes, and fees, directly related to the long-term care outcomes of the participant and to the counseling or therapy received, are included in this service.

Counseling and therapeutic services must meet clearly defined outcomes, be proven effective for the member's condition or outcome and be cost effective. Any alternative therapies and treatments must meet DHS requirements.

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

- Inpatient services
- Services provided by a physician
- Services available through the Medicaid State Plan or covered by other insurance, including Medicare
- Attendant costs, to assist participants in attending counseling and therapeutic sessions

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Counselors
Agency	Counseling Agencies

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Individual Counselors

Provider Qualifications

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

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

Other Standard *(specify):*
When these services are provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification, careful consideration of implementation of services must occur to prevent adverse consequences on the health and safety of the participant.

Verification of Provider Qualifications

Entity Responsible for Verification:
FEAs verify the provider qualifications of individual providers.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Counseling Agencies
Provider Qualifications
License *(specify):*
Agencies or individuals providing counseling and therapeutic services must be appropriately licensed or certified in the State of Wisconsin per Wisconsin Administrative Rule DHS 61.35, found at: https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/61/II/35
Certificate *(specify):*
Only competent and qualified providers may provide services to participants. Alternative therapies and treatments must be provided by licensed professionals who maintain current Wisconsin state licensure or certification in their field of practice.
Other Standard *(specify):*
When these services are provided by trained technicians, therapy assistants or other specially trained persons who do not require state licensure or certification, careful consideration of implementation of services must occur to prevent adverse consequences on the health and safety of the participant.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Customized Goods and Services

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Customized Goods and Services refers to a service, support or good that addresses a participant's assessed long-term support need, enhances the participant's opportunities to achieve long-term care outcomes related to living arrangement, relationship, community inclusion, work or 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 the 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. The item or service must, and also advances the desired contribute to the achievement of the identified long-term care outcomes in his/her Individual Support and Service Plan (ISSP).
* The service, support or good is documented on the ISSP.
* The service, support or good is not prohibited by Federal and State statutes and regulations, or guidance including the State's Procurement Code.
* The service, support or good is not reasonably available through another source (e.g. natural, community-based).
* The service, support or good is not available through Medicaid, Medicare, or HCBS Waiver Services.
* The service, support or good is not experimental (as defined in Wisconsin Administrative Rule DHS 107.035): http://docs.legis.wisconsin.gov/code/admin_code/dhs/101/107/135.

Each service, support or good selected must meet at least one of the following criteria:
* The service, support or good will maintain or increase the participant's safety in the home or community environment.
* The service, support or good will decrease or prevent increased dependence on other Medicaid-funded services to meet a long-term support need.
* The service, support or good will maintain or increase the participant's functioning related to the disability.
* The service, support or good will address a long-term support need and will maintain or increase the participant's access to or presence in the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Items, goods or services that are not for the direct benefit of the participant or to treat a participant's disability-related long-term care need are not allowed.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Home Health Care Agency, Supportive Home Care Agency, Aging Network Agency, Education and Training Agency, Other Merchants or Contractors
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The participant should ensure that only competent and qualified providers of goods and services with the appropriate expertise, training and background are paid with IRIS funds.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually or at the time of purchase

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Family, friend, neighbor, supportive home care worker
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
The participant should ensure that only competent and qualified providers of goods and services with the appropriate expertise, training and background are paid with IRIS funds.
Verification of Provider Qualifications
Entity Responsible for Verification:
FEAs verify the provider qualifications of individual providers.
Frequency of Verification:
Annually or at the time of purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:
Day Services

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Day services programs provide regularly scheduled, individualized skill development activities to participants. Services must be provided in a non-residential setting separate from the participant's private residence or other residential living arrangement.. Program goals may include assistance with acquisitions, retention or improvement in self-help, socialization and adaptive skills that enhance social development and develop skills in preforming activities of daily living and community living. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Services are furnished consistent with the participant's person-centered plan. Day Services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the individual's participant-centered plan. Services may occur in a single physical environment or multiple environments or in the community at large.

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

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Services may occur in a single physical environment, multiple environments, or in the community at large as long as the setting meets setting compliance.

Day services may not provide for the payment of services that are vocational in nature (i.e., for the primary purpose of producing goods or performing services).

For participants with degenerative conditions, day services may be include training and supports designed to maintain skills and functioning and to prevent slow regression, rather than acquiring new skills or improving existing skills.

Day Services may be used to provide supported retirement activities. As some participants get older they may no longer desire to work and may need supports to assist them in meaningful retirement activities in their communities. This may involve altering schedules to allow for more rest time thought out the day, support to participate in hobbies, clubs and/or other senior related activities in their communities.

Participants who receive day services may also receive educational, supported employment and prevocational services. An individual's participant-centered plan may include two or more types of non-residential services. However, different types of non-residential services may not be billed during the same period of the day.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Day Service program operated by agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Day Services

Provider Category:
Agency
Provider Type:
Day Service program operated by agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
The participant should ensure that only competent and qualified providers of day services, with the appropriate expertise, training and background, receive payment with IRIS funds per Wisconsin Administrative Code DHS ch. 61: https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/61/II/41. Providers certified by the Rehabilitation Accreditation Commission for Activity Services may use this certification as evidence of qualification.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Home Delivered Meals

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Provision of home-delivered meals occurs when access to meals outside of the home is unrealistic or difficult to accomplish. Home-delivered meals intend to support the nutritional needs of IRIS participants living in a home or apartment who are without paid or natural supports to assist with meal preparation.
Provider costs of home-delivered meals may include: the planning of meals and purchasing of food, supplies, equipment, labor and the transportation costs associated with delivery of one or two meals per day to the participant's home. Participants in receipt of home-delivered meals may be unable to plan, prepare or obtain nutritional meals without assistance or may be unable to manage a special physician-recommended diet. Generally, the provision of meals occurs in the participant's home.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Excludes payment for meals at federally subsidized nutrition sites.
• Home-delivered meals may not meet that which constitutes a "full nutritional regimen" (i.e., three meals per day).

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Aging network agencies, hospitals or nursing homes, restaurants

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:
Agency
Provider Type:
Aging network agencies, hospitals or nursing homes, restaurants
Provider Qualifications
License *(specify):*

Aging network agencies, hospitals, nursing homes, public schools or restaurants are included as approved providers of home-delivered meals. Providers must be licensed food service providers or Older American's Act program providers, and comply with Wisconsin Administrative Code DHS 196: https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/196_.pdf and § 254 http://docs.legis.wisconsin.gov/statutes/statutes/254.pdf.

Hospitals and nursing homes must comply with Wis. Admin. Code DHS 124, DHS 132 and DHS 134; aging network agencies must comply with Wis. Stats. Chapter 46.82 (3); and restaurants must comply with Wis. Admin. Code DHS 196.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Home Modification

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Home modifications include services designed to assess the need for, arrange for and provide modifications and/or improvements to a participant's residence that address a need identified to improve health, safety, accessibility or provide for the maximization of independent functioning. Home modifications are generally permanent fixtures/changes to a physical structure. Home modifications include the cost of the permit to authorize the changes, the materials, and services needed to complete the installation of specific equipment, the modification of the physical structure or the reconfiguration of essential systems within the home. Only the most economical approach to achieve the outcome is considered.

Home modifications are considered a one-time expense. Home modifications are generally not available in rental units as the IRIS program is not responsible for modifying a rental unit. Items considered portable (portable ramp) are defined as adaptive aids. Home modifications may include adaptations, including, but not limited to:
• Ramps (fixed), ramp extensions and platforms
• Porch/stair lifts
• Doors/doorways, door handles/door opening devices
• Adaptive door bells, locks/security items or devices
• Plumbing, electrical modifications related to adaptations
• Medically necessary heating, cooling or ventilation systems
• Shower, sink, tub and toilet modifications
• Faucets/water controls
• Accessible cabinetry, counter tops or work surfaces
• Grab bars (see exception below), handrails, accessible closets
• Smoke/fire alarms and fire safety adaptations
• Adaptive lighting/light switches
• Flooring and/or floor covering to address health and safety
• Wall protection
• Voice, light or motion activated devices that increase the participant's self-reliance and capacity to function independently

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

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

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

Home modifications made prior to a person leaving an institutional setting cannot be paid for until the person leaves the institution and is enrolled in the IRIS Program with a plan start date.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Modifications which increase the square footage of a privately owned residence may be allowed when this circumstance is a more cost-effective option to meet the participant's long-term care outcome. Increases in square footage will only be considered when there is documented evidence of the cost effectiveness of this option versus remodeling the existing footprint of the residence.

Modifications not recommended in the accessibility assessment are excluded.

Modifications without 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 made prior to a person leaving an institutional setting cannot be paid for until the person leaves the institution and is enrolled in the IRIS Waiver with a plan start date.

Quotations from at least three providers must be obtained and submitted with the request for the home modification for modifications with costs exceeding an amount set annually by the DHS. In all cases, the provider with the most reasonable costs and the assurance of the appropriate level of quality will be selected.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Carpenter, electrician, plumber, contractor, engineer

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modification

Provider Category:
Individual

Provider Type:
Carpenter, electrician, plumber, contractor, engineer

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Completion of home modifications must occur according to American Disability Act (ADA) standards. If the project cannot meet ADA requirements, additional review and approval is required.

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:
At time of modification

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Housing Counseling

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Housing counseling is the provision of comprehensive guidance on housing opportunities that are available to meet the participant's needs and preferences. Housing counseling includes exploring both home ownership and rental options, and both individual and shared housing situations, including situations where the individual lives with his or her family.
Qualified counselors provide guidance on how a participant may gain access to available public and private resources available in order to obtain, or retain, safe, decent, accessible, and affordable housing and remain in the community to avoid institutionalization.
Housing Counseling includes planning, guidance and assistance in accessing resources related to:
• Home ownership, both pre and post purchase
• Home financing and refinancing
• Home maintenance, repair and improvements including the abatement of environmental hazards
• Rental counseling, not including cash assistance
• Accessibility and architectural services and consultation
• Weatherization evaluation and assistance in accessing these services
• Lead based paint abatement evaluation
• Low income energy assistance evaluation
• Access to transitional or permanent housing
• Accessibility inventory design
• Health and safety evaluations of physical property
• Debt/credit counseling
• Homelessness and eviction prevention counseling
• Identifying preferences of location and type of housing
• Explaining the rights and responsibilities of a tenant with disabilities including how to ask for reasonable accommodations and modifications
• How to file a complaint.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Housing Counseling Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Housing Counseling

Provider Category:
Agency
Provider Type:
Housing Counseling Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
Agencies providing Housing Counseling must have expertise in housing issues relevant to the participant and may not be a provider of residential support services to the participant. Housing counseling is not a one-time service and may be accessed by a participant at any time. A qualified provider must be an agency or unit of an agency that provides housing counseling to people who need assistance with housing as a regular part of its mission or activities. Counseling must be provided by staff with specialized training and experience in housing issues. This service is excluded if it is otherwise provided free to the general public.

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
At the time or purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Personal Emergency Response System

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
A Personal Emergency Response System (PERS) is a service that provides immediate assistance in the event of a physical, emotional or environmental emergency through a community-based electronic communications device. The service provides a direct link to health, or other service professionals, enabling the user to secure an immediate response by the activation of an electronic communications unit in the participant's home.

Allowable items under this service may also include a cellular telephone and cellular service as an alternative to a land-based telephone PERS. Cell phone services offered free of charge should be used whenever possible. Several programs offer free wireless, PERS supported, in part, by the Federal Government. If a landline is required for the operation of the PERS, the basic cost of the landline can be funded only when another landline is not already available. This service may include devices and services necessary for operation of PERS when otherwise not available. This service may also include installation, upkeep and maintenance of devices or systems as appropriate.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The IRIS program excludes funding for the installation and/or monthly cost of landline service when a landline currently exists.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	PERS Vendor

Appendix C: Participant Services

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

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

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

Certificate *(specify):*

Other Standard *(specify):*

The PERS provider should assure the devices, where applicable, meet Federal Communication Commission performance standards. Electronic devices must meet UL Standards. Telephonic devices must meet FCC regulations.

The installation of the PERS should be completed by qualified installers, representing the health agency managing the PERS. In the event of the unavailability of qualified installers, the agency should seek experienced technicians to complete necessary line adaptations.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:
At time of purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Relocation - Housing Start Up and Related Utility Costs

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Relocation-related services may be funded by IRIS as a last payment resource when other sources are exhausted. Relocation-related services include the provision of services and essential items needed to establish a community living arrangement for persons relocating from an institution, a residential setting, or for people moving out of a home controlled by another individual, with intent to establish an independent living arrangement. Allowable costs include initial fees to establish utility service or the purchase of basic and essential items and services needed to establish a community living arrangement. Relocation-related housing start-up services include person-specific services, supports or goods that may be arranged, scheduled, contracted or purchased, which support the preparation of the participant's transition to a safe, accessible community living arrangement. No institutional length of stay requirement exists to access this service. When this service is

provided to an individual transitioning from a residential institution to a community-based setting, the service is not billed until the date the individual leaves the institution and enters the IRIS Program. Services or items covered by this service may not be purchased more than 180 days prior to the date the member relocates to the new community living arrangement.

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

Relocation-related housing start-up services exclude: the purchase of food, the payment of rent, the purchase of leisure or recreational devices or services (e.g., television or video equipment, cable or satellite service) and excludes the use of waiver funds to purchase service agreements or extended warranties for appliances or home furnishings. Relocation services exclude home modifications necessary to address safety and accessibility in the member's living arrangement, which may be provided as the waiver service home modifications. Excludes housekeeping services provided after occupancy which are considered the waiver service supportive home care.

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

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

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

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

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

Security deposits for lease agreements may only be made to owners or providers of safe, quality housing, in compliance with all local housing and building codes.

Furnishings and equipment purchased must be in good and safe working condition.

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

Providers of services to prepare the housing arrangement for occupation and assist the participant with the moving of personal belongings, must meet the same standards as applied to Home Care workers (see Provider Qualifications and Standards for Supportive Home Care workers). Providers must be reputable contractors or companies.

Verification of Provider Qualifications

Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:

At the time of purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Residential Care Apartment Complex

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

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

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

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

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

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

RCAC and are therefore not available elsewhere. Care and supervision costs cannot be supplemented by the participant or others.
Waiver funds are not used to pay for the cost of room and board. Supportive Home Care (SHC) is not available to recipients of residential services. This service may not duplicate any other service that is provided under another waiver service definition. RCAC Wisconsin Administrative Code ch. DHS 89 requires that an RCAC maintain a home-like environment defined as follows: all residential care apartment complexes must provide each tenant with an independent apartment in a setting that is home-like and residential in character; make available personal, supportive and nursing services that are appropriate to the needs, abilities and preferences of individual tenants; and operate in a manner that protects tenants' rights, respects tenant privacy, enhances tenant self-direction, self-reliance and supports tenant autonomy in decision-making including the right to accept risk.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Certified RCAC

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Certified RCAC
Provider Qualifications
License *(specify):*

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment and Supplies

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*
Specialized medical and therapeutic supplies include items necessary to maintain the participant's health, manage a medical or physical condition, improve functioning or enhance independence. The cost of items, or devices provided, may be in excess of the quantity of medical equipment or supplies covered under the Medicaid state plan, when coverage of the additional items or devices is denied. Items or devices provided must demonstrate direct medical or remedial benefit to the participant.
Allowable items, devices or supplies include:
• Incontinence supplies
• Wound dressings
• Intravenous or life support equipment
• Orthotics
• Nutritional supplements and associated supplies and equipment not covered under the Medicaid State Plan but needed for the participant to obtain adequate nutrition
• Vitamins
• Over-the-counter medications
• Skin conditioning lotions/lubricants.

Additional allowable items may include books and other therapy aids designed to augment a professional therapy or treatment plan. Room air conditioners, air purifiers, humidifiers and water treatment systems may be allowable when recommended or prescribed by the participant's physician.

Electronic medication compliance management devices includes pieces of equipment that store a participant's medication, notify the participant when to take the medication, and dispenses the correct medications at the appropriate time.
Medications are loaded into the device, which typically holds up to a month's supply of prescribed drugs. The device visually and audibly notifies the person when to take the medication. The device supports the dispensations of medication at the correct time of day, in correct combinations, in correct quantities, and with correct instructions (i.e., take with food). Some devices send telephonic warning alerts to caregivers while continuously tracking medication adherence and providing data for care management.
Electronic medication compliance management devices, including all components and accessories not otherwise classified, are allowable unless covered by the participant's Medicaid ForwardHealth Card or other insurance. Devices can be purchased or rented according to purchase agreements established by DHS.

The devices require a telephone landline; therefore, if a telephone landline is not present in the home, installation and on-going costs of that service may also be covered in the IRIS program.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Excludes items considered as and regulated by the federal Food and Drug Administration (FDA) as nutritional supplements unless specifically covered under this definition or under the Medicaid State Plan.

The IRIS program only utilizes DHS approved vendors for electronic medication compliance management devices.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Purchase of services - other merchants
Agency	Authorized DME Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Individual
Provider Type:
Purchase of services - other merchants
Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
All items and supplies shall meet applicable standards of manufacture, design, installation, safety and treatment efficacy. Items purchased must meet a reasonable buyer expectation of quality and performance. Items considered DME must meet Wisconsin Administrative Rule DHS 105.40:
https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/40

Verification of Provider Qualifications

Entity Responsible for Verification:
FEAs verify the provider qualifications of individual providers.
Frequency of Verification:
At time of purchase

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies

Provider Category:
Agency
Provider Type:
Authorized DME Vendor
Provider Qualifications

License *(specify):*
DHS 105.40 Wisconsin Administrative Code
Certificate *(specify):*

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

The DHS approved three vendors to rent or sell Medication Management devices to IRIS participants. The IRIS program requires the use of the appropriate modifier for the telephone costs, according to the vendor selected.

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:
At time of purchase

Appendix C: Participant Services

C-1/C-3: Service Specification

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

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

Service Title:
Specialized Transportation 2

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Same as other - added another service category for budget break out needs in Appendix J
Specify applicable (if any) limits on the amount, frequency, or duration of this service:

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Same as other for this service category

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Transportation 2

Provider Category:
Individual
Provider Type:
Same as other for this service category
Provider Qualifications
License *(specify):*
Same as other for this service category
Certificate *(specify):*
Same as other for this service category
Other Standard *(specify):*
Same as other for this service category
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of individual providers takes place through a centralized system using a State-approved process completed by the participant's chosen FEA.
Verification of providers which require a license or certification will be validated and maintained by the Third Party Administrator.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Transportation

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Specialized transportation services pay for the cost to transport a participant who does not have reasonable access to appropriate other transportation. The transportation maintains, or improves, the participant's mobility in the community, increases independence and community participation, and prevents institutionalization. Community is broadly defined, and is not limited to, the boundaries of any particular municipality.

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

Use of natural, or community supports, to provide transportation services should be the utilization priority. Specialized transportation is an allowable IRIS Program service when unpaid transportation is not available to participants to support community access to obtain services, use necessary community resources, and to participate in community life.

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

A trip is defined as transportation of the participant from one location to another location. The participant must be physically present in the vehicle for half of the trip. A mileage rate does not include payment for mileage when the participant is not in the vehicle. For each time specialized transportation is used, either the pre-determined trip rate OR the "per mile" rate must be used. The participant's Individual Support and Service Plan must reflect the pre-determined billing method and rate.

Specialized transportation may also be approved as mileage according to the Federal IRS rules related to mileage reimbursement and DHS established limits. Mileage is calculated based on the starting and ending points and is approved by the number of miles needed. Mileage, when transporting more than one IRIS participant, must be split between the plans so that each mile is billed once. The IRIS mileage rate includes the cost of gasoline, oil, insurance and all other car maintenance costs. The mileage rate does not include other costs such as wages paid to the driver or attendant.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Specialized transportation cannot pay for the transportation to/from school, as this is an obligation of the school.

• The mileage reimbursement rate may not be supplemented to cover vehicle operating, maintenance or repair costs.

• Vehicle adaptations and modifications are excluded (these are considered adaptive aids).

• Specialized transportation does not include the participant transporting self to a location.

• Specialized transportation excludes transportation mileage, and other related expenses, when the destination is a vacation. Renting a vehicle while on vacation is not an allowable expense.

• Specialized transportation excludes the mileage incurred when a caregiver runs errands and the participant is not in the

vehicle (supportive home care).

• Excludes transportation services to and from Medicaid medical providers as such transportation is funded by the participant's Medicaid ForwardHealth Card through the State's transportation broker.

• Costs for the participant or participant's family to maintain a vehicle are excluded.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Mass transit provider, taxi or common carrier, specialized transportation provider
Individual	Individual provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Transportation

Provider Category:
Agency
Provider Type:
Mass transit provider, taxi or common carrier, specialized transportation provider
Provider Qualifications
License *(specify):*

Certificate *(specify):*
• Mass transit – Wisconsin Statute § 85.20: http://docs.legis.wisconsin.gov/statutes/statutes/85/20
• Taxi or common carrier – Wisconsin Statute § 194: http://docs.legis.wisconsin.gov/statutes/statutes/194.pdf
• Specialized transportation provider – Wisconsin Statute § 85.21, Wisconsin Administrative Rule DHS 61.45: https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/61/II/45
Other Standard *(specify):*
Providers must provide evidence that the vehicle style and condition can provide transportation safely.

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

Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

FEAs verify the provider qualifications of individual providers.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Transportation

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

Certificate *(specify):*

Other Standard *(specify):*
1. Individual or volunteer providers of transportation services must provide documentation of current liability insurance coverage, possess a valid driver's license and provide written assurance of the following:
a. The vehicle being used is mechanically sound, has properly functioning lights, safety, ventilation and braking systems, and
b. The vehicle has properly inflated tires, without excessive wear.
2. All transportation providers, meeting the definition of caregiver, are subject to the required criminal, caregiver and licensing background checks.
3. Providers of specialized transportation services to IRIS participants must communicate with other providers within confidentiality laws about any occurrences or situations regarded as critical incidents.
4. Providers of specialized transportation services to IRIS participants must promptly communicate with the IRIS consultant, and/or the county adult protective services unit, regarding any incidents or situations or conditions that have endangered, or, if not addressed, may endanger the health or safety of the participant.

Verification of Provider Qualifications
Entity Responsible for Verification:
FEAs verify the provider qualifications of individual providers.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Support Broker

HCBS Taxonomy:

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

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

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

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

Service Definition *(Scope):*
A support broker is an individual who assists participants in planning, securing and directing self-directed supports.

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Support Broker Agency
Individual	Individual Support Broker

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Support Broker

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

Certificate *(specify):*

Other Standard *(specify):*
An individual may be considered a qualified support broker only when they demonstrate adequate knowledge of the unique needs/preferences of the participant and the participant's specific target group, and they have knowledge of the local service delivery system and local resources available to the participant. Criminal and Caregiver background checks are required. The participant can decide the amount and type of training they require of the support broker.
Verification of Provider Qualifications
Entity Responsible for Verification:

Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Support Broker

Provider Category:

Individual

Provider Type:

Individual Support Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

FEAs verify the provider qualifications of individual providers.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Employment - Group

HCBS Taxonomy:

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

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

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

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

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

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

Service Definition *(Scope):*
Supported employment-Small Group employment support are services and training activities provided in regular business, industry and community settings for group of two (2) to eight (8) workers with disabilities. Mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community are considered small group employment support. Supported employment small group employment support must be provided in a manner that promotes integration into the workplace and interaction between participants and people without disabilities in those workplaces. A required outcome of this service is sustained paid employment and work experience leading to further career development and individual integrated community-based employment for which a participant 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. Small group employment support does not include vocational services provided in facility based work settings.

Participants receive the tools, resources, and information annually to assist in making an informed choice about which supports and services to select to meet their employment-related outcomes during the person-centered planning process. Participants should consider group supported employment services only when individual options are unavailable or the person's preference is group services. The appropriateness of the selected supports and services are reviewed annually at minimum.

Supported employment small group employment supports may include any combination of the following services: vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefits support, training and planning transportation and career advancement services. Other workplace support services may include services not specifically related to job skill training that enable the waiver participant to be successful in integrating into the job setting.

The outcome of small group supported employment support service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce, in a job that meet personal and career goals.

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

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

A participant's person-centered plan may include two or more types of non-residential services.

Supported employment small group employment support services may be provided by a co-worker or other job site personnel provided that the services that are furnished are not part of the normal duties of the co-worker, supervisor, or other personnel and these individuals meet the pertinent qualification of the providers of service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Supported employment small group employment supports do not include payment for supervision, training, support and adaptations typically available to other non-disabled workers filling similar positions in the business. IRIS is the funding source of last resort for employment services.

• If the participant has an open case with WI DVR, those funds must be used before any IRIS funds can be utilized.

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

• Federal financial participation is not claimed for incentive payments, subsidies or unrelated vocational training expenses such as:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or
2. Payments that are passed through to users of supported employment services

• Supported employment small group employment support does not include vocational services provided in facility-based work settings or other similar types of vocational services furnished in specialized facilities that are not a part of general community workplaces.

• Supported employment small group employment does not include volunteer work.

• Different types of non-residential services may not be billed for the same period of time.

• Vocational services provided in facility-based work settings or other types of vocational services furnished in specialized facilities that are not part of general community work places.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Prevocational Provider, Supported Employment Agency, or Community Rehabilitation Program (CRP)

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Employment - Group

Provider Category:
Agency
Provider Type:
Prevocational Provider, Supported Employment Agency, or Community Rehabilitation Program (CRP)
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Providers of Supported Employment services must meet the applicable standards set forth by the Wisconsin Department of Vocational Rehabilitation (WI DVR). Information on the certification requirements for WI DVR can be found at: https://dwd.wisconsin.gov/dvr/service_providers/agreement_for_services.pdf.

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

In addition, the provider must comply with all applicable occupational health and safety standards of the federal Occupational Safety and Health Administration (OSHA).
Other Standard *(specify):*
For self-employment, providers must have knowledge of the unique needs/preferences of the participant and knowledge of self-employment best practices.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:
Supportive Home Care

HCBS Taxonomy:

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

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

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

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

SHC services include:

1. Personal Services
   a. Assistance with activities of daily living such as eating, bathing, grooming, personal hygiene, dressing, exercising, transferring and ambulating;
   b. Assistance in the use of adaptive equipment, mobility, and communication aids;
   c. Accompaniment of a participant to community activities;
   d. Assistance with medications ordinarily self-administered;
   e. Assistance with making and attending appointments;
   f. Attendant care;
   g. Supervision and monitoring of participants in their homes, during transportation (if not done by the transportation provider), and in community settings;
   h. Reporting observed changes in the participant's condition and needs;
   i. Extension of therapy services. "Extension of therapy services" includes activities by the SHC worker which assist the participant with Physical Therapy/Occupational Therapy or other therapy/treatment plan. Examples include assistance with exercise routines, range of motion exercises, standing by during therapies for safety reasons, having the SHC worker read the

therapist's directions, helping the participant remember and follow the steps of the exercise plan, or hands-on assistance with equipment/devices used in the therapy routine. The extension of therapy services does not include the actual therapist-provided service; and,

j. Medication reminder services and electronic support equipment, provided via a phone call, text message or electronic notification, in the home.

2. Household Services

a. Performance of household tasks and home maintenance activities including meal preparation, shopping, laundry, house cleaning, simple home repairs, snow shoveling, lawn mowing, running errands, paying bills (at the direction of the participant); and,

b. Assistance with packing/unpacking and household cleaning/organizing when a participant moves.

The participant is encouraged to negotiate lower costs when a worker is on-call (available to work and provide non-active caregiving in a companionship role) or if the services occur at night while the participant sleeps (time frame defined individually depending on the participant's schedule and needs). A night shift should not exceed eight hours.
Additional modifiers, included in the list below, allow for creative acquisition of services using flat fees or lower rates for on-call and night care. The service authorization in the participant's ISSP should indicate the approved hours in the day using these codes/modifiers.

Different levels of supportive home care services include:

1. Routine care services classified as both personal services and household services include hands-on services and those provided on a scheduled basis. Participants may employ providers of routine services or hire through an agency.

2. Chore services typically include lawn care, snow removal, laundry services and house cleaning. Chore services may be paid with a flat rate for the service or on an hourly basis. Participants may employ providers of chore services or hire through an agency.

3. Supervision care services are services provided as an oversight to the participant. In these situations, the participant can complete tasks, but need oversight and guidance to complete the task properly and safely.

4. Companionship care services are services provided as in-home support to participants not needing hands-on care, but who require an attendant should a support need arise. Generally, the rate paid for companionship care is lower than the other supportive home care services.

5. Community Integration Events (CIE): CIE worker expense reimbursement provides reimbursement for participant-hired workers attending CIEs with a participant, because the participant has long-term care needs which necessitate the worker's presence at the event. This reimbursement is limited to the worker's expense only; the participant portion of the expense is the responsibility of the participant. Reimbursement is issued directly to the IRIS participant-hired workers.

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

Meals
If the CIE necessitates a meal purchase at the event and if event rules restrict outside food, the support worker is eligible for meal reimbursement. The action of a participant eating a meal at a restaurant as a CIE, in and of itself, does not meet the qualifications of an event necessitating a meal purchase by the support worker and is not an allowable staff reimbursement expense. Similarly, CIEs such as planned meals including, but not limited to, celebrations or other family traditions (e.g., birthday meals, anniversary meals, holiday meals, Sunday brunch) also do not meet the criteria of an allowable staff meal reimbursement expense.

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

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

Pursuant to Olmstead Letter No.3, Attachment 3-c, in order to assure continuity of care, services may include personal assistance retainer payments for up to 15 consecutive days where there is a reasonable probability that in their absence the

member would not be able to retain a preferred home care worker because the worker would seek other employment, or if the worker is employed by an agency, would be reassigned and may not return to serving the member.

Retainer payments may be made under the following medically-related and non-medically related circumstances as applicable to the participant:

a. Medically- Related
• Hospitalization;
• Nursing home or ICF-I/ID admission ;
• Receipt of medical or rehabilitative care entailing at least an overnight absence; or
• Participation in a therapeutic rehabilitative program as defined in DHS 101.03(175).

There is no yearly limit on the number of medically-related episodes for which retainer payments may be made.

b. Non-Medically Related
• Planned vacation entailing at least an overnight absence and unaccompanied by the worker;
• Visit to relatives or friends unaccompanied by the worker and entailing at least an overnight absence;
• Obtaining education, employment, or job, habilitative or self-advocacy training unaccompanied by the worker and entailing at least an overnight absence; or
• Recreational activities unaccompanied by the worker entailing at least an overnight absence.

Retainer payments may be made for no more than four (4) non-medically related episodes in a calendar year.

The participant shall determine the amount of the per diem retainer payment, not to exceed 75% of the authorized rate amount, which shall be sufficient to accomplish the purpose of providing a reasonable probability of retaining the worker for the member.

All workers must comply with the Training and Documentation Standards for Supportive Home Care and In-Home Respite Care.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
• Services available through the Medicaid State Plan are excluded;

• Training provided to a participant intended to improve the participant's ability to independently perform routine daily living tasks is excluded (this may be provided as daily living skills training);

• Any service provided under another waiver service definition is excluded;

• Services such as grocery shopping, meal preparation, laundry, yard work, and cleaning not for the exclusive benefit of the participant are excluded;

• "Live-in caregiver" services are excluded;

• Representative payee services are excluded;

• Agencies are excluded from worker expense reimbursement; and,

• Payroll bonuses are not allowed.

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

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supportive Home Care

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

Certificate *(specify):*

Other Standard *(specify):*
Participant-hired workers may provide services only after receipt of sufficient training and employer-provided orientation. In addition, participant-hired workers must meet all other employment eligibility requirements including passing the caregiver and criminal background check upon employment, and every four years thereafter.
Verification of Provider Qualifications
Entity Responsible for Verification:
FEAs verify the provider qualifications of individual providers.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supportive Home Care

Provider Category:
Agency
Provider Type:
Supportive Home Care agency, Home Health Care agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
DHS 105.17 Wisconsin Administrative Code
Other Standard *(specify):*
Supportive Home Care agencies and Home Health Care agencies provide services compliant with Wisconsin Administrative Rule DHS 105.17: https://docs.legis.wisconsin.gov/code/admin_code/dhs/101/105/17.

Qualifications and requirements for electronic support equipment vendors include that they are a Medicaid certified provider. The devices must meet all applicable laws, regulations and standards for the manufacture and design for safety and utility. Electronic support equipment should be installed and repairs made only by individuals adequately trained in the installation or repair of the equipment, or according to manufacturer's instructions.
Verification of Provider Qualifications
Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agents.
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vocational and Futures Planning

HCBS Taxonomy:

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

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

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

Service Definition *(Scope):*

Vocational futures planning and support (VFPS) is a person-centered, team-based comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in employment or self employment/microenterprise.

The agency providing VFPS services will ensure that the following service strategies are available as needed to the participant:

Development of an employment plan is based on:

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

VFPS must be provided by qualified professionals that include, for example, an employment specialist, a benefits specialist and an assistive technology consultant. When this service is provided the participant's record must contain activity reports, completed by the appropriate VFPS Team member(s), within thirty (30) days of completing a particular service strategy. When ongoing support is provided, monthly ongoing support reports must be completed by the provider of the on-going support and provided to the participant. The IRIS Consultant will ensure that these reports are included as part of the participant's record.

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

VFPS furnished under the waiver excludes services available from a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17).

VFPS excludes services provided as prevocational or supported employment. Such services may be used to supplement, but may not duplicate any VFPS services provided under the waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Vocational and Futures Planning Professional

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vocational and Futures Planning

Provider Category:
Individual
Provider Type:
Vocational and Futures Planning Professional
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
VFPS furnished under the waiver excludes services available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17).

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:
Verification of providers which require a license or certification will be validated and maintained by the Fiscal Employer Agent.
Frequency of Verification:
Annually

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- [x] **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- [ ] **As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- [ ] **As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- [ ] **As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ◉ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

a. 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 applicant 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 conducts reviews of samples of participant-hired workers to ensure the completion of these background checks.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

a. The SMA, as required under Wisconsin Administrative Codes Chapter DHS 12 and DHS 13, maintains a registry of caregivers as an official record of persons found to have abused or neglected a client or misappropriated a client's property.

Wisconsin Administrative Code DHS Chapter 12 identifies convictions that the Wisconsin State Legislature, under the Caregiver Law, ss. 48.685 and 50.065, Stats., has determined either require rehabilitation review approval before a person may receive regulatory approval, may work as a caregiver, may reside as a non-client resident at or contract with an entity, or that act to permanently bar a person from receiving regulatory approval to be a foster parent. Applicants with a conviction of any crimes on the permanent bar list the worker are denied employment and cannot be paid with IRIS or Medicaid funds. The IRIS program does not have a process by which rehabilitation is reviewed.

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

The ICAs and FEAs, as well as all other entities that are licensed or certified by or registered with the department to provide direct care or treatment services to clients, are required to report to the SMA any allegation of abuse or neglect or misappropriation of client property committed by any person employed by or under contract with the entity. OIM describes the incident reporting process in Appendix G.

b. Positions for which abuse registry screenings must be conducted include all waiver service providers, paid or unpaid, listed on the individual service plan who have regular, direct contact with waiver participants and all persons employed by or under contract with an entity that is licensed or certified by or registered with the department to provide direct care or treatment services to clients,

c. OIM's contract with the FEAs requires FEAs to ensure that all persons working as caregivers have had required registry checks completed. The FEAs will conduct registry checks for participant-hired workers and will verify that agency providers comply with registry check requirements.

The SMA conducts reviews of the providers' performance to ensure required registry checks were completed and a related performance measure is in place to report compliance with this activity.

Appendix C: Participant Services

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

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

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ◉ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

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

Facility Type	

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

Required information is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible

individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

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 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.

IRIS consultants report any concerns about potential payment for unworked hours to the individual(s) at their ICA who are responsible for Fraud Allegation Review and Assessment (FARA). The FARA team completes a FARA and mitigates any risk. OIM 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.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

Individuals who may be paid include relatives, spouses and guardians. Relatives include blood or adoptive relatives, and those individuals related by marriage such as step-parents, step-siblings, step-grandparents, step-aunts/uncles/cousins etc. These individuals may provide specific services as noted by the checkbox as noted in service specifications within Appendix C provided they meet specified qualifications. Specifically, these services are: 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.

IRIS consultants report any concerns about potential payment for unworked hours to the individual(s) at their ICA who are responsible for Fraud Allegation Review and Assessment (FARA). The FARA team completes a FARA and mitigates any risk.

OIM permits the IRIS consultants to make unannounced visits if necessary to determine if fraud is occurring. In situations wherein the guardian is the one committing the fraud, the participant may be disenrolled from the IRIS program as a result. The FARA process is described in the IRIS work instructions manual section 10.1A.1.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

All willing providers who demonstrate evidence of meeting the provider eligibility requirements in Appendix C-3 are eligible to serve IRIS participants. OIM contracts with the IRIS consultant Agencies and fiscal employer agents and require through the ICA and FEA provider certification process that those organizations be familiar with provider enrollment procedures, timelines, and responsibilities relative to the verification of provider qualifications.

IRIS participants, or legally responsible party, identify the agencies or participant-hired worker applicants. The IRIS consultants are responsible to provide the necessary tools, resources, information, and support to participants in locating providers. Participants can also retain the services of a support broker to help locate providers.

The IRIS consultants support participants and the identified providers or participant-hired workers to accurately and thoroughly complete provider enrollment and qualification verification, including all required background checks release forms. The Wisconsin Self-Direction Information Technology System (WISITS) maintains information on providers, including participant-hired workers that are already registered and have had their qualifications including applicable background checks verified. In these cases, the provider is immediately available to be selected during the development of the ISSP in WISITS.

ICAs and Aging and Disability Resource Centers (ADRCs) can provide lists of providers are at the request of the participant. However, as noted previously, most participants have selected the IRIS program so that they can individually recruit and select their providers.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of active providers (non-participant hired workers) that meet provider verification requirements as verified by the FEA. Numerator/Denominator: The number of active providers (non-participant hired workers) who met provider verification requirements over the total number of active providers (non-participant hired workers).

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of active participant hired workers with appropriate criminal background and caregiver registry checks as verified by the FEA. Numerator/Denominator: The number of active participant hired workers with appropriate criminal background and caregiver registry checks over the total number of active providers (non-participant hired workers).

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

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

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of participant-hired workers for whom there was a signed document, "Supportive Home Care/Self-Directed Personal Care/Respite Training Verification" (F-01201B). Numerator/Denominator: Number of participant-hired workers with a signed F-01201B over the number of new participant-hired workers in WISITS.

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

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The FEAs perform criminal background checks, perform caregiver registry checks, and ensure all providers sign Medicaid provider agreements. Verification of any licensure or certification requirements, or other required standards of individuals or agencies are required to be validated and documented prior to the provider being available in WISITS for selection during plan development. The ICAs collect employment related paperwork for employees directly hired by IRIS participants, such as I-9s, and ensure the applicant completed the paperwork correctly. FEAs are responsible for maintaining records for participant-hired workers and individual or agency providers. FEAs maintain the appropriate information in WISITS such that service utilization and budget information is readily available to the IRIS consultants and participants to aid in exercising budget authority. WISITS houses all information and data from the ICAs and FEAs enabling OIM to conduct administrative oversight of these activities and participants to have access to their budget information.

The OIM requires the FEA to provide full access to documentation of completed background checks for each participant-hired worker. FEAs provide a report to OIM on results of its internal quality assurance process following each payroll on a quarterly basis. Through these discovery methods, OIM is able to identify issues or concerns with the FEAs in implementing this process effectively or in documentation requirements. OIM addresses any issues identified through this discovery with the FEAs and require remediation or corrective action as needed.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The 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.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

◉ **No**
○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

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

Participants may access additional funds through the budget amendment or one-time expense request process as described in Chapter 5 of the IRIS policy and work instruction manuals.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☑ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

DHS' Bureau of Long Term Care Financing (BLTCF) worked with their contracted actuaries to develop a regression model that predicts an individual's IRIS expenditures using the members' LTC FS information. The model was developed based on individuals' expenditures in IRIS and their corresponding LTC FS. The resulting statistical models are used to set the budgets for IRIS participants. This model will be updated annually.

OIM calculates 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.

All services in Appendix C-3 are funded by this individual budget allocation with the exception of IRIS Consultant Services and Fiscal Employer Services that are requirements of participation of the IRIS program and are therefore not charged to the participant's budget.

Participants may access additional funds through the budget amendment or one-time expense request process as described in Chapter 5 of the IRIS policy and work instruction manuals. If a person needs additional services as the result of a change in condition, the participant will report the change in condition to the IRIS Consultant and a change in condition Long Term Care Function Screen will be administered. Any change in budget will be considered prior to determining the need for a budget amendment or one-time expense. Participants may exercise their State Fair Hearing rights in cases where budget amendment or one-time expense requests are denied. Participants who are reside in adult family homes or RCACs are not eligible for budget amendments or one-time expense requests. Exceptions are considered by OIM for those participants for whom their budget is reduced following an annual LTC FS and they are unable to negotiate a rate within the new budget and may be required to relocate as a result.

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

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

1) The Division of Long Term Care (DLTC) has assessed and determined that the following residential and non-residential settings meet the requirements of 42 CFR § 441.301(c)(4):

* Participant's private residences, whether owned or rented, including when voluntarily shared with family, friends or chosen residence mates, that are not regulated residential settings for persons with disabilities.
* Places of integrated, competitive employment.
* Community sites predominantly used by the general public for typical community activities, unless specifically prohibited by 42 CFR 441.301(c)(5), including but not limited to: retail establishments; schools; recreational and entertainment facilities; libraries; places of religious worship; public and private transportation settings such as buses, trains and private vehicles; restaurants; community centers; service establishments; streets; and other public accommodations.

DLTC has determined that these settings are not provider owned or controlled residential settings; are integrated in the greater community, or in the case of residences in rural settings are the person's choice and consistent with the character of such communities; do not segregate or isolate participants, except with respect to private residences in rural areas where such is the chosen preference of the person; provide opportunities for regular interaction in daily activities with non-HCBS waiver participants; facilitate individual choice in services, daily activities and assumption of typical, age-appropriate social roles; and support rights to dignity, respect, autonomy and freedom from coercion.

2) To assure continuing compliance with setting requirements the DLTC will:

* Put requirements in its ICA and FEA contracts to assure compliance and ongoing assessment of settings in which waiver services are provided; and
* Inform members, through the IRIS Participant Handbook, of the settings requirements and how to report any concerns in regards to the settings in which they receive services.

Appendix D: Participant-Centered Planning and Service Delivery

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

State Participant-Centered Service Plan Title:
Individual Support and Service Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- ☐ **Registered nurse, licensed to practice in the State**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- ☐ **Licensed physician (M.D. or D.O)**
- ☑ **Case Manager** (qualifications specified in Appendix C-1/C-3)
- ☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

  Specify qualifications:

- ☐ **Social Worker**

  Specify qualifications:

- ☐ **Other**

  Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- ◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- ○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

During orientation and annually, participants receive regular education related to all aspects of plan development in a self-directed program including but not limited to information about:

* Person-centered principles and processes
* Roles of legal and non-legal representatives in the ISSP development process
* Strategies for developing an Individual Support and Service Plan (ISSP) that addresses all aspects of the participant's life
* Available supports and services
* Strategies for finding, training, and managing service providers, including participant-hired workers
* Strategies managing an individual budget
* Processes for changing supports and services
* Tools and resources available for use during the planning process

On an ongoing basis, the participant can receive information and support from the IRIS consultant, IRIS Consultant Agency, and Fiscal Employer Agent with whom they have chosen to do business. While the IRIS Consultant is required to meet with the participant quarterly and have monthly phone contacts, the participant has the right to contact the IRIS Consultant at any time to obtain support and information regarding the IRIS program.

The participant (or legal representative) has the right to include anyone they choose in the plan development process including family members, medical or behavior professionals, and other sources of support. Legal and non-legal representatives are required to ensure that the final ISSP reflects the participant's voice.

Appendix D: Participant-Centered Planning and Service Delivery

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

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

A) The Individual Support and Service Plan (ISSP) is developed by the participant (or legal representative), under the guidance of the IRIS consultant, with the support of individuals of the participant's choosing. The IRIS consultant facilitates the completion of the paperwork and data entry relative to the completion of the ISSP.

The participant and the IRIS consultant develop the initial ISSP during the 90-day orientation period. The participant's start date in the IRIS program is the date of implementation of the initial ISSP. At minimum, the participant and the IRIS consultant formally review and update the ISSP annually. The participant and the IRIS consultant must also formally review and update the ISSP when a change in the condition of the participant occurs. During every quarterly face-to-face visit and every monthly phone contact, the IRIS consultant and participant informally review the ISSP. In all situations, formal or informal, in which a need or desired change is identified the IRIS consultant is responsible to assist the participant in updating the ISSP.

B) The participant and the IRIS consultant have several assessments used to help identify the participant's needs, determine which services and supports the participant needs to meet their needs, as well as the appropriate quantities of the identified supports and services.

* The Long Term Care Functional Screen (LTC FS) helps identify the participant's needs relative to the participant abilities to complete activities of daily living and instrumental activities of daily living as well as medical and behavior needs
* The Behavior Assessment helps identify behavior needs
* The Home and Community Support (HCS) Assessment helps quantify the amount of supportive home care needed by the participant to meet their needs.

In the event that a participant disagrees with the number of supportive home care hours recommended by the HCS Assessment, the participant can request reconsideration by the Office of IRIS Management (OIM). Participants can request OIM to review the HCS Assessment and information supporting the request for hours above what the assessment supports. OIM issues a Notice of Action and information about exercising State Fair Hearing rights in denials of requests for additional hours.

C) OIM requires the following discussion components during the planning process. Participants and IRIS consultants use the aforementioned tools to identify the participant's needs. From there, the participant and the IRIS consultant identify long-term care outcomes to address the participant's needs. The participant then identifies supports and services to address the identified outcomes. The participant and IRIS consultant first explore unpaid and natural supports, then supports and services funded by non-waiver services such as Medicaid card services are explored, followed by services and support funded by the IRIS program. The IRIS waiver funding is the funding source of last resort. The IRIS consultant is required to assist the participant in evaluating the services and supports that will most effectively meet the participant's needs. As a written resource, the participant has access to the document, "IRIS Service Definition Manual" (P-00708B) which defines each service available in the IRIS program including the requirements for provider qualifications. IRIS consultants must be skilled in explaining available services and supports from all funding sources.

D) IRIS Consultants are required to document the participant's needs and preferences that were identified through a collaborative review of the aforementioned tools and exploratory discussion about needs and preferences. Prior to concluding the ISSP development, IRIS consultants must cross-reference the documentation of the planning conversations with the participant to ensure the ISSP meets all of the identified needs and preferences.

When one of the participant's chooses not to address one of their needs or preferences on the ISSP, the IRIS consultant discusses this choice with the participant. If the participant elects to not address the identified need or preference through a supported long-term care outcome, this conversation must be documented including the IRIS consultant's effort to encourage the participant to address the need. In cases wherein the unaddressed need is related to health and safety or presents another type of risk, the IRIS consultant completes the document, "Risk Agreement – IRIS Program" (F-01558) with the participant to document information and resources provided to the participant and to document any risk of involuntary disenrollment of the participant (when appropriate).

ICAs are required to ensure that the ISSPs developed by their IRIS consultants meet the needs of the participant as required by this waiver and IRIS program policy and work instructions. OIM conducts record reviews that evaluate a sample of participant ISSPs to ensure that the ISSPs adequately meet the participant's needs and long-term care outcomes. ICAs will be required to remediate any individual negative findings as well as complete quality management templates to improve insufficient performance.

E) When the participant and IRIS consultant have identified services and supports to meet the participant's needs as described by the participant's long-term care outcomes, the participant determines whether they will be serving as the employer of record, using agency providers, or using a combination of agency services and participant-hired workers.

When the participant chooses to employ participant-hired workers, the participant identifies the workers and provides them with the new hire paperwork. The participant also completes the required paperwork to obtain a Federal Employer Identification Number (FEIN) and other paperwork required by the FEA to establish the participant as an employer. The IRIS consultant is required to ensure that the employer paperwork and the new hire packets are completed accurately before sending them to the FEA for processing. Sending accurate and complete paperwork helps the FEA expedite the hiring process for the participant.

The FEA completes the criminal and caregiver background checks, processes the paperwork, enters the participant's FEIN and other employer-related information into WISITS, adds participant-hired worker information into WISITS, and notifies the participant and participant-hired workers of the start date.

No participant-hired worker or agency provider may receive IRIS funding for hours performed in advance of the start date. It is a requirement of the IRIS program that IRIS funds will not be issued for hours completed before all provider requirements outlined in Appendix C, including the criminal and caregiver background checks, are completed and a start date is given.

FEAs complete criminal and caregiver background checks. The IRIS program reviews additional convictions beyond those listed on the permanent bar list in Chapter 12 of the Wisconsin Administrative Code and Wisconsin Statute 50.065 when validating the qualifications of participant-hired workers. The purpose of this is to ensure the participant's safety due to the enhanced vulnerability of the participant when serving as the employer of record. OIM furnished a list of additional convictions in the appendix of section 6.1B.1 in the document, "IRIS Policy Manual: Work Instructions".

Participants and applicants can complete the form, "Background Check Appeal Request – IRIS Program" (F-01352) to appeal denials of employment based on convictions of crimes listed in the appendix of section 6.1B.1 in the document, "IRIS Policy Manual: Work Instructions". OIM reviews these requests and either approves or denies employment. Applicants for whom OIM denies the appeal may contact the Wisconsin Department of Workforce Development for additional recourse. This decision is not subject to the State Fair Hearing process because there was no denial, reduction, limitation, or termination of services .

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.

F) The IRIS consultants are required to ensure participants have the tools, resources, and information needed to implement the ISSP. The participant is responsible for implementing the ISSP. IRIS consultants are required to complete monthly phone contacts and quarterly visits to monitor the implementation of the ISSP. Participants have the right to contact their IRIS consultant at any time if concerns with the implementation of the ISSP arise.

G) Participants have the obligation to notify their IRIS Consultant of changes in their condition that either positively or negatively affects their ability to complete activities of daily living or instrumental activities of daily living immediately. ICAs are required to ensure completion of a change of condition LTC FS. Participants and their IRIS Consultants are required to review the results of the LTC FS and the efficacy of the current ISSP to ensure continued appropriateness. In cases wherein the participant requires a change in the type or frequency of services, the IRIS consultant facilitates the ISSP update. When the cost of a participant's needs exceed the budget estimate, the IRIS consultants are required to assist the participant in completing the paperwork for a budget amendment or one-time expense request.

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, 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

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 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 are able to define their own practices for assessing risks to participants during the ISSP development process.

OIM monitors the health and safety of participants through 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 back-up plans in the event that needed services are for any reason not accessible. Emergency back-up 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 back-up providers
* contact information for service providers including medical providers and the IRIS Consultant
* other pertinent participant-specific information

ICAs may implement their own emergency back-up plan format approved by OIM. All formats must provide sufficient information to ensure a back-up 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 back-up plan as part of the ISSP development process. The participant and the IRIS Consultant review the accuracy and effectiveness of the emergency back-up 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 back-up plan.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The IRIS consultant agencies are required to ensure participants have the necessary tools, resources, and information to assist them in identifying qualified participant-hired workers, providers, and vendors. IRIS consultants are required to have a list of providers and vendors in their area. Aging and Disability Resource Centers can assist the ICAs in building their resource lists. IRIS participants select their own providers to deliver supports and services.

All providers and participant-hired workers meeting the provider or participant-hired worker requirements and already providing services to IRIS participants are listed in WISITS. Participant-hired workers already working for an IRIS participant who have been hired by another IRIS participant will need to submit separate paperwork to work under the second participant's FEIN, but will not have to undergo another criminal background check until four years have passed, or there is reason to believe the individual has been convicted of an applicable crime.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The participant, with the assistance of their IRIS consultant, completes the Individual Support and Service Plan (ISSP) and budget. In most cases, the IRIS consultants can approve the ISSP in the field. In some cases, the ICA may require IRIS consultants to obtain a secondary approval from the ICA. An example of such a case would be an ISSP in which the participant elected to include

Customized Goods and Services or a rate for a provider considered above the usual and customary for the region and service type. On behalf of the Office of IRIS Management (OIM), the ICA approves each participant's ISSP annually or more often if there is a change in the participant's needs or long-term care outcomes.

OIM completes record reviews to ensure the quality of the plans approved by the IRIS consultants. If OIM identifies any issues that are inconsistent with Medicaid requirements identified in this waiver application at any time, OIM ensures that the ICAs or FEAs remediate the negative findings. ICAs and FEAs must address system-level issues through the quality management plan process. OIM reviews ISSPs as part of the budget amendment or one-time expense request review processes.

Appendix D: Participant-Centered Planning and Service Delivery

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

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☑ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

A) The participant, in collaboration with the IRIS Consultant, is responsible for monitoring the implementation of the Individual Support and Service Plan (ISSP). The participant collaborates with the IRIS Consultant to ensure the services and supports are meeting the participant's needs, and if the participant's chosen providers are doing a satisfactory job of providing services. The participant is responsible for resolving identified issues, including matters of their own health and safety, through providing their providers with additional training, enlisting new providers, or communicating identified issues to their IRIS Consultant for assistance in solving the problem.

The IRIS Consultant has the responsibility of monitoring for problems with the implementation of the ISSP. When the IRIS Consultant identifies an issue with the quantity or frequency of services, or with the manner in which providers are providing the services, the IRIS Consultant has the added responsibility of communicating the issue to the participant and facilitating the resolution of the issue bearing in mind the participant's ability to self-direct. It is not the IRIS Consultant's job to case-manage the situation, but rather to provide the amount of guidance in the form of tools, resources, and information needed by the participant to resolve the problem.

Participants and IRIS consultants share in the responsibility of reporting critical incidents as defined in Appendix G. IRIS consultants are responsible for ensuring the immediate and ongoing health and welfare of the participants. IRIS consultants accomplish this through a wide range of activities from making reports to Adult Protective Services or law enforcement on behalf of the participant, down to providing participants with the tools, resources, and information required to address their own health and safety risks. Overall, the IRIS consultant has the responsibility to ensure the health and welfare of the participant. If the participant refuses, or is unable, to address their own health and safety, or refuses the assistance of the IRIS Consultant, the IRIS Consultant has

the responsibility to recommend involuntary disenrollment.

B) IRIS consultants monitor and ensure proper follow-up through the regular phone contacts and face-to-face visits with the participants. IRIS consultants also monitor the use of IRIS funds by the participants by reviewing budget utilization in WISITS. 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.

C) IRIS consultants meet with participants face-to-face quarterly and have monthly telephone contacts. Participants can contact their IRIS consultants for additional guidance or assistance at any time. IRIS consultants are required to respond to all participant requests for additional guidance or assistance. Conversely, participants who meet the criteria outlined in IRIS program policy and work instructions have the opportunity to request a decrease in the frequency of contacts to two face-to-face visits per year (every six months) and phone contacts every other month.

b. Monitoring Safeguards. *Select one:*

- (●) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ( ) **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

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

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants with service plans that address all participant needs including health and safety risks. Numerator/Denominator: Number of plans reviewed that addressed all participant needs including health and safety risks over the number of plans reviewed.

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

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
[x] **State Medicaid Agency**	[ ] **Weekly**	[ ] **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans that have participant-driven long-term care outcomes.
Numerator/Denominator: Number of plans that have participant-driven outcomes over the number of plans reviewed.

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

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

		Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of service plans with outcomes that are adequately supported.
Numerator/Denominator: Number of plans with outcomes that are adequately supported over the number of plans reviewed.

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

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

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

Performance Measure:
Number and percent of most recent service plans that were signed by the participant or legal representative. Numerator/Denominator: Number of current service plans that were signed by the participant or legal representative over the number of service plans reviewed.

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

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

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

Data Aggregation and Analysis:

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

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

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

Performance Measure:
Number and percent of participant records with an ISSP that was updated in the last 364 days. Numerator/Denominator: Number of participant records with an ISSP that was updated in the last 364 days over the number of participant records reviewed.

Data Source (Select one):
Record reviews, off-site

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of ISSPs updated appropriately to meet the participant's needs after a change in the participant's condition was identified. Numerator/Denominator: Number of ISSPs with appropriate updates after a change in the participant's condition was identified over the number of applicable ISSPs reviewed.

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

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*

☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:

Number and percent of participants who received services within the approved individual budget. Numerator/Denominator: Number of participants whose claims paid were within the current approved individual budget over the total number of participants reviewed.

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

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

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants that have a current signed choice form that specifies choice was offered among waiver services and providers. N/D: Number of records reviewed with a signed, current form, "Participant Education: IRIS Self-Direction Responsibilities" (F-01205) over the total number of records reviewed.

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

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The ICAs are responsible for administering all aspects of service plan development, including developing accurate service authorizations within the participant's individual budget estimate. ICAs must ensure services funded by IRIS must meet the waiver service definitions outlined in Appendix C. ICAs must ensure annual plan updates, change in condition plan updates, and plan updates related to a change in the participant needs or long-term care outcomes are completed timely and accurately. IRIS consultants are required to document all components of the service planning process in the WISITS system. OIM has administrative oversight over the ICAs and FEAs, and monitors these processes through related performance measures, record review indicators, and other reporting conducted by the ICAs, and independently via the WISITS system. The primary discovery method used by the OIM in overseeing service plans is the participant record review. OIM reviews service plans and other key documents contained in the participant's electronic record in WISITS to respond to several indicators related to service plan quality and person-centered planning documentation. OIM aggregates and analyzes results on a quarterly and yearly basis to identify trends and facilitate remediation of individual and systemic negative findings.

In addition to the record review, OIM aggregates service plan data electronically via the WISITS system and exports the data into reports for the purpose of identifying trends and facilitating individual and system-level remediation. Participant complaints, grievances, and appeals related to the ISSP process is another method of discovery. Complaints and grievances are addressed by the participant's ICA, FEA, or external agencies contracted by OIM to resolve participant complaints, grievances, and appeals (MetaStar or Disability Rights Wisconsin - ombudsman). Appeals are addressed through the State Fair Hearing process under the governance of an Administrative Law Judge (ALJ) from the Division of Hearings and Appeals (DHA). OIM collects and analyzes data regarding participant complaints, grievances, and appeals from a variety of internal and external data sources and reports including WISITS, OIM-owned SharePoint sites, and reports from MetaStar and DRW.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The ICAs are responsible for remediating all individual negative findings and system-level issues relative to the ISSP. The FEAs are required to remediate all individual negative findings and system-level issues relative to the verification of provider and participant-hired workers qualifications

OIM tracks the remediation of issues that are discovered through the participant record review. OIM prescribes other remediation activities using quality management plan templates and tracks remediation efforts through reviewing reports pulled from WISITS or submitted by ICAs and FEAs as evidence of progress on the quality management plans. OIM ensures the ICAs and FEAs perform identified corrections and provide follow up as needed.

ii. Remediation Data Aggregation

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

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

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

c. Timelines
When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- **No**
- **Yes**

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

Appendix E: Participant Direction of Services

Applicability*(from Application Section 3, Components of the Waiver Request)*:

- **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

NATURE OF PARTICIPANT-DIRECTION OPPORTUNITIES

IRIS is an entirely self-directed program meaning all participants in the program have elected to self-direct their own services. Individuals can exercise budget authority and employer authority as participants in the IRIS program.

HOW PARTICIPANTS ACCESS PARTICIPANT-DIRECTION OPPORTUNITIES

Participants access participant-direction opportunities in the IRIS program simply by choosing the IRIS program during enrollment counseling at the Aging and Disability Resource Center (ADRC). The participant then chooses to what extent they want to exercise their budget authority and employer authority.

Participants exercise their budget authority through the requirements of developing their Individual Support and Service Plan (ISSP) which includes the following ways:
* Participants, or legal representatives, engage independently with the IRIS consultant to develop their ISSP
* Participants can also choose to incorporate family members or friends in their planning process
* Participant may use their IRIS funding to purchase the supports of a support broker to help develop their ISSP and coordinate their services

Participants can exercise employer authority in the following ways:
* Participants choosing to serve as the employer of record are required to hire, train, and discipline their employees
* Participants can identify workers and hire them through an agency who serves as the employer of record
* Participants can hire agencies that provide workers hired by the agency and serve as the employer of record

Participants can change the extent to which they exercise their budget authority and employer authority at any time.

ENTITIES WHO SUPPORT INDIVIDUALS WHO DIRECT THEIR SERVICES

The Office of IRIS Management (OIM) certifies IRIS consultant agencies (ICAs) and fiscal employer agents (FEAs) and contracts with these providers to support IRIS participants in self-directing their services.

ICAs provide oversight to IRIS consultants (ICs) who support participants in self-direction in the following ways:

* Providing participants with education relative to IRIS program requirements
* Assisting participants in developing the Individual Support and Service Plan (ISSP)
* Ensuring the participant-hired worker new hire paperwork and agency provider paperwork is completed accurately
* Ensuring the health and safety of participants through monitoring activities and critical incident reporting
* Assisting participants to exercise budget authority and employer authority

FEAs support participants in self-direction in the following ways:

* Processing new hire paperwork
* Completing background checks and other provider verification activities
* Processing payroll for participant-hired workers including withholding taxes
* Processing payments to agency providers
* Making individual spending data available to participants

OIM contracts with Disability Rights Wisconsin to provide ombudsman services to participants between the ages of 18-59 years old. OIM assists participants who are 60 years and older in resolving problems with the IRIS program or certified ICAs and FEAs.

OIM contracts with MetaStar to support participants in self-direction. MetaStar operates a hotline to help participants report and resolve complaints and grievances.

OTHER RELEVANT INFORMATION

This waiver recognizes the essential leadership role of participants in planning and purchasing of services and supports. In order to effectively self-direct their services, participants must have receive on-going education, tools, resources, information, and support related to the IRIS program, including but not limited to information about the following:

* Basic core values and philosophy of self-direction
* Rights, risks, and responsibilities of self-direction
* Processes and procedures of the ISSP development
* Services and supports available through IRIS funding and other sources
* Fundamentals of exercising employer authority
* How to report complaints and grievances
* How to exercise rights to the State Fair Hearing process
* How to report a critical incident
* How to operate within the approved individual budget
* How to work with the ICA and the FEA
* How to participate in quality monitoring activities

Participants have numerous resources made available to them to help them understand self-direction including several participant education forms, the participant handbook, and the IRIS program's website: https://www.dhs.wisconsin.gov/iris/index.htm.

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.

Participants are able to both live in a residential facility (adult family home - AFH or certified residential care apartment complex - RCAC) and self-direct their services in the IRIS program. Participants living in an AFH or RCAC exercise self-direction by making the decision to reside in a residential facility of their choosing and entering into an agreement with the provider. AFH and RCAC providers must offer participants the opportunity to self-direct as much of their day-to-day services as possible within the facility. As DHS executes the statewide transition plan, specific requirements regarding self-direction within residential facilities will be developed. These requirements will be implemented prior to the March 17, 2019 deadline. Providers must permit participants to self-direct any waiver services that are not included in the facility rate. Examples of these services include transportation, day services, and supported employment as examples.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Residential Care Apartment Complex (RCAC) and Adult Family Homes (AFH).

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- **Waiver is designed to support only individuals who want to direct their services.**
- **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The Aging and Disability Resource Centers (ADRCs) complete individuals' initial Long Term Care Functional Screen (LTC FS) and coordinate with the county's Income Maintenance Unit or Consortium to determine individuals' functional and financial eligibility for long-term care programs. ADRCs then provide individuals with enrollment counseling including information about all long-term care programs for which the individual is eligible to assist the person in making an informed choice about his or her long-term care program. Enrollment counseling includes the provision of information on the benefits of participant direction in both the IRIS program and the Family Care program, including the participant's rights and responsibilities.

DHS' Bureau of Long Term Care Financing (BLTCF) worked with their contracted actuaries to develop a regression model that

predicts an individual's IRIS expenditures using the members' LTC FS information. The model was developed based on individuals' expenditures in IRIS and their corresponding LTC FS. The resulting statistical models are used to set the budgets for IRIS participants.

OIM calculates 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.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The term, "legal representatives" includes legal guardians, corporate guardians, and Health Care Powers of Attorney (HC-POA). Participants are obligated to perform all duties described as the responsibility of the legal representative when the participant does not have an active legal representative. Having a legal representative is neither a pre-requisite nor a disqualifier for participation in the IRIS program.

The legal representative is required to sign the form authorizing the services listed on the ISSP. However, the participant should also sign the form indicating authorization of the services as an element of best practice given that IRIS is a self-directed program. The legal representative may direct services on the behalf of the participant; however, it is necessary that the IRIS consultant ensure that the ISSP reflect the participant's voice and preferences. The legal representative may include other people may assist the person in plan development and execution if they choose. The legal representative signs off on timesheets to verify that the employee or provider provided the services as documented.

Non-legal representatives are able to participate in the development of the ISSP at the request of the participant or legal representative, but do not have any decision-making authority. Non-legal representatives may provide input when requested by the participant or legal representative and may be a source of support and encouragement to the participant during the process. The IRIS consultant and legal representative, if involved, have the responsibility to ensure that non-legal representatives do not exercise decision-making authority that they do not have. IRIS consultants are required to honor the participants' wishes regarding the level of involvement, or non-involvement, of non-legal representatives.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
IRIS Consultant Services	☐	☐
Consumer Education and Training	☐	☑
Specialized Medical Equipment and Supplies	☐	☑
3-4 Bed Adult Family Home	☐	☑
Vocational and Futures Planning	☐	☑
Nursing Services	☑	☑
Personal Emergency Response System	☐	☑
Specialized Transportation 2		

Waiver Service	Employer Authority	Budget Authority
	☑	☑
Residential Care Apartment Complex	☐	☑
Customized Goods and Services	☑	☑
Fiscal Employer Agent Services	☐	☐
Counseling and Therapeutic Services	☐	☑
Housing Counseling	☐	☑
Day Services	☐	☑
Assistive Technology/Communication Aids/Interpreter Services	☐	☑
Supported Employment - Group	☐	☐
Relocation - Housing Start Up and Related Utility Costs	☐	☑
Supported Employment - Individual	☑	☑
Prevocational Services	☑	☑
Home Delivered Meals	☑	☑
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	☑
Respite	☑	☑
Home Modification	☐	☑
Specialized Transportation	☑	☑
Support Broker	☑	☑
Adult Day Care	☐	☑
Adaptive Aids	☐	☑
Supportive Home Care	☑	☑
1 -2 Bed Adult Family Home	☐	☑
Daily Living Skills Training	☐	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:
Fiscal Employer Agent Services

FMS are provided as an administrative activity.

Provide the following information

i. **Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Certified fiscal employer agents (FEAs) provide Financial Management Services (FMS) to participants in the IRIS program. The Office of IRIS Management (OIM) certifies the FEAs according to the document, "Fiscal Employer Agent Certification Criteria" (F-00825) available for review on the OIM website: https://www.dhs.wisconsin.gov/iris/whatsnew.htm.

Potential FEAs must demonstrate the following as part of the certification process:
* The agency's business practices and philosophies must align with the core principles of self-direction.
* The agency has a comprehensive understanding of the financial service responsibilities required to be an FEA
* The agency is able to demonstrate evidence of the required business infrastructure, information technology infrastructure, qualified personnel requirements, and financial solvency to provide FEA services to IRIS participants

Similar to the ICA certification process, the process by which OIM certifies an FEA includes mechanisms to allow OIM to certify an FEA through successful demonstration of the core requirements of FEA functions while allowing OIM to impose Certification Criteria Improvement Plans (CCIP). OIM requires CCIPs when there are deficiencies in areas that OIM does not consider core FEA services, including waiver-related assurances. OIM can mandate CCIPs to ensure that any non-core functional areas of the FEA service that do not meet OIM's requirements are remediated in a timely and standardized manner regulated by OIM.
As part of the certification process, FEAs identify whether they plan to serve IRIS participants statewide or in one or more of the geographic service regions. Once certified, participants have the choice of any FEA certified statewide or in the geographic service region in which they reside. The participant chooses their FEA with the assistance of their IRIS Consultant as part of the development of the initial ISSP.

ii. **Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

FEA services are provided as a waiver service and are further described in Appendix C, including all functions included in the waiver service. OIM reimburses the FEAs through a monthly rate of service for participants utilizing their agency for FEA services. OIM developed this monthly rate of service based on historical costs and enrollment in the IRIS program. OIM tracks and monitors the number of participants being served by each individual FEA on a monthly basis using the Wisconsin IRIS Self-Directed Information Technology System (WISITS) as the source of data. Because these services are required as a part the IRIS program model, neither OIM nor the FEA charge these monthly rates against the participant's budget.

iii. **Scope of FMS.** Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- [x] **Assist participant in verifying support worker citizenship status**
- [x] **Collect and process timesheets of support workers**
- [x] **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

Conducts criminal background checks

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other services and supports**

Specify:

Additional functions/activities:

☑ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
☐ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
☑ **Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

OIM monitors the FEAs at least quarterly. The monitoring practices range in formality from performance measures with Federal reporting requirements to informal discussions on a monthly basis regarding progress on the FEA's quality management strategies. Oversight and monitoring activities include:

* Monitoring of payments issued in contrast to approved service authorizations
* Monitoring of payroll accuracy and timeliness
* Monitoring of provider verifications including background checks
* Monitoring of notifications to ICAs of participant overspending
* Monitoring of employer and provider paperwork accuracy
* Monitoring of fraud allegation review and assessment activities (FARA)
* Monitoring of Quality Management Plan templates and tracking mechanisms
* Monitoring of customer service data from participant satisfaction surveys
* Monitoring of data relative to complaints and grievances

FEAs are required to demonstrate remediation of all individual negative findings. OIM validates the FEAs' demonstrated remediation of all individual negative findings.

OIM oversees the implementation of system-level improvement activities, using information derived from the aforementioned discovery activities, identifying trends that affect IRIS participants as a group; designs improvements to the system to prevent or reduce future occurrences of quality issues. OIM facilitate these changes through approved Quality Management Plan templates submitted and implemented by the FEAs. FEAs provide OIM with quarterly data and OIM monitors the FEA's progress on the plan identified on the template.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Certified IRIS consultant agencies (ICAs) provide information and assistance in support of participant direction to participants in the IRIS program. The Office of IRIS Management (OIM) certifies the ICAs according to the document, "IRIS Consultant Agency Certification Criteria" (F-00826) available for review on the OIM website: https://www.dhs.wisconsin.gov/iris/whatsnew.htm.

* The agency's business practices and philosophies must align with the core principles of self-direction.
* The agency has a comprehensive understanding of the responsibilities required to be an ICA
* The agency is able to demonstrate evidence of the required business infrastructure, information technology infrastructure, qualified personnel requirements, and financial solvency to provide ICA services to IRIS participants

Similar to the FEA certification process, the process by which OIM certifies an ICA includes mechanisms to allow OIM to

certify an ICA through successful demonstration of the core requirements of ICA functions while allowing OIM to impose Certification Criteria Improvement Plans (CCIP). OIM requires CCIPs when there are deficiencies in areas that OIM does not consider core ICA services, including waiver-related assurances. OIM can mandate CCIPs to ensure that any non-core functional areas of the ICA service that do not meet OIM's requirements are remediated in a timely and standardized manner regulated by OIM.

Upon successful completion of the certification criteria, ICAs are required to provide all ADRCs in the IRIS region they intend to serve with Department-approved and predefined information about their agency. OIM developed an ICA Biography Form that provides the following standardized information:

* Agency contact information
* Corporate structure
* Chief Operating Officer
* Number of participants being served
* IRIS consultant to participant ratio
* Areas of specialty, certification, and licensures
* DHS certification effective date
* Mission statement
* Goals

In the future, this information will also include data compiled from the results of customer satisfaction surveys completed by other IRIS participants for whom the ICA provides consulting services. This data will rate the ICA in different core areas of services, such as customer service, responsiveness, program knowledge, issue resolution, and accuracy of information provided. OIM will compile the data in a uniform, impartial manner for use by individuals receiving enrollment counseling. This information serves to ensure that participants have the tools, resources, and information to make the most informed decision regarding their choice of ICA. If a participant has no preference regarding the selection of their ICA, an ICA will be auto-assigned to the participant at the ADRC based on ICA availability in that region. The ADRC routes the referral information to the ICA chosen by the participant during enrollment counseling.

ICAs are required to do the following:

* Conduct annual level of care redeterminations and change in condition screens using the Long Term Care Functional Screens (LTC FS)
* Develop ISSPs
* Perform prior authorization of waiver services
* Monitor participant spending and provide participants with tools, resources, and information to address budget authority issues
* Recruit and train IRIS Consultants
* Assist the participant in ensuring all employee and provider new-hire paperwork is completed accurately

ICAs must ensure there are adequate, well-trained IRIS Consultants to assist participants in facilitating self-direction within the IRIS program regulations. The extent of IRIS Consultant services may range from very limited, minimal assistance to ongoing support in plan development and implementation based upon the needs of the individual IRIS participant. The IRIS Consultants are also responsible to provide ongoing contacts to monitor implementation of the plan, to ensure participant health and safety, to ensure the participant receives services according to the approved plan, and to review monthly expenditure reports to assure appropriate use of the authorized budget.

ICA services are provided as a waiver service and are further described in Appendix C, including all functions included in the waiver service. OIM reimburses the ICAs through a monthly rate of service for participants utilizing their agency for ICA services. OIM developed this monthly rate of service based on historical costs and enrollment in the IRIS program. OIM tracks and monitors the number of participants served by each individual ICA on a monthly basis using WISITS as the source of data. Because these services are required as a part the IRIS program model, neither OIM nor the FEA charge these monthly rates against the participant's budget.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
IRIS Consultant Services	☑
Consumer Education and Training	☐
Specialized Medical Equipment and Supplies	☐
3-4 Bed Adult Family Home	☐
Vocational and Futures Planning	☐
Nursing Services	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
	☐
Personal Emergency Response System	☐
Specialized Transportation 2	☐
Residential Care Apartment Complex	☐
Customized Goods and Services	☑
Fiscal Employer Agent Services	☑
Counseling and Therapeutic Services	☑
Housing Counseling	☑
Day Services	☐
Assistive Technology/Communication Aids/Interpreter Services	☑
Supported Employment - Group	☐
Relocation - Housing Start Up and Related Utility Costs	☐
Supported Employment - Individual	☐
Prevocational Services	☐
Home Delivered Meals	☐
Live-in Caregiver (42 CFR §441.303(f)(8))	☐
Respite	☐
Home Modification	☐
Specialized Transportation	☐
Support Broker	☑
Adult Day Care	☐
Adaptive Aids	☐
Supportive Home Care	☐
1 -2 Bed Adult Family Home	☐
Daily Living Skills Training	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Independent advocacy is available from Disability Rights Wisconsin, the Board on Aging and Long Term Care and the Independent Living Centers in the state. The ICAs and the ADRCs provide information to participants in IRIS of the services provided including how to engage their services.
Participants are able to access these services by contacting the agencies directly as follows:

Board on Aging and Long Term Care
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
(800) 815-0015 Toll-free
(608) 246-7001 Fax
boaltc@ltc.state.wi.us

Disability Rights Wisconsin has offices in Madison, Milwaukee and Rice Lake.

Madison
131 W. Wilson St., Suite 700
Madison, WI 53703
608-267-0214
TTY: 888-758-6049
Fax: 608-267-0368
Toll Free: 800-928-8778*

Milwaukee
6737 W. Washington St., Suite 3230
Milwaukee, WI 53214
414-773-4646
TTY: 888-758-6049
Fax: 414-773-4647
Toll Free: 800-708-3034*

Rice Lake
217 W. Knapp St. Rice Lake, WI 54868 715-736-1232
TTY: 888-758-6049
Fax: 715-736-1252
Toll Free: 877-338-3724

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

OIM permits participants to disenroll from the IRIS program voluntarily at any time, for any reason. ICAs refer participants choosing to disenroll from the IRIS program to the Aging and Disability Resource Centers (ADRCs) for enrollment counseling. Participants are not required to notify their ICA of their intention to leave the program and can engage the ADRCs for enrollment counseling independent of a referral from the ICA. ADRCs provide participants with unbiased information about all long-term care programs for which the participant qualifies and communicates the participant's decision to both IRIS and the receiving program. The participants continue to receive IRIS services until the transition is complete and the participant begins services in the long-term care program. All transfers between long-term care programs will have an effective date of the first of the following month. There is no disruption in services when IRIS participants change long-term care programs. ICAs are required to continue all contacts and other activities to ensure participant health and welfare through the disenrollment process.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

OIM makes the final determination regarding involuntary disenrollments. ICAs submit the appropriate request for disenrollment for OIM review and approval. As described in 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

In cases wherein OIM approves an ICA's request for involuntary disenrollment, the ICA is required to notify the participant of the decision and provide a Notice of Action for the termination of IRIS services. In addition, the ICA must provide the participant with information regarding how to engage the State Fair Hearing process. The ICA also refers the participant to the ADRC for enrollment counseling to receive information about the other long-term care programs from which they can choose. It is the participant's responsibility to follow up with the ADRC. The ICA is responsible for completing contacts and activities to ensure the participant's health and safety until the disenrollment date or through the State Fair Hearing process when the Administrative Law Judge (ALJ) grants a continuation of services.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		15716
Year 2		16739
Year 3		17772
Year 4		19006
Year 5		20638

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☑ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participants can identify workers and refer them to an agency who serves as the employer of record. Identified employees must meet the hiring standards, including the criminal background check requirements, of the agency who will serve as the employer of record. This is known as co-employment. Participants share in the responsibility of training and providing oversight to co-employed participants.

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**

☑ **Refer staff to agency for hiring (co-employer)**

- [x] **Select staff from worker registry**
- [x] **Hire staff common law employer**
- [x] **Verify staff qualifications**
- [ ] **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

- [x] **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
- [x] **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
- [x] **Determine staff wages and benefits subject to State limits**
- [x] **Schedule staff**
- [x] **Orient and instruct staff in duties**
- [x] **Supervise staff**
- [x] **Evaluate staff performance**
- [x] **Verify time worked by staff and approve time sheets**
- [x] **Discharge staff (common law employer)**
- [x] **Discharge staff from providing services (co-employer)**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- [x] **Reallocate funds among services included in the budget**
- [x] **Determine the amount paid for services within the State's established limits**
- [x] **Substitute service providers**
- [x] **Schedule the provision of services**
- [x] **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- [x] **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- [x] **Identify service providers and refer for provider enrollment**
- [x] **Authorize payment for waiver goods and services**
- [x] **Review and approve provider invoices for services rendered**
- [ ] **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of

reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The Aging and Disability Resource Centers (ADRCs) complete individuals' initial Long Term Care Functional Screen (LTC FS) and coordinate with the county's Income Maintenance Unit or Consortium to determine individuals' functional and financial eligibility for long-term care programs. ADRCs then provide individuals with enrollment counseling including information about all long-term care programs for which the individual is eligible to assist the person in making an informed choice about his or her long-term care program. Enrollment counseling includes the provision of information on the benefits of participant direction in both the IRIS program and the Family Care program, including the participant's rights and responsibilities.

DHS' Bureau of Long Term Care Financing (BLTCF) worked with their contracted actuaries to develop a regression model that predicts an individual's IRIS expenditures using the members' LTC FS information. The model was developed based on individuals' expenditures in IRIS and their corresponding LTC FS. The resulting statistical models are used to set the budgets for IRIS participants. This model will be updated annually.

OIM calculates 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.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Prior to enrollment, individuals receive their initial budget estimate as part of the enrollment counseling process at the Aging and Disability Resource Center (ADRC). Individuals are able to use this information when making an informed choice of long-term care programs. Individuals choosing IRIS can seek additional funding through a budget amendment or one-time expense request if they are unable to develop an Individual Support and Service Plan (ISSP) that meets their long-term care needs during the orientation process.

When the cost of supporting a participant's long-term support needs, during initial or ongoing ISSP development, exceed the available individual budget either on a one-time basis or on an ongoing basis (budget amendment), then the IRIS Consultant assists the participant in preparing a request per OIM procedures and submits the information to the OIM for review. OIM has developed a review committee of OIM employees and BLTCF financial specialists to review requests from IRIS participants. The review committee analyzes the request and issues one of the following decisions: approval, partial approval, request for further information, or denial. In cases where the review committee denied or only partially approved the request, the participant has the option to request an Independent Review by OIM through a committee convened by the OIM Section Chief. No individual who was part of the initial decision may be part of the Independent Review committee. The Independent Review Committee evaluates the initial decision and any additional information provided by the participant for final approval or denial. If the Independent Review Committee denies the request, or the participant chooses not to engage in the Independent Review process, the IRIS participant receives a Notice of Action (NOA) informing them of the decision. The NOA also includes information regarding how to access their Medicaid Fair Hearing rights.

Budget amendments and one-time expenses are contained on separate SharePoint lists within the same Budget Amendment SharePoint site. Each ICA has its own Budget Amendment SharePoint site. These sites document libraries consisting of the Budget Amendment and One-Time Expense policies and work instructions that detail the process; applicable forms including instructions and examples; and the Budget Amendment and One-Time Expense SharePoint User's Manuals. Each time a new ICA is certified, OIM meets with the new agency and walks through the entire process from identification of the participant's need through the completion of the paperwork, through the use of the SharePoint sites, through the decision-making process, and finally through the Independent Review and appeals process.

Each time the LTC FS is administered, either for annual recertification or as a result of a change in condition, the participant is notified by the ICA of their new budget estimate. Initially, when the LTC FS generates a budget estimate that is lower than the cost of the current ISSP, the participant and IC submit a budget amendment request for OIM review following the full procedure outlined in the IRIS Policy: Work Instructions manual. A full review of the participant's plan, spending, and needs is included as part of the budget amendment process. In subsequent years, when an approved budget amendment is in the participant's record, an abbreviated budget amendment request is submitted in which OIM reviews key components of the original budget amendment to ensure the continued appropriateness of the initial budget amendment.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The IRIS consultant agencies track and monitor expenditures to ensure that IRIS waiver participants do not overspend or deplete their individually allocated budgets prematurely. A monthly report is produced that identifies individual IRIS participants who have gone over or under budget, which is provided to the IRIS consultant agencies and the DHS IRIS staff for review each month. IRIS participants and/or their designated representative also receive a monthly report informing them of their previous month's expenditures and remaining budget for the year so they are aware of the status of their budget on a regular basis. A real-time view of service authorization and utilization will be available to participants via WISITS in a future system upgrade. If concerns or trends are identified by the ICAs or OIM, the IRIS consultant contacts the IRIS participant or designated representative to determine the reasons for the discrepancy and provide assistance as needed.

If the IRIS participant experiences a change in needs (increase or decrease) the ICAs conduct a change in condition screen using the Long Term Care Functional Screen and notify the Department. The Department then determines, based on the individual's situation, if the individual budget would be affected. In addition, if the person requests an increase in their individual budget, the participant would follow the process for a budget amendment or one-time expense as described in Appendix E-2.b.iii. If changes are made to the individual budget, this would be reflected in an updated Individual Service and Support Plan.

IRIS consultants must contact the participant related to both significant under and overspending. Since some costs are incurred intermittently, it is possible that overspending is consistent with the participant's approved plan. However, the IC follows up to assure that overspending does not represent mismanagement of the participant's individual budget. The IC also follows up related to underspending to ensure participant health and safety and to determine if there are issues to be resolved to ensure receipt of waiver services.

ICAs must complete change in condition LTC FS within 30 days of the identified change. A participant may also request a change in condition LTC FS at any time.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

IRIS participants receive information about State Fair Hearing rights in the following ways:

* Aging and Disability Resource Centers (ADRCs) provide information about State Fair Hearings during enrollment counseling and upon request
* IRIS consultants provide information annually
* Information is mailed with issued Notices of Action
* Advocacy groups, such as Disability Rights Wisconsin (ombudsman) provide information upon request
* MetaStar provides information during concurrent review process and to participants who call the complaints and grievances hotline

The Aging and Disability Resource Center (ADRC) informs individuals of their right to the fair hearing process prior to enrollment. 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 Notices of Action to inform individuals of ineligibility that include information about the right to a fair hearing. ADRCs will also provide information about the State Fair Hearing process to enrolled participants upon request.

At the time of orientation and annually thereafter, the IRIS consultant reviews the document, “Participant Education: Notices of Action and Appeals” (F-01205G) with the participant. This document explains what is a Notice of Action (NOA), explains what the participant’s options are if they receive an NOA, and describes the Fair Hearing process. The participant signs the form indicating that they received the information, had the opportunity to ask questions, and understand their rights. The IRIS consultant signs the form confirming they reviewed the information with the participant and answered the participant’s questions. All participant education sheets are available to IRIS participants at any time on the IRIS website: https://www.dhs.wisconsin.gov/iris/forms.htm.

NOAs are issued each time the IRIS program limits, denies, reduces, or terminates a services, including participation in the IRIS program. The NOA describes the action taken and an explanation for the decision. When the IRIS consultant agencies or Office of IRIS Management (OIM) issue an NOA, 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 form their desire to continue their services while their appeal is under consideration.

Ombudsman services are available to IRIS participants through Disability Rights Wisconsin (DRW). DRW provides information about the State Fair Hearing process to participants as part of their services.

When the participant requests a State Fair Hearing, MetaStar completes a concurrent review. MetaStar provides additional information to the participant about their rights during the State Fair Hearing process. MetaStar also operates a complaints and grievances hotline on OIM’s behalf and provides information to callers in situations wherein an NOA has been issued.

When a participant elects to continue their services and submits their request to continue services to the Administrative Law Judge (ALJ) on or before the effective date of the intended action, the ALJ services provides OIM with notification of a continuation of services when appropriate. When the participant does not submit their request to continue services to the ALJ on or before the effective date of the intended action, the participant receives written notification from the ALJ that the IRIS program will not continue the participant’s services. IRIS participants must submit the Request for a State Fair Hearing within 45 days of the date on the NOA.

OIM uses Notice of Action SharePoint sites to track NOAs from the date of the decision through the State Fair Hearing process. These SharePoint sites serve as OIM’s source of data relative to the hearings and appeals process. The data is used to identify trends and inform policy changes.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ◉ **Yes. The State operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

When the review committee denies a participant’s budget amendment or one-time expense request (BA/OTE), the participant has the opportunity to request the Office of IRIS Management (OIM) complete an “Independent Review.” OIM issues a letter to the participant informing them of the denial of the BA/OTE request and includes information regarding how to request and Independent Review. OIM must receive requests for Independent Reviews within ten days of the date on the decision letter. Participants must submit additional information for consideration by the Independent Review committee. OIM convenes a committee of one or more

OIM staff who were not part of the additional BA/OTE decision to reconsider the decision. The participant's right to a State Fair Hearing are preserved in two ways:

* If the participant does not request an Independent Review within ten days, the OIM mails the participant an Notice of Action (NOA) informing the participant of the decision, providing an explanation for the decision, and providing information on the participant's rights to a State Fair Hearing.
* If OIM again denies or limits the BA/OTE request during the Independent Review process, the OIM issues an NOA informing the participant of the decision, providing an explanation for the decision, and providing information on the participant's rights to a State Fair Hearing.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- **No. This Appendix does not apply**
- **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Office of IRIS Management (OIM) is responsible for overseeing the grievance and complaint system for the IRIS program. OIM and the IRIS consultant agencies, fiscal employer agents, Disability Rights Wisconsin – DRW (ombudsmen), and MetaStar share the responsibility of resolving participant complaints and grievances.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

IRIS participants have the right to file a complaint or grievance about any perceived negative action or inaction experienced in the IRIS program. However, participants generally dispute denials, limitations, reductions, or terminations of IRIS services using the State Fair Hearing process.

IRIS participants can submit complaints or file grievances using one or more of the available avenues concurrently, though OIM encourages participants to try to resolve the issue with the source of the problem first. For example, if the participant is dissatisfied with how their Individual Support and Service Plan (ISSP) is set up, they should first try to resolve the issue with their IRIS consultant or IRIS Consultant Agency. The following resources are available to assist participants in resolving complaints and grievances:

* IRIS Consultant
* IRIS consultant agencies
* Fiscal employer agents
* MetaStar complaints and grievances hotline
* OIM staff
* Ombudsmen program at Disability Rights Wisconsin (DRW)
* Division of Long Term Care (DLTC) Administration
* Department of Health Services (Secretary's Office)
* State Legislator
* Office of the Governor

DLTC Administration, the Department of Health Services, the State Legislators, and the Office of the Governor forwards received complaints and grievances to OIM for resolution.

No matter which party, or parties, receives the participant's complaint or grievance, expeditious resolution is required. IRIS consultants, ICAs, FEAs, and OIM staff should resolve complaints and grievances within two working days; however, the complexity of some complaints and grievances does not permit such a quick resolution.

At the time of orientation and annually thereafter, the participant receives information and education regarding the appeals and grievances processes using the document, "Participant Education: Complaints and Grievances" (F-01205F). This document explains the complaint and grievance processes through the ICAs, FEAs, and MetaStar. The IRIS consultants are required to meet face-to-face with the participants and explain the material in the education sheets. The participant signs the form indicating that they received the information, had the opportunity to ask questions and understand the information. The IRIS consultant signs the form confirming they reviewed the information with the participant and answered the participant's questions. All participant education sheets are available to IRIS participants at any time on the IRIS website: https://www.dhs.wisconsin.gov/iris/forms.htm.

OIM contracts with MetaStar to operate a hotline (888-203-8338) and an email address (DHSIRISGrievances@wisconsin.gov) to

assist OIM in resolving participant complaints and grievances. MetaStar has twenty working days to resolve complaints and grievances, with the exception of complaints related to participant-hired worker payment, which should be resolved within three working days.

OIM contracts with DRW to provide ombudsmen services to IRIS participants between the ages of 18-59. Participants ages 60 and over may contact OIM for additional assistance in resolving complaints and grievances. OIM is working to address this inequity in the availability of ombudsmen services. DRW collaborates with the necessary entities, including OIM, to resolve the participant's complaint.

All of the aforementioned entities who assist in the resolution of participant complaints and grievances are required to complete the following steps in collaboration with any other involved entities:

* Communicate directly with the participant or legal representative to understand the nature and details of the complaint or grievance
* Identify entity as being involved in the resolution of the complaint or grievance
* Ensure the participant or legal representative understands their rights
* Work with necessary parties to ensure resolution of the complaint or grievance
* Communicate the outcome directly to the participant or legal representative
* Provide an adequate explanation to the participant or legal representative, as well as any options for recourse, if the outcome is not the desired outcome of the participant or legal representative
* Document contacts made and outcomes for future reference

OIM is developing a system by which OIM, ICAs, FEAs, and MetaStar can directly enter contacts to streamline the process and centralize communication between entities when the participant registers the complaint or grievance with multiple entities. OIM will enter all contacts between OIM and DLTC Administration, the Department of Health Services Secretary's Office, State Legislators, and the Office of the Governor. OIM will either use OIM-owned SharePoint sites or build an appropriate module within the centralized IT system. Implementation will be prior to December 31, 2016. In the meantime, each entity will continue to use the individual entity's method of recording the information.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

(●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*

( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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 Department of Health Services Office of IRIS Management (OIM) help to ensure the participants' health and safety.

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 has 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 the instructions, "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 incidents wherein DHS may receive a phone call due to media involvement. (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.)

* 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 ISITS and the DHS Critical Incident Reporting SharePoint site within 30 days.

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

OIM 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.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

ICAs are required to provide participants and legal representatives with training during orientation and annually, at minimum. The ICAs are required to use the document, "Participant Education – Health and Safety – Incident Reporting" (F-01205A), which defines reportable critical incidents and describes the process by which participants report incidents. The form also describes what

happens when a participant reports an incident. The participant or legal representative signs the form indicating that the IRIS consultant reviewed the information with them and that they had all of their questions answered. The IRIS consultant also signs the form confirming that they reviewed each element of the form with the participant and answered all of the participant's questions.

In addition to the participant education form, the participants have access to the following documents that also describe how to identify and report abuse, neglect, and misappropriation of funds:

* IRIS Participant Handbook (P-01008)
* IRIS Policy Manual: Work Instructions (P-00708A)

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

ICAs are required to ensure the immediate and ongoing health and welfare of the participant. Activities to ensure the immediate health and welfare of the participant must take place and be documented within 14 calendar days of the ICA receiving notification of the incident. Activities to ensure the ongoing health and welfare of the participant must take place and be documented within 30 calendar days of the ICA receiving notification of the incident.

ICAs are required to make separate reports to Adult Protective Services (APS) when alleged or actual abuse, neglect, self-neglect, or misappropriation of the participant's funds has occurred (Wisconsin State Statute 46.90). The Bureau of Aging and Disability Resources (BADR) provides oversight to the county APS units who are responsible for investigating allegations of abuse, neglect, self-neglect, and misappropriation. APS units are not required to disclose details of the investigation or the outcome to the ICAs. APS units are responsible for communicating needed changes to the Individual Support and Service Plan (ISSP) or participant-hired workers as a result of the investigation. The OIM and the ICAs are responsible for the following activities relative to APS investigations:

* Ensuring the immediate and ongoing health and welfare of the participant
* Providing APS with any requested information
* Responding to direction from APS relative to changes to the ISSP resulting from the APS investigation.

In some cases, law enforcement agencies may be responsible for conducting the investigation when a crime has been committed, or alleged to have been committed. With the exception of documentation considered public record, the law enforcement agencies are not required to disclose details of the investigation or the outcome of the investigation to the ICAs. The Office of IRIS Management and the ICAs are responsible for the following activities relative to law enforcement investigations:

* Ensuring the immediate and ongoing health and welfare of the participant
* Providing law enforcement with any requested information
* Responding to direction from law enforcement relative to changes to the ISSP resulting from the law enforcement investigation.

For incidents involving a participant who resides in, or otherwise receives services from, a licensed or certified facility, both the facility and the participant's ICA must report the incident. The OIM collaborates with the Division of Quality Assurance (DQA) and Lutheran Social Services (LSS) to ensure proper reporting. DQA licenses all 3-4 bed adult family homes, Residential Care Apartment Complexes (RCACs), Community-Based Residential Facilities (CBRF) used for respite, and Adult Day Cares. LSS certifies 1-2 bed adult family homes. The OIM also honors certifications from managed care organizations and county waiver agencies until the time of renewal.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The OIM has a multi-faceted approach to ensuring the ICAs have met the requirements of this waiver and the IRIS policy and work instructions including the following steps:

* Reviewing and approving each critical incident to ensure the participant or ICA took adequate steps to ensure the participant's health and safety
* Facilitating the ICA's remediation of all individual negative findings
* Reviewing the aggregate DHS Critical Incident Report SharePoint data to identify trends
* Reviewing participant records to ensure participants received annual education about what is reportable and how to report critical incidents
* Reviewing participant records to ensure that there is a corresponding critical incident in the DHS Critical Incident Reporting SharePoint site for each reportable incident identified in case notes
* Facilitating the ICAs' implementation of quality improvement strategies to address OIM's record review findings

The OIM also completes the Remediation Assurance Process (RAP) to ensure the ICAs carry out and document the activities identified on the "Incident Report – Medicaid Waiver Programs" (F-22541) in the participant's case notes. The OIM randomly

samples 10 percent of each month's reported incidents excluding deaths. OIM validates through the RAP that the case notes document the steps taken to ensure the participant's immediate health and welfare within 14 days of the ICA received notification the incident occurred. OIM validates through the RAP that the case notes document the steps taken to ensure the participant's ongoing health and welfare within 30 days of the ICA receiving notification the incident occurred.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The State does not permit or prohibits the use of restraints**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

◉ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The 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 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 ninety days or less for respite or rehabilitation purposes.

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 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 demonstrate 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 fifteen 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.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

ICAs are required to ensure the safe use of restraints in accordance with the approved application. IRIS consultants are required to discuss the use and progress of the behavior support plan including the use of the approved restraints during each phone contact and home visit. The IRIS consultants must document these discussions in case notes. IRIS consultants must also review the documentation of the use of the restraints as identified in the application for the use of restraints.

ICAs are responsible for providing oversight to the IRIS consultants to ensure adequate documentation of the IRIS consultants' oversight of the use of restraints. ICAs are also responsible for ensuring IRIS consultants are able to correctly identify restraints, prepare applications for the use of a restraint, and monitor the use of approved restraints.

The Office of IRIS Management (OIM) provides oversight of the use of restrictive measures in several ways.

* Evaluating critical incident report data to monitor for an increase in reports of restraints being used in crises
* Evaluating the performance of the ICAs and IRIS consultants through the record review

The OIM's record review process examines the use of restraints through four separate indicators:

* All participants for whom the use of restraints, isolation, and seclusion are identified have an approved restrictive measures application in their record.
* Participants supported using restrictive measures received information regarding the Restrictive Measures Application Process.
* All participants for whom behaviors are identified on the Long Term Care Functional Screen (LTC FS) or other means have a completed behavior assessment in their record.
* Incident reports were completed and submitted for each reportable incident. (Emergency use of restraints is a reportable incident.)

OIM uses the DHS Record Review SharePoint site to facilitate the communication of negative findings and the validation of remediation. Each ICA has its own DHS Record Review SharePoint site to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA). The data reporting capabilities of the DHS Record Review SharePoint sites allow for sophisticated individual and aggregate reporting on the findings of the record review, the reasons for any negative findings, and the prescription and completion of remediation activities by the ICAs. The ICAs are required to remediate all negative findings identified through the record review process.

The Division of Quality Assurance (DQA) provides additional oversight of the use of restrictive measures in facilities under DQA's regulatory authority.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

◉ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The Office of IRIS Management (OIM) allows interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights, or employ aversive methods to modify behavior, or otherwise ensure the participant's health and safety. Examples of such restrictions include restricting access to the kitchen because the participant has Prader-Willi Syndrome; restricting access to alcohol because of the participant's prescription medication; or restricting access to the participant's medication because of an inability to self-direct medication administration. The IRIS consultant must clearly document these types of restrictions in the participant's Individual Support and Service Plan (ISSP) and/or Behavior Support Plan (BSP). The IRIS consultant must document the following:

* The reason for the restriction
* An explanation as to why the restriction is the least restrictive way to modify the participant's behavior and/or ensure the participant's health and safety including previously attempted solutions and the outcomes
* Criteria for removal of the restriction

IRIS consultants must ensure that the rights restrictions and other restrictive interventions do not also restrict the rights of other individuals in the living setting.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

IRIS consultant agencies are required to ensure minimal restriction of participants' rights. IRIS consultants are required to discuss the use and progress of the BSP including the use of the documented restrictive interventions during each phone contact and home visit. The IRIS consultants must document these discussions in case notes. IRIS consultants must also review the continued need for restrictive interventions in contrast with the documented criteria for removal of the restriction.

ICAs are responsible for providing oversight to the IRIS consultants to ensure adequate documentation of the IRIS consultants' oversight of the use of restrictive interventions. ICAs are also responsible for ensuring IRIS consultants are able to correctly identify restrictive interventions, document the need for restrictive interventions, and monitor the use of restrictive interventions.

The Office of IRIS Management (OIM) provides oversight of the use of restrictive interventions in several ways.

* Evaluating critical incident report data to monitor for an increase in reports of restraints being used in crises
* Evaluating the performance of the ICAs and IRIS consultants through the record review

The OIM's record review process examines the use of restrictive interventions through two separate indicators:

* All participants for whom behaviors are identified on the Long Term Care Functional Screen

(LTC FS) or other means have a completed behavior assessment in their record.
* Restrictive interventions are adequately documented in the participant's ISSP or BSP.

OIM uses the DHS Record Review SharePoint site to facilitate the communication of negative findings and the validation of remediation. Each ICA has its own DHS Record Review SharePoint site to ensure compliance with HIPAA. The data reporting capabilities of the DHS Record Review SharePoint sites allow for sophisticated individual and aggregate reporting on the findings of the record review, the reasons for any negative findings, and the prescription and completion of remediation activities by the ICAs. The ICAs are required to remediate all negative findings identified through the record review process are remediated.

The Division of Quality Assurance (DQA) provides additional oversight of the use of restrictive interventions in facilities under DQA's regulatory authority.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The State does not permit or prohibits the use of seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

◉ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Office of IRIS Management (OIM) permits the use of seclusion 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 OIM defines "seclusion" as a form of isolation in which the person is physically set apart by staff from others through the use of locked doors. Seclusion does not include the use of devices like "wander guards" or similar products that may also involve locking doors.

The use of seclusion 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 seclusion 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 IRIS consultant and participant must submit the appropriate request for approval. For seclusion to be used as part of a behavior support plan, the form, "Requests for Use of Restraints, Isolation, and Protective Equipment as Part of a Behavior Support Plan" (F-62607) is required. 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 seclusion 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, to review requests for the use of seclusion from participants with developmental disabilities. DQA reviews requests for the use of seclusion 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 seclusion, 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 fifteen 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.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

IRIS consultant agencies are required to ensure the safe use of seclusion in accordance with the approved application. IRIS consultants (ICs) are required to discuss the use and progress of the behavior support plan including the use of the approved seclusion strategies during each phone contact and home visit. The ICs must document these discussions in case notes. ICs must also review the documentation of the use of the seclusion strategies as identified in the application for the use of seclusion.

ICAs are responsible for providing oversight to the ICs to ensure adequate documentation of the ICs' oversight of the use of seclusion. ICAs are also responsible for ensuring ICs are able to correctly identify seclusion, prepare applications for the use of seclusion, and monitor the use of approved seclusion strategies.

The Office of IRIS Management (OIM) provides oversight of the use of seclusion in several ways:

* Evaluating critical incident report data to monitor for an increase in reports of seclusion being used in crisis situations
* Evaluating the performance of the ICAs and ICs through the record review

The OIM's record review process examines the use of seclusion through four separate indicators:

* All participants for whom the use of restraints, isolation, and seclusion are identified have an approved restrictive measures application in their record.
* Participants supported using restrictive measures received information regarding the Restrictive Measures Application Process.
* All participants for whom behaviors are identified on the Long Term Care Functional Screen (LTC FS) or other means have a completed behavior assessment in their record.
* Incident reports were completed and submitted for each reportable incident. (Emergency use of seclusion is a reportable incident.)

OIM uses the DHS Record Review SharePoint site to facilitate the communication of negative findings and the validation of remediation. Each ICA has its own DHS Record Review SharePoint site to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA). The data reporting capabilities of the DHS Record Review SharePoint sites allow for sophisticated individual and aggregate reporting on the findings of the record review, the reasons for any negative findings, and the prescription and completion of remediation activities by the ICAs. The ICAs are required to remediate all negative findings identified through the record review process are remediated.

The Division of Quality Assurance (DQA) provides additional oversight of the use of seclusion in facilities under DQA's regulatory authority.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Wisconsin's Nurse Practice Act regulates the roles and responsibilities of a nurse in delegating tasks to unlicensed workers, thereby allowing non-nursing staff to administer medications only under the supervision of a registered nurse (RN). Staff administering medications must receive participant-specific training related to medication administration, including the specifics of documenting the administration of the medication. The RN provides oversight to the participant's medication regimen.

For participants self-directing their own medication administration and management tasks, the participant delegates the waiver service provider or participant-hired worker, to administer the medications. The participant or legal representative assumes responsibility for the overall monitoring of the participant's medication regimen.

For IRIS participants served in licensed or certified living arrangements where a provider has responsibility for the health and safety of residents such as an adult family home or residential care apartment complex, the on-going medication management and follow-up is the responsibility of the provider under the supervision of an appropriately licensed health care professional. The Division of Quality Assurance (DQA) is the division within the Department of Health Services (DHS) with statutory responsibility to monitor regulatory compliance in all areas, including the provider's monitoring of the participant's medication regimen, for licensed and certified facilities.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

IRIS consultants are required to have monthly phone calls and quarterly visits with participants. Health and safety concerns, including concerns with medications, or access to medications, are to be discussed during each contact. The IRIS consultants must document summaries of these contacts in the case notes in the participant's record. The IRIS consultants must also document resolutions to all concerns identified during the monthly and quarterly contacts.

IRIS Consultants are required to report medication errors in compliance with the IRIS program's critical incident reporting process to include the use of the form, "Incident Report – Medicaid Waiver Programs" (F-22541) via the ICA's assigned DHS Critical Incident Reporting SharePoint site. As part of the critical incident reporting process, the ICAs are required to submit information describing how the participant's immediate and ongoing health and welfare were ensured. The OIM reviews all critical incidents and examines trends to identify any increases in medication errors.

OIM provides additional oversight through the record review process. The OIM's record review process ensures the participant's Individual Support and Service Plan (ISSP) addresses all identified needs, including issues related to medication administration, and incident reports were completed and submitted for each reportable incident. (A medication error resulting in emergency medical treatment is a reportable incident.)

OIM uses the DHS Record Review SharePoint site to facilitate the communication of negative findings and the validation of remediation. Each ICA has its own DHS Record Review SharePoint site to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA). The data reporting capabilities of the DHS Record Review SharePoint sites allow for sophisticated individual and aggregate reporting on the findings of the record review, the reasons for any negative findings, and the prescription and completion of remediation activities by the ICAs. The ICAs are required to remediate all negative findings identified through the record review process are remediated.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.*(complete the remaining items)*

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Wisconsin's Nurse Practice Act regulates the roles and responsibilities of a nurse in delegating tasks to unlicensed workers, thereby allowing non-nursing staff to administer medications only under the supervision of a registered nurse (RN). Staff administering medications must receive participant-specific training related to medication administration, including the specifics of documenting the administration of the medication.

For participants residing in a regulated facility such as an adult family home or residential care apartment complex, the provider ensures ongoing medication management and follow-up in accordance with the Division of Quality Assurance's regulatory requirements. DQA monitors the provider's performance as part of their regulatory oversight activities.

For participants self-directing their own medication administration and management tasks, the participant delegates the waiver service provider or participant-hired worker, to administer the medications. The participant or legal representative assumes responsibility for training the provider, monitoring the provider, and ensuring quality administration of medication.

For all prescription medications, there must be a written order from a physician and a properly labeled medication that includes the dosage. When medication is used on an as-needed basis, then a clear definition of when the medication should be administered must be provided as well.

iii. Medication Error Reporting.*Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

IRIS consultant agencies must report all medication errors resulting in the need for medical treatment to the Office of IRIS Management (OIM) using the form, "Incident Report – Medicaid Waiver Programs" (F-22541). OIM works with the ICA through the DHS Critical Incident Reporting SharePoint site to ensure that the participant, the legal representative (when appropriate), and the IRIS consultant took adequate steps to ensure the participant's immediate health and welfare and to ensure adequate steps were taken to prevent future medication errors.

For IRIS waiver participants residing in, or otherwise using, facilities regulated by Department of Health Services (DHS), the Division of Quality Assurance (DQA) provides oversight of medication administration. Facilities regulated by DQA are required to report medication errors, and other reportable critical incidents, to DQA. DQA monitors for concerns with the facilities ability to administer medication correctly as part of its oversight activities.

(b) Specify the types of medication errors that providers are required to *record:*

Providers are required to record all medication errors, including medication errors for which there are no negative consequences to the participant.

(c) Specify the types of medication errors that providers must *report* to the State:

Providers are required to report only medication errors resulting in the need for medical treatment to the OIM and DQA using the form, "Incident Report – Medicaid Waiver Programs" (F-22541).

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

DQA monitors the performance of Residential Care Apartment Complex (RCAC), 3-4 bed Adult Family Home (AFH), and Adult Day Care providers in the administration of medications in accordance with DQA's requirements based on Wisconsin

State Statute and Wisconsin Administrative Code. DQA regulation of licensed facilities includes on-site monitoring and investigation of complaints or incidents.

DQA sends the findings, or Statements of Deficiency (SOD), directly to the OIM. The OIM reviews the SODs regularly and notifies the appropriate ICA of concerns relative to IRIS participants.

When IRIS participants live in their own home, or that of a family member or friend, the IRIS consultant monitors the administration of medication during the monthly phone calls and quarterly home visits.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
Number and percent of participant records reviewed that indicate the ICA completed and submitted an incident report for each reportable incident. Numerator/Denominator: Number of participant records reviewed for which the ICA completed and submitted an incident report over the number of participant records reviewed for which there was at least one incident discovered.

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
Number and percent of critical incident reports that indicated that the ICA adequately ensured health and safety of the participant. Numerator/Denominator: Number of critical incidents reported in which the ICA adequately ensured the health and safety of the participant over the number of incidents reported during the time period.

Data Source (Select one):
Other
If 'Other' is selected, specify:
OIM-owned Critical Incident Reporting SharePoint sites

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Number and percent of participant records reviewed containing a current "Participant Education - Health and Safety - Incident Reporting" (F-01205A) with appropriate signatures. Numerator/Denominator: Number of records containing a current "Participant Education - Health and Safety - Incident Reporting" (F-01205A) with appropriate signatures over the number of records reviewed.

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

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

		95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
Number and percent of participants supported using restrictive measures with an approved and current Restrictive Measures Application. Numerator/Denominator: Number of participants supported using restrictive measures with an approved and current Restrictive Measures Application over the number of participants supported using restrictive measures identified in the participant record review.

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of participants receiving annual education about accessing a primary care provider, the benefits of receiving influenza and pneumonia vaccines, and identifying symptoms of urinary tract infections. N/D: Number of participant records containing a current, signed document, "Participant Education: Annual Health Information (F-01205K) over the number of participant records reviewed.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95%
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The OIM employs the following strategies for discovering issues pertaining to the health, safety, and welfare of IRIS waiver participants:

* Completing participant record reviews
* Resolving participant complaints
* Reviewing each critical incident report
* Reviewing critical incident data at monthly critical incident meetings with the ICAs
* Discussing all death and abuse/neglect reports at monthly critical incident meetings with the ICAs
* Pre-reviewing all restrictive measures applications

OIM completes record reviews through a manual review of the participants' electronic records. OIM uses WISITS as the primary source of data for the record review information. The record review tool contains a combination of indicators that measure data for performance measure reporting as well as elements of best practice. OIM has been conducting record reviews since 2011. OIM revises the record review tool each year to clarify the data collected or to add more indicators to measure aspects of best practice and contract compliance. OIM identifies a random sample of participants who have been in the program for at least one year. OIM uses the sample calculator at www.raosoft.com to calculate the sample with a 95% confidence rating. OIM completes record reviews quarterly. OIM communicates all findings to the ICAs using OIM-owned Record Review SharePoint sites.

In addition to the findings of the record review, OIM uses the Record Review SharePoint sites to communicate the reasons for negative findings as well as the required remediation activities to the ICAs. The ICAs document the actions taken to remediate the negative findings in the Record Review SharePoint site. OIM also documents validation of the remediation activities completed by the ICAs in the Record Review SharePoint sites. The data reporting capabilities of these Record Review SharePoint sites allow for sophisticated individual and aggregate reporting on the findings of the record review, the reasons for any negative findings, and the prescription and completion of remediation activities by the ICAs.

OIM completes a separate, more succinct record review process for participants who have been in the IRIS program for 90-364 days for ensuring quality service in counties that are part of expansion areas, or that have had a new ICA begin providing services. This record review focuses on orientation activities, including initial plan development. Several of the record review indicators are in common with the previously described record review.

OIM assists participants in resolving complaints. OIM collaborates with the ICAs and FEAs to ensure the participant receives answers to their questions, and resolution to the participant's satisfaction whenever possible. Records of contacts regarding participant complaints are stored in an internal OIM SharePoint site.

ICAs submit all critical incident reports to the OIM for review, approval, and aggregation. The IRIS quality management team reviews critical incidents and deaths on an on-going basis, as the reports are received.

All critical incident data is stored in OIM-owned SharePoint sites. Each ICA has its own SharePoint site specific to Critical Incident Reporting to ensure HIPAA compliance. ICAs are responsible for entering the description of the report, the steps taken to ensure immediate health and welfare, and the steps taken to ensure ongoing health and welfare. OIM reviews these steps to ensure compliance with the performance measures and either closes the incident report or returns the incident report for additional work to remediate individual negative findings. The SharePoint sites clearly record whether the ICA adequately ensured the participant's health and welfare at the time of report submission and, if remediation was required, whether the ICA had adequately ensured the participant's health and welfare at the time of closure.

OIM meets monthly with each ICA to discuss aggregate data from the SharePoint sites including trends identified. Additionally, the team discusses each death and each report of abuse, neglect, self-neglect, and misappropriation. The team reviews these reports for an in-depth discussion to determine if the ICA or IRIS program is able to implement any individual or systemic preventative measures.

The OIM pre-reviews all applications for restrictive measures to ensure the application is complete and contains all required attachments before advancing the application to the appropriate committee for review, and approval, when appropriate. OIM uses ICA-specific DHS-owned Restrictive Measures SharePoint sites to document the process and to centralize the communication between OIM, the ICA, and the reviewing entity. The Division of Long Term Care (DLTC) Restrictive Measures lead facilitates the committee that reviews the applications for all participants with intellectual or developmental disabilities. OIM is represented on this review committee. The Division of Quality Assurance (DQA) facilitates the review and approval of all applications for participants who are elderly or have physical disabilities that reside in a facility regulated by DQA. The OIM facilitates the review and approval of all applications for participants who are elderly or have physical disabilities that do not reside in a facility regulated by DQA. The DLTC Restrictive Measures lead serves as a resource to the OIM team in making accurate approvals in the rare instance that an application is made for a participant who is elderly or has physical disabilities, but does not reside in a facility regulated by DQA.

OIM uses many SharePoint sites to facilitate the identification and resolution of issues relative to participant health and

safety, as well as the collection of data pertinent to performance measures. The SharePoint sites will serve as the foundations for the corresponding modules within WISITS in future iterations.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The IRIS consultant agencies are responsible for addressing individual issues related to the health, safety, and welfare of participant; however, there may be occasions when the fiscal employer agents are involved. The Office of IRIS Management (OIM) works with these agencies, and other officials such as adult protective services units and law enforcement agencies, to ensure appropriate and timely remediation occurs and follow-up is provided as needed. OIM uses Critical Incident Reporting SharePoint sites to monitor critical incident reporting and document all individual remediation activities that occurred. The ICA documents the remediation activities completed and the OIM validates the completion of the remediation activities. The SharePoint sites help OIM determine whether these issues were resolved in a timely manner. OIM aggregates and analyzes critical incident data monthly and quarterly, which the OIM uses to monitor for any trends that might indicate a system-level issue. If OIM identifies a systemic issue in the area of critical incident reporting or any other area, the ICA submits a quality management plan template describing the ICA's intended plan to resolve the issue including the method by which progress is measured.

OIM established a secondary monitoring process in 2014 in which the OIM obtains a sample of ten percent of the critical incident reports and goes into the participant's case record to ensure the steps taken to ensure the participants' immediate and ongoing health and welfare the IRIS Consultant Agency reported actually occurred as reported. This process is known as the Remediation Approval Process (RAP).

OIM samples record reviews on a quarterly basis and completes the reviews on an ongoing basis throughout the first half of each quarter. The data, findings, and remediation activities are calculated and communicated to the ICAs during the second half of each quarter. OIM completes written reports providing analysis of the results of each indicator including the primary reasons for not met responses. OIM meets each month with the ICAs to discuss trends identified through the record review, provide technical assistance, and facilitate the quality management plan template process to address any system-level issues identified in the report. All remediation of individual negative findings takes place in the Record Review SharePoint site.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

○ **No**

◉ **Yes**

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

All components of the Quality Improvement Strategy are operational as of January 1, 2016. However, the OIM does anticipate that the various SharePoint sites used by OIM to facilitate the critical incident reporting, restrictive measure pre-review, resolution of participant complaints, and record review processes to be incorporated into WISITS by December 31, 2017. OIM does not anticipate this system improvement to cause any change in the method by which OIM provides oversight or the

frequency by which oversight occurs. OIM does anticipate that incorporating the SharePoint activities into WISITS will streamline OIM's ability to utilize the data because there will only be one system being used.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

TRENDING
The Office of IRIS Management (OIM) uses many sources of data to help identify trends and areas of potential program improvement including:
* Wisconsin IRIS Self-Directed Information Technology System (WISITS)
  * Enrollment
  * Disenrollment, including program requested disenrollment
  * Service utilization

* Long-term care outcomes and strategies
* Demographics
* Provider data, including participant-hired workers

* OIM-owned SharePoint sites (pending incorporation into WISITS)
* Record Review
* Critical Incident Reporting
* Fraud Allegation Review and Assessment (FARA)
* Budget Amendments and One-Time Expense Requests
* Notice of Action
* Restrictive Measures
* Participant Complaint

OIM monitors for upward and downward trends in results. ICAs and FEAs are all required to take action on agency-specific trends that fall below 86 percent.

PRIORITIZATION
OIM is part of the Bureau of Long Term Care Financing (BLTCF) within the Division of Long Term Care (DLTC) within the Department of Health Services (DHS). OIM answers to all levels of leadership within BLTCF, DLTC, and DHS relative to the prioritization of program-wide quality improvement strategies.

OIM overlaps with the following entities within DHS and seeks input relative to prioritization of quality strategies when appropriate:
* Bureau of Managed Care (BMC) relative to coordination of shared resources with Wisconsin's managed care program (Family Care) and matters concerning the Long Term Care Functional Screen (LTC FS)
* Bureau of Aging and Disability Resources concerning the Aging and Disability Resource Centers (ADRCs) and Adult Protective Services (APS) units
* Division of Health Care Access and Accountability concerning Medicaid card service utilization
* Division of Quality Assurance concerning regulatory activities of 3-4 bed Adult Family Homes (AFHs), Residential Care Apartment Complexes (RCACs), and Adult Day Cares
* Office of the Inspector General concerning matters of program integrity

OIM seeks input from the following entities external to DHS relative to the prioritization of quality improvement strategies when appropriate:
* Department of Justice concerning matters of program integrity
* IRIS Advisory Committee regarding changes to policies, work instructions, and process

OIM seeks input from the following groups when prioritizing quality improvement strategies when appropriate:
* IRIS participants via surveys and requests for comment
* IRIS consultant agencies
* IRIS fiscal employer agents
* Advocacy groups
* General public

OIM considers the input from all aforementioned parties and develops program-wide priorities accordingly. Leadership from OIM, BLTCF, and DHS approves the quality improvement strategies taking into consideration the needs of all entities involved. Generally, quality strategies that improve the areas of participant health and safety and program integrity are given greatest priority followed closely by strategies that build efficiencies within the program that enhance the participants' experience.

In addition to program-wide improvements, OIM prescribes ICAs and FEAs agency-specific quality improvement activities to achieve compliance with program requirements. OIM prioritizes required quality improvement strategies in the following order:
* Participant health and safety
* Program integrity
* Compliance with CMS performance measures
* Compliance with the OIM contract and certification criteria
* Participant satisfaction

IMPLEMENTATION
Prior to a program-wide implementation of a system-level improvement, the OIM develops the following deliverables to ensure a smooth transition:
* Process to address the identified need for the system-level improvement
* Policy and work instructions to support the newly created process
* SharePoint sites or components within the WISITS to collect data relative to the system-level improvement activities
* Method by which to measure progress and monitor compliance with the system-level improvement activities including

identifying the responsible parties
* Communication plan to educate participants, ICAs and FEAs, and other involved entities on the new system-level improvement activities
* Plan for evaluation of the success of the system-level improvement activities post-implementation
* Overall implementation strategy for all components of the system-level improvement activities

More frequently, the need arises for a system-level improvement within a single IRIS consultant agency or fiscal employer agent to achieve compliance with IRIS program requirements. The designated representative within OIM who is responsible for the oversight of the agency's quality management plan requires the agency to complete a Quality Management Plan template according to IRIS Policy Manual: Work Instructions section 10.4B.1 (P-00708A). The agency includes the following components on the Quality Management Plan template:
* Strategy for addressing the issue
* Method by which progress or compliance will be measured
* Agency personnel responsible for implementation
* Details of implementation

The agency must report quarterly to their assigned OIM representative on the progress on the agency's system-level improvement strategies unless otherwise arranged. OIM approves all templates. OIM and the agency meet quarterly to discuss progress on strategies and determine whether to continue the strategy, modify the strategy, or discontinue the strategy.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: ICAs and FEAs will be involved in activities as determined by the SMA	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The Office of IRIS Management (OIM) is responsible for evaluating the impact and effectiveness of system design changes. Prior to implementation, OIM develops a system by which the design change is monitored and measured. In some cases, this is accomplished through a performance measure included in the approved waiver. In other cases, OIM develops other reports via WISITS or one of the OIM-owned SharePoint sites to measure compliance and progress with the system design change.

OIM documents results of system change activities in a format to share as appropriate with DHS leadership, the IRIS Advisory Committee, the IRIS consultant agencies, the fiscal employer agents, IRIS participants, and other stakeholders as appropriate depending on the nature of the change. OIM's format contains a description of the issue, the desired outcome of the system change activities, the steps implemented to achieve the desired change, the method by which OIM measures progress, and a summary of findings upon completion of the activity.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

For each agency (ICA, FEA), the agency and its assigned OIM representative maintain a quality management tracking mechanism upon which the progress on approved quality management plan templates is documented. This occurs quarterly unless otherwise approved by OIM. During quarterly meetings with each agency, the OIM representative reviews the data with the agency and discusses whether OIM requires the agency to continue the strategy, modify the strategy, or discontinue the strategy. The IRIS Policy Manual: Work Instructions section 10.4B.1 (P-00708A) describes this process in section 10.4B.1.

For program-wide strategies, OIM maintains a Quality Management Plan upon which OIM documents the steps implemented and data collected at minimum quarterly. Project-specific evaluation occurs on an ongoing basis. OIM

modifies or replaces ineffective strategies. In addition, OIM reviews the program in its entirety annually as part of the data collection and evaluation for CMS 372 reporting. A formal review of the program occurs again after Waiver Year 3, when OIM examines the three years of data and compiles the causes of trends as well as implemented quality improvement strategies over the course of the three-year period. This report, known as the CMS Interim Procedural Guidance (IPG) report, informs the waiver renewal process.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department of Health Services ensures the financial integrity of payments that have been made for waiver services. The Division of Long Term Care (DLTC), Bureau of Long-Term Care Finance (BLTCF), Office of IRIS Management (OIM), and Division of Enterprise Services, Bureau of Financial Services (BFS) each have responsibilities in monitoring key aspects of financial accountability. These functions are described below.

The BLTCF provides oversight of the service utilization data reported to DHS by the fiscal employer agencies. Service utilization data is submitted to the Department through the encounter data reporting system. The FEA's are the exclusive submitter of data in this system. The encounter system collects data submitted electronically through a standard .xml file format. The encounter reporting system has edits in place to detect errors in reporting which reject errors and flag potential errors. The FEA's are notified of these errors. The FEA's correct and resubmit data until it is accepted by the system.

The state contracts directly with two types of service providers, IRIS Consultant Agencies and IRIS Fiscal Employer Agents (Reference Appendix C for service definitions). The DHS contract with the ICAs and F/EAs require each agency to have an annual independent third party audit for contract and expenditure compliance by a certified public accounting (CPA). The IRIS Section Chief in collaboration with BLTCF audit personnel who are also CPAs reviews the results of these audits. Any findings resulting from the independent third party must be remediated by the contracted agencies. The IRIS Section Chief takes advisement from the BLTCF audit personnel to implement corrective action with the contract agencies, including but not limited to updated policy and procedures and/or additional internal controls. These corrective actions are implemented and monitored through the contract quality assurance protocols established within the IRIS Section.

The BLTCF audit section will conduct data integrity audits annually, this audit will include the performance measure identified in this appendix. The audit includes the following submittal of encounter data encounter data submission claims submitted and certified within 30 days, service claims found compliant with claim submission standards and source data authorizations (i.e. Individual Support and Service Plans), and claim rate submission compared to source data authorizations (i.e. Individual Support and Service Plans). The audit conducted for claim submission standard will include the following areas of review service, frequency, authorization period, date of service, code, applicable modifiers, unit, and provider. BLTCF will document the findings in a best practice industry standard auditing format, and submit the finding report to the IRIS Section. As part of the provider's contractual obligations, providers are required to comply with any Corrective Actions required by the state including those required from audit findings.

The FEA certification process also includes requirements of the FEA's standard operating procedure internal controls. The SOP must include a a control to review 100% of claims submitted against the source data of the authorization. This review includes all of the claim submission standard outlined above. The State will also conduct annual audits of the policy and procedure manuals of each provider, this review will include all internal audit controls used during for claims processing. The IRIS section requires an annual review of the policy and procedure manual of each certified ICA and FEA provider. Providers are required to have their policy and procedure manual be 100% certified to comply with the States claim processing requirements, including put not limited to validation of participant enrollment, service date, service unit, service amount and qualified provider as reflected on the participant's plan.

In addition to the above annual audit, OIM also conducts audits of the claim file submitted to DHS bi-weekly for provider and participant hired worker payroll claims. This audit includes a check of 20% of the claims exceeding $2500.00 or more. The FEA certification.

The OIM has also developed and deployed functionality in the WISITS centralized system to help ensure finaincal integrity and accountability. Some of the features deployed in June of 2015 include:

1.) HCBS waiver codes and modifiers are hard coded into the system removing the opportunity for services to be miscoded compromising the integrity of the encounter data submission. The hard code can only be modified by the WISITS system administrator.

2.) All approved authorizations are submitted electronically to the FEA in standard .xml format eliminating the opportunity for data entry errors.

3.) A service cannot be added to an ISSP without an identified long term care outcome, strategy and status (e.g. in progress, maintaining).

4.) The plan setup page in WISITS also requires you identified the funding source of the service or support. If HCBS is chosen as the funding source the system is hard coded to allow only the services approved in Appendix C of this waiver to be chosen as a possible service to be authorized. This eliminates the opportunity to add a non-HCBS funded service to an ISSP under the HCBS funding source.

5.) The is a complete separation between provider set up and adding provider to an authorization. The FEA is the only entity allowed to add providers to the WISITS system and must follow the internal system controls in place in order to add a provider. These controls included organizational contact information, billing contact information including IRS and DOR tax identification information, rendering location, and licensure/certification validation of requested services.

6.) During new provider setup all providers must be linked only to the approved services they are eligible to provide. This eliminates the opportunity for providers to be added to an ISSP for a service they are not authorized to provide.

7.) In addition to the controls in place providers above participant hired workers are also link directly to the participant they are employed by, eliminating the opportunity for a PHW to be added to and ISSP of a participant they are not authorized to work for.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. ***Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.*** *(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of monthly encounter data submissions that were accepted and certified within 30 days. Numerator/Denominator: Number of monthly submissions accepted and certified within 30 days over the total number of submissions.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter reporting program database

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify: 	☐ **Annually**	☐ **Stratified** Describe Group:
	☑ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: TPA	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number of waiver service claims reviewed by Bureau of Long Term Care Financing (BLTCF) that are in compliance with the service claim standards as compared to the approved service authorization. Numerator: Number of service claim payments that are compliant with the service claim standards as compared to the approved service authorization. Denominator: Number of service claims reviewed by BLTCF.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Source Data and WISITS

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample**

		Confidence Interval = 95%
☐ **Other** Specify:	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number and percent of waiver service claims that had a rate of service that is consistent with the rate on the approved service authorization. Numerator: Number of waiver service claims with rates consistent with the approved service authorization. Denominator: Number of claims reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:

WISITS, Source data

Responsible Party for data collection/generation *(check each that applies):*	Frequency of data collection/generation *(check each that applies):*	Sampling Approach *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly	☐ 100% Review
☐ Operating Agency	☐ Monthly	☑ Less than 100% Review
☐ Sub-State Entity	☐ Quarterly	☑ Representative Sample Confidence Interval = 95%
☐ Other Specify:	☑ Annually	☐ Stratified Describe Group:
	☐ Continuously and Ongoing	☐ Other Specify:
	☐ Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis *(check each that applies):*
☑ State Medicaid Agency	☐ Weekly
☐ Operating Agency	☐ Monthly
☐ Sub-State Entity	☐ Quarterly
☐ Other Specify:	☑ Annually
	☐ Continuously and Ongoing
	☐ Other Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The State will conduct a data integrity audit to certify the FEA's encounter reporting as it does with all encounter reporting entities. The Department's encounter data integrity program is intended to both prevent and discover errors in the encounter data. This oversight results in corrective actions to be taken against the causes of the errors. Once a sample size is determined, random records are selected from the repository for review. These records are reviewed for completeness and consistency to assure an accurate reflection of the data sampled. These same records are compared with the FEA's systems to verify the data transmission. In some cases, these records will be traced back to the originating provider to ensure the

integrity of the data transferred between providers and the FEA.

In addition to the above, the Department conducts record reviews of the participant's ISSP to ensure on that the services included on the ISSP are allowable waiver services and that the goods and services are classified under the appropriate allowable waiver service for submission to the FEA. Any errors discovered as part of the record review process require 100% remediation of the participant's ISSP and may also require corrective action with the ICA that validated the ISSP including changes to policy and procedure and/or additional internal controls.

Data is not aggregated and analyzed for these performance measures on a daily basis. However, in several respects, the collection of the information is a continuous and ongoing process. The data aggregation and analysis takes place according to the schedules identified in the aggregation/analysis tables, typically on quarterly basis, with additional annual reporting.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
There are multiple approaches the state uses to address individual problems with financial integrity. For those issues that involve remediation of the claims submitted by providers to the 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 participant's or participant employee's they are required to complete additional training with the participant and the participant's employee(s) to ensure proper understanding of timesheet submission protocols.

Issues with individual claims submissions to the encounter system must be corrected through a reversal process. This process involves the 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. In turn, the state will use the fraud monitoring protocols to investigate the activity and take action the Department's Office of Inspector General when applicable.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☑ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

Within this renewal period the rates ranges established for the IRIS program will be done by the IRIS Section in collaboration with the BLTCF. The rate ranges established for the IRIS waiver services will be based on actual historical costs based on geographic region. The methods used to establish these rates will be identical in all jurisdictions where the IRIS program is furnished. The methods and standards used to establish the rates will be equivalent and any variation in rates would only be due to geographical complexities such as qualified provider availability. Providers will be able to comment on rate setting methodology and standards.

The state establishes guidelines for a suggested payment range based on market and geographic complexities of providers and analysis of historical costs per unit and trending program expenditures. These guidelines are shared with the ICAs who in turn educate participant's on these historical costs and trending to ensure Participants have the tools resources and information to negotiate the most cost effective rate with their providers including those providers employed directly by the participant. Participants may exceed these parameters in their rate agreements with service providers, but the total of all service expenses may not exceed the total the individual budget amount. If the participant's individual budget is not sufficient to meet the needs of the participant, budget amendment or one-time expense request can be made to the DHS. A committee within the DHS reviews these request using a standard set of criteria to determine if the request will be approved, partially approved, or denied. Additionally, documentation must be part of the participant's record when pay ranges exceed the expected range.

The state contracts directly with two types of service providers, IRIS Consultant Agencies and IRIS Fiscal Employer Agents (Reference Appendix C for service definitions). The state has established monthly rate for service for these services based on historical costs of services and participant enrollment in the program. As the state continues to promote and introduce competition through choice of provider of these services, the state will require implementation of best service delivery models from these providers in order to realize the most cost effective methods of delivering these services. The intention of the state is to implement the best practice methods and standards identified through competition of providers to ensure the most cost effective method of service delivery. Once the state has identified the best practice it will modify the certification criteria so all other providers adhere to the same best practice. If this best practice results in a rate driver reduction, the State would also reduce the rate of the provider based on the statewide implementation of the best practice. The addition of competition to the market of ICA and FEA providers will also help inform the state's rate setting methods for these services.

The state does not have established mandated rates for those services provided by participant hired workers. If the state established and mandated such rates the state would be viewed as the employer of the participant hired worker instead of the participant. The state has established the rates for two waiver services IRIS Consultant Agencies Services and IRIS Fiscal / Employer Agent Services. The methodology used to establish these rates included a review of historical costs associated with these services relevant to enrollment at the time the services were provided.

The rate for ICA and FEA services will be uniform across all counties in 2014 and 2015. The state may wish to adjust rates in future years based on ICA or FEA performance, regional variation, etc. If the state does implement a rate change, it will included in the certification criteria. The rates and/or methodology is included in the certification criteria which was publicly released in 2014.

WISITS will house the rate ranges for all services by region. Once the provider and participant have negotiated and agreed on a rate and the participant's plan has been approved, the FEAs will receive a prior authorization for each service generated by WISITS. The ICAs and the participants will have access to these rate averages via WISITS. The state will also provide ICAs a reference tool that has the rate averages for waiver services per region to help inform the participants and the ICAs of the average cost of services.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Department uses a FEA for claims adjudication and processing. There are two types of claims which are submitted for reimbursement within the IRIS waiver program, traditional provider claims, and participant-hired payroll claims.
Traditional Provider claims are submitted from provider agencies that provide services to participants in which the participant is not the employer. Examples of these services include Adult Family Home Services, Adult Day Care Services, and Supportive Home Care Services provided through a Supportive Home Care Agency. These types of claims will be submitted directly to the 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% all claim files submitted where the claim exceeds $2500.00

BFS staff prepares the documentation required for Federal Financial Participation and complete and certify the CMS-64. Additionally, claims paid are reviewed and analyzed by BFM staff through encounter reporting and IRIS quality assurance staff and through the participant record review process.

Additionally, the State utilizes the encounter data reporting system that was established and tested for Family Care for the SDS encounter reporting. The 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.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one)*:

- (○) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Providers, Participants and Participant hired workers are all instructed on claims submission and participant hired worker timesheet submission through different training mechanisms. The providers receive instruction on proper claim submission protocols from the FEA as part of the FEA's contractual obligations. Participants receive instruction on timesheet (claim) authorization and submission upon enrollment into the IRIS program from the ICA, as part of the ICA's contractual obligations. Participant hired workers receive instruction from the participant and the ICA on proper timesheet (claim) submission at the time they identified as a qualified participant hired worker.

Provider claims and PHW payroll claims are validated by the FEA through the prior authorization the FEA received from WISITS. This prior authorization includes, but is not limited to, the participant ID (ensuring waiver program eligibility), provider ID (ensuring validation of applicable provider licenses or certification), service type (ensuring allowable waiver services), service code, frequency, unit, rate, and date of service and authorization period. The FEA is responsible to assure that payment is only made when the participant was eligible for Medicaid waiver service payment on the dates of service and that the service was included in the participant's approved Individual Support and Service Plan and is within the allowable budget amount.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS (*select one*):

- **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system (s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

  a) DHS makes payments directly from a State-held bank account upon receipt of an appropriate payment file from the FEA.

  b) Payments are processed through the FEA claims adjudication system. The FEA claims adjudication system receives a prior authorization from WISITS. The FEA assures that payments to providers are in accordance with prior authorization generated from the participant's ISSP. Services that are not part of the ISSP or that exceed the approved use of the individual budget are denied.

  c) The FEA submits paid claims through the DHS encounter reporting system and certifies that the submitted claims are true and accurate. To ensure financial integrity and accountability, DHS performs audits of the FEA to check its certified paid claims against participants authorized individualized budgets, and to determine if there is documentation that the services for paid claims were included in the ISSP and individual budget and were rendered. Where deficiencies are identified, corrective action will be required, according to the terms of the contract.

  d) The draw of federal funds and claiming occurs based upon the information entered in the DHS encounter reporting system.

- **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☐ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- ☑ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The Department uses a FEA for claims adjudication and processing. There are two types of claims which are submitted for reimbursement within the IRIS waiver program, traditional provider claims, and participant-hired payroll claims. Traditional Provider claims are submitted from provider agencies that provide services to participants in which the participant is not the employer. Examples of these services include Adult Family Home Services, Adult Day Care Services, and Supportive Home Care Services provided through a Supportive Home Care Agency. These types of claims will be submitted directly to the 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% all claim files submitted where the claim exceeds $2500.00

BFS staff prepares the documentation required for Federal Financial Participation and complete and certify the CMS-64. Additionally, claims paid are reviewed and analyzed by BFM staff through encounter reporting and IRIS quality assurance staff and through the participant record review process.

Additionally, the State utilizes the encounter data reporting system that was established and tested for Family Care for the SDS encounter reporting. The 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.

Under no circumstances can a waiver service be directly billed to Medicaid. Waiver services are not included in the MA State plan, and would therefore be rejected.

In addition to the above, the Department conducts record reviews of the participant's ISSP to ensure on that the services included on the ISSP are allowable waiver services and that the goods and services are classified under the appropriate allowable waiver service for submission to the FEA. Any errors discovered as part of the record review process require 100% remediation of the participant's ISSP and may also require corrective action with the ICA that validated the ISSP including changes to policy and procedure and/or additional internal controls.

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- **No. The State does not make supplemental or enhanced payments for waiver services.**
- **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to State or Local Government Providers. *Specify whether State or local government providers receive payment for the provision of waiver services.*

- **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I-3-e.
- **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

County departments of human service, social services and community programs provide certain services in some counties. These services may be selected by participants in IRIS and are reimbursed by the FEA as authorized by the participant. These services could include:

Adult Family Home
Supportive Home Care
Day Services
Pre-vocational Services
Supported Employment
Specialized Transportation

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any**

supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**

The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

Appropriation of State Tax Revenues to the State Medicaid agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

Check each that applies:

- [ ] **Health care-related taxes or fees**
- [ ] **Provider-related donations**
- [ ] **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**
- (●) **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Residential settings other than the personal home of the participant specified in Appendix C where the State furnishes waiver services are required to break out the cost of room and board from the cost of allowable waiver services using the following guidelines prescribed by the State Medicaid Agency. In most instances the participant uses her or his own resources to pay for the cost of room and board.

A. The following are room and board costs for which FFP is unavailable. These costs may be included in its room and board rate as long as the facility can demonstrate that the costs are actually attributable to room and board. To calculate its room and board rate, a facility is to separate these costs actually attributable to room and board from other facility costs and divide this total by the number of residents licensed for the living arrangement. This room and board rate is paid for out of the waiver participant's personal maintenance allowance. Room and board costs must be facility specific. Items related to room and board

NOT ALLOWABLE waiver costs:

Rent, mortgage payments, title insurance, mortgage insurance.
Property and casualty insurance
Building and/or grounds maintenance costs Resident's food
Household supplies and equipment necessary for the room and board of the individual Furnishings used by the individual (does not include office furnishings)
Utilities, resident phones, cable TV, etc. Property taxes
Specific individual special dietary needs

B. The following are allowable elements in residential provider rates for which FFP can be claimed. Items related to personal care and supervision ALLOWABLE waiver costs
Staff costs
* Salaries*

* FICA
* Staff health insurance costs (benefits)
* Worker's compensation
* Unemployment compensation
* Staff travel
* Staff liability insurance
* Staff development/education
* Resident travel (includes depreciation on vehicle)

Administrative overhead-contractor's costs to do business, including:
* Office Supplies and Furnishings
* Percentage of administrative staff salaries
* Office telephone
* Recruitment
* Audit fees
* Operating fees/permits/licenses
* Percentage of office space costs
* Data processing fees
* Legal fees
* Agency liability insurance

In certain circumstances a staff person's wages and benefits may need to be apportioned between room and board costs and support and supervision. For example, a live-in manager of a facility, depending on her/his duties, may have time apportioned for supervision and support as well as building and ground maintenance.

Room and board costs are negotiated between the provider and the participant or legal decision-maker; the participant uses their own funds to cover these costs.

Currently the SMA gives providers the option to use Appendix J of Wisconsin Medicaid Waivers Manual that is used in other waiver programs (referenced in the web link - http://www.dhs.wisconsin.gov/bdds/waivermanual/app_j1.pdf) as a tool to distinguish room and board costs from service costs OR the residential provider can provide their own documentation of this breakdown. During the individual plan development process with participants, both the room and board costs and support/services costs are individual line items included on the plan. The FEA can only pay for services billed under the service/supports line, and not room and board.

In instances where the State or ICAs have questions as to whether the amount of the service includes room and board, the State requests a detailed breakdown of service costs from the provider. These requests also include the tool referenced in the above link distinguishing room and board costs.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

The rent and food expenses of an unrelated live-in caregiver, who does not hold the lease or own the residence, will be determined by dividing total household rent and food expenses by the number of residents in the home, including the caregiver. In other words, the caregiver is considered a resident in the home, and food and rent expenses are apportioned equally among all persons residing in the home. It is the responsibility of the ICA to document and report any waiver funds used to pay rent and food expenses of an unrelated live-in caregiver. These costs are authorized on the participants Individual Support and Service Plan and billed on an invoice that is submitted to the FEA. These costs are calculated on an estimated basis. The ICA reviews the calculations to ensure that only allowable items are calculated.

Participants are not reimbursed for these costs. Rather a direct payment is made to the live-in care provider. These costs are calculated on an estimated basis.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- (●) **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- ( ) **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] **Nominal deductible**
- [ ] **Coinsurance**
- [ ] **Co-Payment**
- [ ] **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Nursing Facility, ICF/IID

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	20282.75	18967.12	39249.87	67388.42	3652.59	71041.01	31791.14
2	20479.53	19558.01	40037.54	68650.83	3755.16	72405.99	32368.45
3	20657.27	20127.89	40785.16	70079.11	3864.70	73943.81	33158.65
4	20661.50	20543.07	41204.57	71046.85	3945.83	74992.68	33788.11
5	20856.61	21261.92	42118.53	72685.74	4088.15	76773.89	34655.36

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.**Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Nursing Facility	Level of Care: ICF/IID
Year 1	15716	10782	4934
Year 2	16739	11486	5253
Year 3	17772	12191	5581
Year 4	19006	13049	5957
Year 5	20638	14217	6421

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.**Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

Average Length of Stay is calculated by dividing the total number of projected enrollment days for the year by the number of projected unduplicated participants served during the year.

The total number of enrollment days for the year is calculated by summing the product of each month's projected enrollment multiplied by the number of calendar days in each month. Monthly projected enrollment is generally based on historical enrollment experience in the Self-Driected Supports (SDS) waiver. However, in counties that have people participating in legacy HCBS

waivers or on a waitlist, projected enrollment is based on the number of people in the legacy waivers or on a waitlist multiplied by the statewide proportion of eligible individuals that have chosen to enroll in the SDS waiver. The legacy waiver enrollment and the waitlists are the number of people known to be eligible for long term care. These numbers have been stable historically. When a county transitions, members have the option to enroll in either the Family Care (Waiver #0367) or SDS (Waiver #0484) program. The historical statewide proportion of members that have chosen to enroll in the SDS waiver during the previous transitions is used.

SDS waiver implementation in the remaining counties is dependent on legislative approval. Transition period assumptions are preliminary and are used for budgeting purposes only. Actual transition periods will be determined upon consultation with counties, ADRCs, Family Care PIHPs, and other interested parties after contracts have been awarded.

Transition to the Family Care and SDS waivers in seven northeast Wisconsin counties begins in CY2015 and the remaining eight counties are assumed to begin transitioning by the end of CY2019 consistent with assumptions in the approved Family Care waiver (#0367). Enrollment in counties beginning implementation in CY2015 is based on waiver and waitlist transition plans submitted by the counties and approved by the State. Enrollment in counties assumed to transition in CY2019 is based on CY2014 year end legacy waiver enrollment and waitlist data.

The transition periods for counties with existing waivers range from one to six months. The "transition period" is the length time it takes a county to transition their existing wavier population to the Family Care (#0367) or SDS (#0484) programs once the transition begins. This is dependent on the size of the population transitioning and PIHP and ADRC capacity. Dane and Rock counties are assumed to transition over a six month period; Brown and Shawano counties are assumed to transition over a four month period; Marinette county is assumed to transition over a three month period; Kewaunee, Oconto, and Door counties are assumed to transition over a two month period; and Adams, Florence, Forest, Menominee, Oneida, Taylor, and Vilas counties are assumed to transition within a single month.

Persons on a waitlist are assumed to be enrolled evenly over 36 months. The State has enrolled persons from waitlists in expanding counties evenly over 36 months since May 2009. Counties are required to submit a transition plan for State approval, which includes a requirement that the waitlist population be enrolled evenly over 36 months. Counties have the option to postpone waitlist enrollment until legacy waiver members are enrolled. By the second month after all legacy waiver members are transitioned, the number of people enrolled from the waitlist must be the same as if members on the waitlist had been enrolled evenly since the first month of waiver transition. The Department has already communicated to ADRCs the current number of individuals enrolled in the waivers or on the waitlist. This information provides a good basis by which to estimate of the total number of individuals who will receive enrollment counseling at the ADRC by the end of the 36 month period. The Department will continue to communicate with ADRCs to ensure they are fully informed of anticipated enrollment.

The number of unduplicated participants served during the year is calculated by adding the number of members expected to disenroll during the year to the projected participant count at the end of the year. A churn factor based on the waiver's historical monthly disenrollment rate is applied to the projected monthly member count to calculate the number of members projected to disenroll each month. The sum of the monthly disenrollments is then added to the projected member count at year end to arrive at the total number of unduplicated participants served during the year.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

The Factor D estimate is generally based on actual CY2014 SDS waiver service costs as reported in certified encounter data. This is the most recent calendar year of complete encounter data. Alternate data sources were used for the following services:

--Costs for IRIS Consultant Services and Fiscal/Employer Agent Services added as benefits in CY2015 are based on current contracted rates. These services are assumed to be utilized by all members.

--Live-in Caregiver, Housing Counseling, and Relocation-Housing Start-up and Related Utility Costs, and Nursing services all had low utilization with minimal encounter data available. In this case, additional years of SDS waiver encounter data was used as well as encounter data from the Family Care waiver (#0367), which is a similar population.

--Supported Employment is split between Individuals and Small Groups based on historical membership in each employment situation. This change was made based on the September 16, 2011 CMS Informational Bulletin updating the 1915(c) Waiver Instructions and Technical Guide regarding employment and employment related services. In this guidance, supported employment was changed into two separate 1915(c) waiver services, Supported Employment-Small Group Employment Support and Supported Employment-Individual Employment Support.

Service costs are trended using the target group specific trend factor in the individual budget allocation model. The ICF-IID

target popoulation is trended at approximately 1.0%. The Nursing Facility target population is trended at approximately 0.5%.

The unduplicated participant count in the derivation is projected using the same method to derive Average Length of Stay as described above.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is based on actual CY 2014 service costs paid by the State Medicaid plan for SDS waiver members as well as self-directed personal care costs. The portion of Factor D' related to self-directed personal care services is from certified encounter data. All other State plan service costs in Factor D' are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. The cost of prescribed drugs furnished to Medicare / Medicaid dual eligible under the provisions of Part D are not included in the estimate.

Average cost per member is trended forward at an annual rate of 3.1% using the Consumer Price Index for Medical Care. The trend for each factor is applied consistently in all five years in the application.

The unduplicated participant count used in the derivation is projected using the same method to derive Average Length of Stay as described above.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on a blend of CY2014 Medicaid institutional costs for individuals residing in ICFs-IID, State Centers, and Nursing Facilities to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. Costs are trended forward at an annual rate of 2.0% using the Consumer Price Index for All Items. The trend for each factor is applied consistently in all five years in the application.

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay between the institutional populations and the SDS waiver population. The average length of stay (ALOS) in the institutional population base data is 245 days. The ALOS for the wavier population is 306 days. With the institutional population having a lower ALOS, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional populations are adjusted by the ratio of the institutional ALOS to the wavier ALOS, which increases Factors G and G' for the SDS waiver population relative to the institutional population.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on a blend of CY2014 Medicaid non-institutional costs for individuals residing in ICFs-IID, State Centers, and Nursing Facilities to approximate a comparable institutionalized population. These costs are pulled from Medicaid fee-for-service paid claims data in the State's MMIS. Costs are trended forward at an annual rate of 2.8% using the Consumer Price Index for Medical Care. The trend for each factor is applied consistently in all five years in the application.

The annual average cost per participant is adjusted by a factor to reflect the variation in the average length of stay between the institutional populations and the SDS waiver population. The average length of stay (ALOS) in the institutional population base data is 245 days. The ALOS for the wavier population is 306 days. With the institutional population having a lower ALOS, it follows that the annual average cost per person is lower as well resulting in an artificially low institutional cost benchmark. To arrive at a comparable benchmark, the costs of the institutional populations are adjusted by the ratio of the institutional ALOS to the wavier ALOS, which increases Factors G and G' for the SDS waiver population relative to the institutional population.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Care	
Daily Living Skills Training	
IRIS Consultant Services	
Live-in Caregiver (42 CFR §441.303(f)(8))	
Prevocational Services	
Respite	
Supported Employment - Individual	

Waiver Services	
Nursing Services	
Fiscal Employer Agent Services	
1 -2 Bed Adult Family Home	
3-4 Bed Adult Family Home	
Adaptive Aids	
Assistive Technology/Communication Aids/Interpreter Services	
Consumer Education and Training	
Counseling and Therapeutic Services	
Customized Goods and Services	
Day Services	
Home Delivered Meals	
Home Modification	
Housing Counseling	
Personal Emergency Response System	
Relocation - Housing Start Up and Related Utility Costs	
Residential Care Apartment Complex	
Specialized Medical Equipment and Supplies	
Specialized Transportation 2	
Specialized Transportation	
Support Broker	
Supported Employment - Group	
Supportive Home Care	
Vocational and Futures Planning	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**1799409.39**
Adult Day Care	☐	hours	267	181.85	37.06	**1799409.39**	
Daily Living Skills Training Total:							**4172276.93**
Daily Living Skills Training	☐	hours	632	319.85	20.64	**4172276.93**	
IRIS Consultant Services Total:							**42319889.21**
IRIS Consultant Services	☐					**42319889.21**	
					GRAND TOTAL:		**318763689.19**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		318763689.19
					Total Estimated Unduplicated Participants:		**15716**
					Factor D (Divide total by number of participants):		**20282.75**
					Services included in capitation:		
					Services not included in capitation:		20282.75
					Average Length of Stay on the Waiver:		314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		months	15716	10.29	261.69		
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							**1150.19**
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	days	2	26.26	21.90	**1150.19**	
Prevocational Services Total:							**5535073.86**
Prevocational Services	☐	hours	914	708.29	8.55	**5535073.86**	
Respite Total:							**12855274.79**
Respite	☐	hours	2088	491.36	12.53	**12855274.79**	
Supported Employment - Individual Total:							**1779635.57**
Supported Employment - Individual	☐	hours	378	216.86	21.71	**1779635.57**	
Nursing Services Total:							**778331.53**
Nursing Services	☐	hours	16	1553.68	31.31	**778331.53**	
Fiscal Employer Agent Services Total:							**11556342.55**
Fiscal Employer Agent Services	☐	months	15716	10.29	71.46	**11556342.55**	
1 -2 Bed Adult Family Home Total:							**8157401.69**
1 -2 Bed Adult Family Home	☐	days	182	323.08	138.73	**8157401.69**	
3-4 Bed Adult Family Home Total:							**10903120.23**
3-4 Bed Adult Family Home	☐	days	239	307.39	148.41	**10903120.23**	
Adaptive Aids Total:							**1887792.93**
Adaptive Aids	☐	items	1132	59.73	27.92	**1887792.93**	
Assistive Technology/Communication Aids/Interpreter Services Total:							**43197.91**
Assistive Technology/Communication Aids/Interpreter Services	☐	items	25	40.59	42.57	**43197.91**	
Consumer Education and Training Total:							**135094.37**
Consumer Education and Training	☐	hours	71	55.28	34.42	**135094.37**	
Counseling and Therapeutic Services Total:							**2535945.17**
Counseling and Therapeutic Services	☐	hours	1566	55.25	29.31	**2535945.16**	
Customized Goods and Services Total:							**623342.43**
Customized Goods and Services	☐					**623342.43**	

GRAND TOTAL:	**318763689.19**
Total: Services included in capitation:	
Total: Services not included in capitation:	318763689.19
Total Estimated Unduplicated Participants:	**15716**
Factor D (Divide total by number of participants):	**20282.75**
Services included in capitation:	
Services not included in capitation:	20282.75
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		each	873	16.18	44.13		
Day Services Total:							**13510323.08**
Day Services	☐	hours	1469	248.03	37.08	**13510323.08**	
Home Delivered Meals Total:							**484264.50**
Home Delivered Meals	☐	meals	408	155.56	7.63	**484264.50**	
Home Modification Total:							**799861.85**
Home Modification	☐	projects	117	1.71	3997.91	**799861.85**	
Housing Counseling Total:							**15092.84**
Housing Counseling	☐	hours	2	164.41	45.90	**15092.84**	
Personal Emergency Response System Total:							**473341.13**
Personal Emergency Response System	☐	rent/mon	1536	9.12	33.79	**473341.13**	
Relocation - Housing Start Up and Related Utility Costs Total:							**277.99**
Relocation - Housing Start Up and Related Utility Costs	☐	each	3	0.51	181.69	**277.99**	
Residential Care Apartment Complex Total:							**106515.13**
Residential Care Apartment Complex	☐	days	11	226.19	42.81	**106515.13**	
Specialized Medical Equipment and Supplies Total:							**74525.18**
Specialized Medical Equipment and Supplies	☐	items	204	28.21	12.95	**74525.18**	
Specialized Transportation 2 Total:							**4098618.99**
Specialized Transportation 2	☐	trips	1752	124.04	18.86	**4098618.99**	
Specialized Transportation Total:							**7502258.48**
Specialized Transportation	☐	miles	4319	3101.85	0.56	**7502258.48**	
Support Broker Total:							**498257.16**
Support Broker	☐	hours	218	30.03	76.11	**498257.16**	
Supported Employment - Group Total:							**239878.06**
Supported Employment - Group	☐	hours	60	278.41	14.36	**239878.06**	
Supportive Home Care Total:							**185829139.43**
Supportive Home Care	☐	hours	14239	1067.98	12.22	**185829139.43**	

GRAND TOTAL:	**318763689.19**
Total: Services included in capitation:	
Total: Services not included in capitation:	318763689.19
Total Estimated Unduplicated Participants:	**15716**
Factor D (Divide total by number of participants):	**20282.75**
Services included in capitation:	
Services not included in capitation:	20282.75
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vocational and Futures Planning Total:							**48056.64**
Vocational and Futures Planning	☐	hours	11	95.43	45.78	**48056.64**	
					GRAND TOTAL:		**318763689.19**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		318763689.19
					Total Estimated Unduplicated Participants:		**15716**
					Factor D (Divide total by number of participants):		**20282.75**
					Services included in capitation:		
					Services not included in capitation:		20282.75
					Average Length of Stay on the Waiver:		314

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**1932587.54**
Adult Day Care	☐	hours	284	182.29	37.33	**1932587.54**	
Daily Living Skills Training Total:							**4493011.26**
Daily Living Skills Training	☐	hours	673	320.35	20.84	**4493011.26**	
IRIS Consultant Services Total:							**45497967.90**
IRIS Consultant Services	☐	months	16739	10.32	263.38	**45497967.90**	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							**1741.07**
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	days	3	26.32	22.05	**1741.07**	
Prevocational Services Total:							**5969772.23**
Prevocational Services	☐	hours	974	709.39	8.64	**5969772.23**	
Respite Total:							**13830470.97**
Respite	☐	hours	2223	492.21	12.64	**13830470.97**	
Supported Employment - Individual Total:							**1914196.00**
	☐					**1914196.00**	
					GRAND TOTAL:		**342806919.93**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		342806919.93
					Total Estimated Unduplicated Participants:		**16739**
					Factor D (Divide total by number of participants):		**20479.53**
					Services included in capitation:		
					Services not included in capitation:		20479.53
					Average Length of Stay on the Waiver:		314

Waiver Service/ Component	Capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Supported Employment - Individual		hours	402	217.23	21.92		
Nursing Services Total:							**834694.04**
Nursing Services	☐	hours	17	1557.73	31.52	**834694.04**	
Fiscal Employer Agent Services Total:							**12423926.84**
Fiscal Employer Agent Services	☐	months	16739	10.32	71.92	**12423926.84**	
1 -2 Bed Adult Family Home Total:							**8791046.48**
1 -2 Bed Adult Family Home	☐	days	194	323.63	140.02	**8791046.48**	
3-4 Bed Adult Family Home Total:							**11715729.17**
3-4 Bed Adult Family Home	☐	days	254	307.91	149.80	**11715729.17**	
Adaptive Aids Total:							**2027860.64**
Adaptive Aids	☐	items	1205	59.91	28.09	**2027860.64**	
Assistive Technology/Communication Aids/Interpreter Services Total:							**47172.07**
Assistive Technology/Communication Aids/Interpreter Services	☐	items	27	40.64	42.99	**47172.07**	
Consumer Education and Training Total:							**146116.60**
Consumer Education and Training	☐	hours	76	55.39	34.71	**146116.60**	
Counseling and Therapeutic Services Total:							**2729521.54**
Counseling and Therapeutic Services	☐	hours	1668	55.34	29.57	**2729521.54**	
Customized Goods and Services Total:							**671001.60**
Customized Goods and Services	☐	each	930	16.21	44.51	**671001.60**	
Day Services Total:							**14546521.27**
Day Services	☐	hours	1564	248.42	37.44	**14546521.27**	
Home Delivered Meals Total:							**520552.93**
Home Delivered Meals	☐	meals	435	156.02	7.67	**520552.93**	
Home Modification Total:							**859644.79**
Home Modification	☐	projects	125	1.71	4021.73	**859644.79**	
Housing Counseling Total:							**22899.52**
Housing Counseling	☐					**22899.52**	

GRAND TOTAL:	**342806919.93**
Total: Services included in capitation:	
Total: Services not included in capitation:	342806919.93
Total Estimated Unduplicated Participants:	**16739**
Factor D (Divide total by number of participants):	**20479.53**
Services included in capitation:	
Services not included in capitation:	20479.53
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		hours	3	164.65	46.36		
Personal Emergency Response System Total:							**508360.82**
Personal Emergency Response System	☐	rent/month	1636	9.15	33.96	**508360.82**	
Relocation - Housing Start Up and Related Utility Costs Total:							**279.30**
Relocation - Housing Start Up and Related Utility Costs	☐	each	3	0.51	182.55	**279.30**	
Residential Care Apartment Complex Total:							**117163.49**
Residential Care Apartment Complex	☐	days	12	226.85	43.04	**117163.49**	
Specialized Medical Equipment and Supplies Total:							**80368.43**
Specialized Medical Equipment and Supplies	☐	items	218	28.25	13.05	**80368.42**	
Specialized Transportation 2 Total:							**4412115.01**
Specialized Transportation 2	☐	trips	1866	124.25	19.03	**4412115.02**	
Specialized Transportation Total:							**8005085.63**
Specialized Transportation	☐	miles	4599	3108.24	0.56	**8005085.63**	
Support Broker Total:							**537951.73**
Support Broker	☐	hours	233	30.09	76.73	**537951.73**	
Supported Employment - Group Total:							**258932.69**
Supported Employment - Group	☐	hours	64	278.83	14.51	**258932.69**	
Supportive Home Care Total:							**199857215.86**
Supportive Home Care	☐	hours	15166	1070.51	12.31	**199857215.86**	
Vocational and Futures Planning Total:							**53012.49**
Vocational and Futures Planning	☐	hours	12	95.58	46.22	**53012.49**	
				GRAND TOTAL:			**342806919.93**
				Total: Services included in capitation:			
				Total: Services not included in capitation:			342806919.93
				Total Estimated Unduplicated Participants:			**16739**
				Factor D (Divide total by number of participants):			**20479.53**
				Services included in capitation:			
				Services not included in capitation:			20479.53
				Average Length of Stay on the Waiver:			314

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2071966.49**
Adult Day Care	☐	hours	302	182.42	37.61	**2071966.49**	
Daily Living Skills Training Total:							**4822526.85**
Daily Living Skills Training	☐	hours	715	320.57	21.04	**4822526.85**	
IRIS Consultant Services Total:							**48619372.23**
IRIS Consultant Services	☐	months	17772	10.32	265.09	**48619372.23**	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							**1755.70**
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	days	3	26.35	22.21	**1755.70**	
Prevocational Services Total:							**6400438.49**
Prevocational Services	☐	hours	1034	709.86	8.72	**6400438.49**	
Respite Total:							**14839642.41**
Respite	☐	hours	2361	492.58	12.76	**14839642.41**	
Supported Employment - Individual Total:							**2053111.82**
Supported Employment - Individual	☐	hours	427	217.37	22.12	**2053111.82**	
Nursing Services Total:							**890160.90**
Nursing Services	☐	hours	18	1559.06	31.72	**890160.90**	
Fiscal Employer Agent Services Total:							**13276835.63**
Fiscal Employer Agent Services	☐	months	17772	10.32	72.39	**13276835.63**	
1 -2 Bed Adult Family Home Total:							**9427228.16**
1 -2 Bed Adult Family Home	☐	days	206	323.85	141.31	**9427228.16**	
3-4 Bed Adult Family Home Total:							**12579931.07**
3-4 Bed Adult Family Home	☐	days	270	308.13	151.21	**12579931.07**	
Adaptive Aids Total:							**2169688.58**
Adaptive Aids	☐	items	1280	59.96	28.27	**2169688.58**	
Assistive Technology/Communication Aids/Interpreter Services Total:							**51211.65**
	☐	items				**51211.65**	

GRAND TOTAL:	**367120985.44**
Total: Services included in capitation:	
Total: Services not included in capitation:	367120985.44
Total Estimated Unduplicated Participants:	**17772**
Factor D (Divide total by number of participants):	**20657.27**
Services included in capitation:	
Services not included in capitation:	20657.27
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology/Communication Aids/Interpreter Services			29	40.68	43.41		
Consumer Education and Training Total:							**157144.05**
Consumer Education and Training	☐	hours	81	55.43	35.00	**157144.05**	
Counseling and Therapeutic Services Total:							**2926336.80**
Counseling and Therapeutic Services	☐	hours	1772	55.38	29.82	**2926336.80**	
Customized Goods and Services Total:							**719661.57**
Customized Goods and Services	☐	each	988	16.23	44.88	**719661.57**	
Day Services Total:							**15607922.02**
Day Services	☐	hours	1661	248.59	37.80	**15607922.02**	
Home Delivered Meals Total:							**555076.59**
Home Delivered Meals	☐	meals	461	156.17	7.71	**555076.59**	
Home Modification Total:							**919997.56**
Home Modification	☐	projects	133	1.71	4045.19	**919997.56**	
Housing Counseling Total:							**23147.13**
Housing Counseling	☐	hours	3	164.76	46.83	**23147.13**	
Personal Emergency Response System Total:							**543039.70**
Personal Emergency Response System	☐	rent/month	1737	9.16	34.13	**543039.70**	
Relocation - Housing Start Up and Related Utility Costs Total:							**280.60**
Relocation - Housing Start Up and Related Utility Costs	☐	each	3	0.51	183.40	**280.60**	
Residential Care Apartment Complex Total:							**127758.66**
Residential Care Apartment Complex	☐	days	13	227.07	43.28	**127758.66**	
Specialized Medical Equipment and Supplies Total:							**85804.42**
Specialized Medical Equipment and Supplies	☐	items	231	28.29	13.13	**85804.42**	
Specialized Transportation 2 Total:							**4732445.18**
Specialized Transportation 2	☐	trips	1982	124.36	19.20	**4732445.18**	
Specialized Transportation Total:							**8660817.71**
Specialized Transportation	☐	miles				**8660817.71**	

GRAND TOTAL:	**367120985.44**
Total: Services included in capitation:	
Total: Services not included in capitation:	367120985.44
Total Estimated Unduplicated Participants:	**17772**
Factor D (Divide total by number of participants):	**20657.27**
Services included in capitation:	
Services not included in capitation:	20657.27
Average Length of Stay on the Waiver:	314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
			4884	3111.06	0.57		
Support Broker Total:							**575339.47**
Support Broker	☐	hours	247	30.11	77.36	**575339.47**	
Supported Employment - Group Total:							**277959.72**
Supported Employment - Group	☐	hours	68	279.02	14.65	**277959.72**	
Supportive Home Care Total:							**213950816.44**
Supportive Home Care	☐	hours	16102	1071.55	12.40	**213950816.44**	
Vocational and Futures Planning Total:							**53567.83**
Vocational and Futures Planning	☐	hours	12	95.65	46.67	**53567.83**	
					GRAND TOTAL:		**367120985.44**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		367120985.44
					Total Estimated Unduplicated Participants:		**17772**
					Factor D (Divide total by number of participants):		**20657.27**
					Services included in capitation:		
					Services not included in capitation:		20657.27
					Average Length of Stay on the Waiver:		314

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2211233.12**
Adult Day Care	☐	hours	322	181.24	37.89	**2211233.12**	
Daily Living Skills Training Total:							**5169590.22**
Daily Living Skills Training	☐	hours	763	318.99	21.24	**5169590.22**	
IRIS Consultant Services Total:							**51979604.43**
IRIS Consultant Services	☐	months	19006	10.25	266.82	**51979604.43**	
					GRAND TOTAL:		**392692414.85**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		392692414.85
					Total Estimated Unduplicated Participants:		**19006**
					Factor D (Divide total by number of participants):		**20661.50**
					Services included in capitation:		
					Services not included in capitation:		20661.50
					Average Length of Stay on the Waiver:		312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							**1757.05**
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	days	3	26.17	22.38	**1757.05**	
Prevocational Services Total:							**6871102.25**
Prevocational Services	☐	hours	1104	706.45	8.81	**6871102.25**	
Respite Total:							**15914247.73**
Respite	☐	hours	2522	489.92	12.88	**15914247.73**	
Supported Employment - Individual Total:							**2202266.77**
Supported Employment - Individual	☐	hours	456	216.28	22.33	**2202266.77**	
Nursing Services Total:							**938949.23**
Nursing Services	☐	hours	19	1547.71	31.93	**938949.23**	
Fiscal Employer Agent Services Total:							**14193965.89**
Fiscal Employer Agent Services	☐	months	19006	10.25	72.86	**14193965.89**	
1 -2 Bed Adult Family Home Total:							**10108139.76**
1 -2 Bed Adult Family Home	☐	days	220	322.18	142.61	**10108139.76**	
3-4 Bed Adult Family Home Total:							**13474277.68**
3-4 Bed Adult Family Home	☐	days	288	306.51	152.64	**13474277.68**	
Adaptive Aids Total:							**2317408.98**
Adaptive Aids	☐	items	1369	59.50	28.45	**2317408.98**	
Assistive Technology/Communication Aids/Interpreter Services Total:							**55000.35**
Assistive Technology/Communication Aids/Interpreter Services	☐	items	31	40.47	43.84	**55000.35**	
Consumer Education and Training Total:							**167285.89**
Consumer Education and Training	☐	hours	86	55.12	35.29	**167285.89**	
Counseling and Therapeutic Services Total:							**3135765.10**
Counseling and Therapeutic Services	☐	hours	1893	55.07	30.08	**3135765.10**	
Customized Goods and Services Total:							**770026.04**
Customized Goods and Services	☐	each	1055	16.13	45.25	**770026.04**	
Day Services Total:							

GRAND TOTAL:	**392692414.85**
Total: Services included in capitation:	
Total: Services not included in capitation:	392692414.85
Total Estimated Unduplicated Participants:	**19006**
Factor D (Divide total by number of participants):	**20661.50**
Services included in capitation:	
Services not included in capitation:	20661.50
Average Length of Stay on the Waiver:	312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
							16750308.28
Day Services	☐	hours	1774	247.37	38.17	**16750308.28**	
Home Delivered Meals Total:							**592958.08**
Home Delivered Meals	☐	meals	494	154.88	7.75	**592958.08**	
Home Modification Total:							**982186.59**
Home Modification	☐	projects	142	1.70	4068.71	**982186.59**	
Housing Counseling Total:							**23271.60**
Housing Counseling	☐	hours	3	164.00	47.30	**23271.60**	
Personal Emergency Response System Total:							**579143.19**
Personal Emergency Response System	☐	rent/mon	1859	9.08	34.31	**579143.19**	
Relocation - Housing Start Up and Related Utility Costs Total:							**276.39**
Relocation - Housing Start Up and Related Utility Costs	☐	each	3	0.50	184.26	**276.39**	
Residential Care Apartment Complex Total:							**137247.48**
Residential Care Apartment Complex	☐	days	14	225.21	43.53	**137247.48**	
Specialized Medical Equipment and Supplies Total:							**91584.64**
Specialized Medical Equipment and Supplies	☐	items	247	28.09	13.20	**91584.64**	
Specialized Transportation 2 Total:							**5067400.24**
Specialized Transportation 2	☐	trips	2117	123.64	19.36	**5067400.24**	
Specialized Transportation Total:							**9197562.64**
Specialized Transportation	☐	miles	5221	3090.61	0.57	**9197562.64**	
Support Broker Total:							**616239.54**
Support Broker	☐	hours	264	29.93	77.99	**616239.54**	
Supported Employment - Group Total:							**295927.78**
Supported Employment - Group	☐	hours	72	277.71	14.80	**295927.78**	
Supportive Home Care Total:							**228789390.57**
Supportive Home Care	☐	hours	17221	1063.69	12.49	**228789390.57**	
Vocational and Futures Planning Total:							**58297.34**

GRAND TOTAL:		**392692414.85**
Total: Services included in capitation:		
Total: Services not included in capitation:		392692414.85
Total Estimated Unduplicated Participants:		**19006**
Factor D (Divide total by number of participants):		**20661.50**
Services included in capitation:		
Services not included in capitation:		20661.50
Average Length of Stay on the Waiver:		312

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vocational and Futures Planning	☐	hours	13	95.17	47.12	**58297.34**	
					GRAND TOTAL:		**392692414.85**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		392692414.85
					Total Estimated Unduplicated Participants:		**19006**
					Factor D (Divide total by number of participants):		**20661.50**
					Services included in capitation:		
					Services not included in capitation:		20661.50
					Average Length of Stay on the Waiver:		312

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§1915(c) Waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Care Total:							**2426673.43**
Adult Day Care	☐	hours	349	182.26	38.15	**2426673.43**	
Daily Living Skills Training Total:							**5646424.00**
Daily Living Skills Training	☐	hours	823	319.85	21.45	**5646424.00**	
IRIS Consultant Services Total:							**57081798.04**
IRIS Consultant Services	☐	months	20638	10.30	268.53	**57081798.04**	
Live-in Caregiver (42 CFR §441.303(f)(8)) Total:							**1778.41**
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	days	3	26.30	22.54	**1778.41**	
Prevocational Services Total:							**7500002.72**
Prevocational Services	☐	hours	1191	708.35	8.89	**7500002.72**	
Respite Total:							**17385240.28**
Respite	☐	hours	2724	491.32	12.99	**17385240.28**	
Supported Employment - Individual Total:							**2407015.04**
Supported Employment - Individual	☐	hours	492	217.05	22.54	**2407015.04**	
Nursing Services Total:							
					GRAND TOTAL:		**430438751.78**
					Total: Services included in capitation:		
					Total: Services not included in capitation:		430438751.78
					Total Estimated Unduplicated Participants:		**20638**
					Factor D (Divide total by number of participants):		**20856.61**
					Services included in capitation:		
					Services not included in capitation:		20856.61
					Average Length of Stay on the Waiver:		314

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
							1000059.10
Nursing Services	☐	hours	20	1556.27	32.13	**1000059.10**	
Fiscal Employer Agent Services Total:							**15587860.76**
Fiscal Employer Agent Services	☐	months	20638	10.30	73.33	**15587860.76**	
1 -2 Bed Adult Family Home Total:							**11073290.91**
1 -2 Bed Adult Family Home	☐	days	238	323.19	143.96	**11073290.91**	
3-4 Bed Adult Family Home Total:							**14722611.62**
3-4 Bed Adult Family Home	☐	days	311	307.36	154.02	**14722611.62**	
Adaptive Aids Total:							**2545603.00**
Adaptive Aids	☐	items	1486	59.96	28.57	**2545603.00**	
Assistive Technology/Communication Aids/Interpreter Services Total:							**59208.20**
Assistive Technology/Communication Aids/Interpreter Services	☐	items	33	40.51	44.29	**59208.20**	
Consumer Education and Training Total:							**183381.45**
Consumer Education and Training	☐	hours	93	55.42	35.58	**183381.45**	
Counseling and Therapeutic Services Total:							**3430282.36**
Counseling and Therapeutic Services	☐	hours	2047	55.16	30.38	**3430282.36**	
Customized Goods and Services Total:							**843163.95**
Customized Goods and Services	☐	each	1142	16.17	45.66	**843163.95**	
Day Services Total:							**18285453.35**
Day Services	☐	hours	1913	248.08	38.53	**18285453.35**	
Home Delivered Meals Total:							**651747.23**
Home Delivered Meals	☐	meals	537	155.80	7.79	**651747.23**	
Home Modification Total:							**1078416.80**
Home Modification	☐	projects	154	1.71	4095.15	**1078416.80**	
Housing Counseling Total:							**23563.03**
Housing Counseling	☐	hours	3	164.42	47.77	**23563.03**	

GRAND TOTAL:		**430438751.78**
Total: Services included in capitation:		
Total: Services not included in capitation:		430438751.78
Total Estimated Unduplicated Participants:		**20638**
Factor D (Divide total by number of participants):		**20856.61**
Services included in capitation:		
Services not included in capitation:		20856.61
Average Length of Stay on the Waiver:	314	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Emergency Response System Total:							**637672.94**
Personal Emergency Response System	☐	rent/mon	2024	9.14	34.47	**637672.94**	
Relocation - Housing Start Up and Related Utility Costs Total:							**283.25**
Relocation - Housing Start Up and Related Utility Costs	☐	each	3	0.51	185.13	**283.25**	
Residential Care Apartment Complex Total:							**148672.26**
Residential Care Apartment Complex	☐	days	15	226.60	43.74	**148672.26**	
Specialized Medical Equipment and Supplies Total:							**100582.81**
Specialized Medical Equipment and Supplies	☐	items	268	28.05	13.38	**100582.81**	
Specialized Transportation 2 Total:							**5545150.27**
Specialized Transportation 2	☐	trips	2290	123.86	19.55	**5545150.27**	
Specialized Transportation Total:							**9997517.62**
Specialized Transportation	☐	miles	5659	3099.40	0.57	**9997517.62**	
Support Broker Total:							**674988.60**
Support Broker	☐	hours	286	30.00	78.67	**674988.60**	
Supported Employment - Group Total:							**324425.09**
Supported Employment - Group	☐	hours	78	278.40	14.94	**324425.09**	
Supportive Home Care Total:							**251012357.42**
Supportive Home Care	☐	hours	18707	1067.47	12.57	**251012357.42**	
Vocational and Futures Planning Total:							**63527.83**
Vocational and Futures Planning	☐	hours	14	95.39	47.57	**63527.83**	

GRAND TOTAL:		**430438751.78**
Total: Services included in capitation:		
Total: Services not included in capitation:		430438751.78
Total Estimated Unduplicated Participants:		**20638**
Factor D (Divide total by number of participants):		**20856.61**
Services included in capitation:		
Services not included in capitation:		20856.61
Average Length of Stay on the Waiver:	314	